

Communicable Disease Newsletter

Mapping of Neglected Tropical Diseases in the South-East Asia Region

Neglected tropical diseases (NTDs) continue to have crippling effects on at least one billion people living in poverty. Even though 26.5 % of the 6.8 billion (2010) of the world population live in the South-East Asia Region, an estimated 0.5 billion (about 50%) of the one billion people living in poverty are in this Region. SEA Region is the second among WHO Regions with largest burden of NTDs.

Lymphatic filariasis (LF), soil transmitted helminthiasis (STH), visceral leishmaniasis (VL), trachoma, yaws, schistosomiasis, dengue, rabies, leprosy, leptospirosis, Japanese encephalitis (JE) and Chikungunya¹ are reported from one or more of the Member States of this Region. Mapping of country-wise information on NTDs (Fig.1 and

Table 1) showed that India and Indonesia bear the maximum burden of NTDs since they report 11 and 10 NTDs respectively. The lowest burden is in DPR Korea (2).

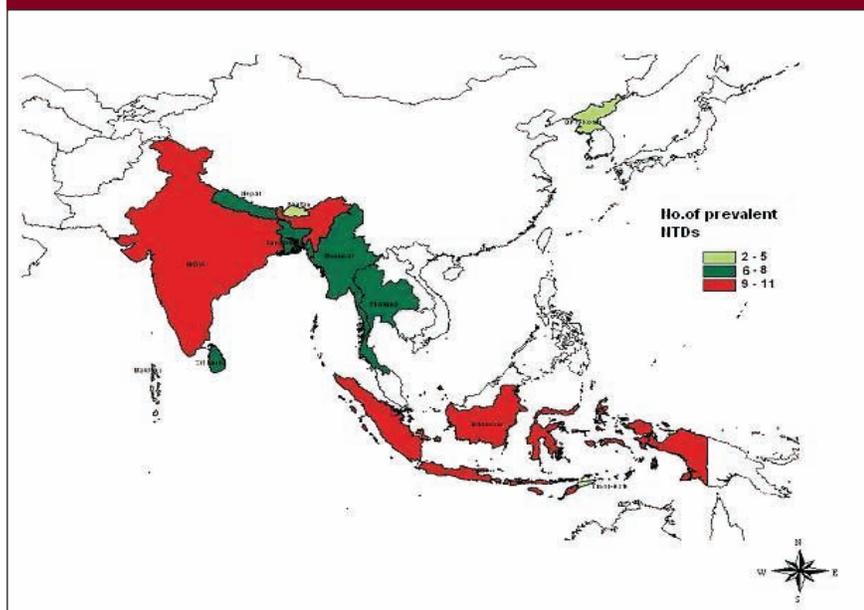
The commonly reported NTDs from the countries are lymphatic filariasis (nine countries), soil transmitted helminthiasis (11 countries), leprosy (11 countries), dengue (10 countries), rabies (eight countries), visceral leishmaniasis (four countries), trachoma (three countries), Japanese encephalitis (6 countries) and Chikungunya (5 countries). Schistosomiasis (some pockets in one province in Indonesia) and yaws (isolated pockets in Indonesia and Timor-Leste) are still prevalent. India eliminated yaws in 2006.

The Region has achieved tremendous success in controlling some of the major NTDs like leprosy, lymphatic filariasis and yaws by implementing effective interventions.

Multidrug therapy (MDT) with rifampicin, clofazimine and dapsones for leprosy, annual mass drug administration (MDA) with Diethyl carbamazine citrate (DEC) and albendazole for lymphatic filariasis and a single dose injection benzthine penicillin for cases and contacts in yaws proved to be very effective in reducing the disease burden. Leprosy is eliminated as a public health problem in all the

¹ Though Chikungunya is not listed as an NTD, it is included here in view of its importance in the Region and since it occurs with dengue.

Figure 1: Country-wise distribution of number of Neglected Tropical Diseases in South-East Asia Region.



Inside

- Mapping of Neglected Tropical Diseases in the South-East Asia Region 1
- Outbreaks and public health emergencies 2
 - Situation update of dengue in the South-East Asia Region, 2010
 - Influenza (H1N1) 2009: Post-pandemic period or inter-pandemic period
 - Unusual outbreak of human anthrax in Bangladesh
- Progress Updates 6
 - HIV/AIDS in the South-East Asia Region—status update 2010
 - WHO-FAO-OIE Collaboration in animal-human-ecosystems interface in the South-East Asia Region
 - Tuberculosis Control in the South-East Asia Region shows steady progress
- NewsBytes 8
- New SEARO publications 11
- Surveillance corner 12

Table 1: Country-wise distribution of Neglected Tropical Diseases in the South-East Asia Region

Country	LF	STH	VL	TRA	Yaws	SCH	Dengue	Rabies (2008)	LEP	LEPTO (2008)	JE	CHI	Total
1. Bangladesh	X	X	X				X	X	X				6
2. Bhutan		X	X				X	X	X				5
3. DPR Korea		X							X				2
4. India	X	X	X	X	X *		X	X	X	X	X	X	11
5. Indonesia	X	X			X	X	X	X	X	X	X	X	10
6. Maldives	X	X					X		X			x	5
7. Myanmar	X	X		X			X	X	X		X	x	8
8. Nepal	X	X	X	X			X	X	X		X		8
9. Sri Lanka	X	X					X	X	X	X	X		7
10. Thailand	X	X					X	X	X	X	X	x	8
11. T. Leste	X	X			X		X		X				5

LF: Lymphatic filariasis; STH: Soil transmitted helminthiasis; VL: Visceral Leishmaniasis (Bhutan reported only 6 cases in 2006); TRA: Trachoma (no information after 2006 in India); SCH: Schistosomiasis; Rabies (2008 data); LEP: Leprosy; Lepto-Leptospirosis (2008 data); JE: Japanese Encephalitis; CHI: Chikungunya; X* India eliminated yaws (2006) and moving towards eradication

Member States except in one. Two of the nine endemic countries have reached the point of elimination of lymphatic filariasis. India has declared yaws elimination (reaching zero new case) in 2006 and heading towards eradication. MDA (albendazole component) in LF elimination programme also has its impact on STH control. Visceral Leishmaniasis elimination in three endemic countries (India, Nepal and Bangladesh) is progressing well. MDT blister packs and MDA (albendazole) is supplied free to the programmes through WHO.

However, there is a need to concentrate efforts to maintain the gains and to control other NTDs with an integrated approach since many NTDs are overlapping in some countries and population-based preventive chemotherapy (as applicable) is to be implemented in endemic countries. WHO and big donor/development agencies recommend integrated neglected tropical diseases control strategies wherever applicable. Nepal

and Myanmar have already developed such a plan. Indonesia is in the process of developing it. Integrated vector management (IVM) as an additional effective tool is being emphasized to scale up NTDs control.

To achieve the global targets of elimination and address the issues of sustainability and disabilities, with continued technical and financial assistance to the Member States, the Region would need to focus on advocacy of donors/partners and governments to allocate adequate resources.

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Outbreaks and Public Health Emergencies

Situation update of dengue in the South-East Asia Region, 2010

It is estimated that nearly 50 million dengue infections occur annually in the world. Dengue Fever/ Dengue Haemorrhagic Fever (DF/ DHF) have been reported all over the world but WHO South-East Asia Region (SEAR) together with the Western Pacific Region bears nearly 75% of the current global disease burden.

Dengue is described as 'endemic' in many countries in the SEAR. In 2003, eight countries — Bangladesh, India, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand and Timor-Leste — reported dengue cases followed by an outbreak

in Bhutan in 2004 and first indigenous dengue case in Nepal in November 2006. The Democratic Peoples' Republic of Korea is the only SEAR country that has not reported indigenous dengue cases. Table 2 shows the number of reported cases of dengue in Member States in the Region.

Overall, for the majority of countries in the Region, the total cases reported so far in 2010 (between January and October/ November) are lower than the total in 2009, largely due to lower number of cases in Indonesia. India and Thailand experienced an upsurge in reported cases of dengue in 2010, while there were outbreaks in Timor Leste and Nepal. Dengue in Delhi claimed eight deaths among 6229 reported cases in

July - November, 2010 (Figure 2). In Timor Leste, there was an outbreak of dengue in Manatuto district and a total of 284 cases (no deaths) were reported (Figure 3). Similarly in Nepal, there were outbreaks of dengue in Chitwan (398 cases out of 1896 samples tested) and Rupendehi (93 cases and 1 death), and Dhangadi (15 cases) areas.

Figure 2: Weekly trend of dengue cases in Delhi, 2010

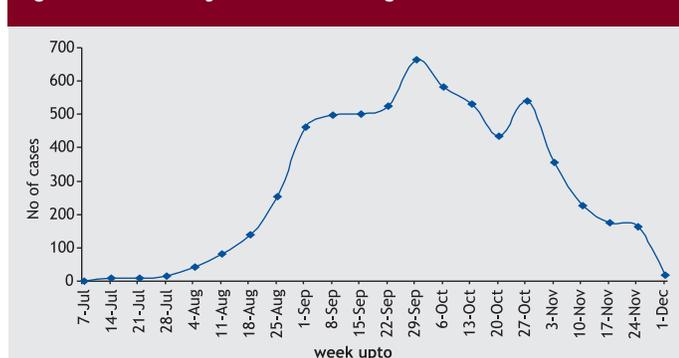
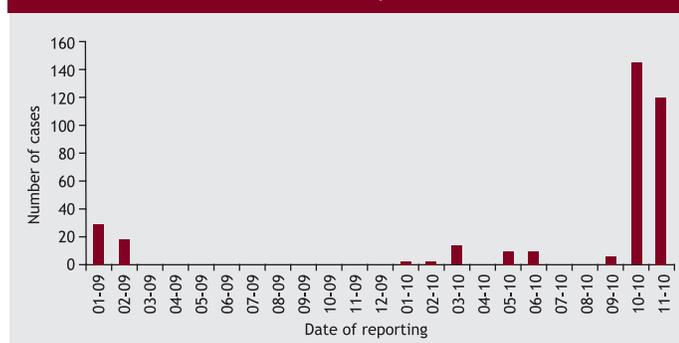


Figure 3: Number of reported dengue cases by month, Manatuto district, 2009-2010



There was a sudden increase in the number of reported cases of dengue in Sri Lanka in 2009 and the trend is

continuing. In other countries such as Bangladesh, Myanmar, Maldives it is following an endemic pattern. It must be noted that the number of reported cases in Bangladesh and India is lower than other countries because of variation in reporting. Bangladesh and India report only laboratory-confirmed cases while the reported case count in other countries include confirmed/ probable/ and suspected cases.

In different countries in the Region, the seasonal pattern of dengue differs: high number of cases is seen in India in August - November while in Indonesia, the peak is January and February. Myanmar and Sri Lanka have reported more cases between May and August.

It can be seen that the incidence of reported cases in selected countries in the Region varies (Table 2). The fluctuations in the incidence over the years are characteristic of dengue, which causes outbreaks periodically.

The exact reason for this upsurge in reported cases is not clear, but weather patterns, especially relative increases in rainfall and climate change are very likely to be an important feature. Patterns of dengue cases can be challenging to explain and predict, because they are influenced by a large number of different factors, including climate, movements of mosquitoes, type of dengue virus that is circulating, environmental factors such as temperature and humidity and human behaviour. In India and Thailand, the prominent strain of dengue has been DEN 1 which is linked with high morbidity and low mortality. Overall in countries in SEAR, there has been slight decrease in the Case Fatality Rate (CFR) in the past 10 years which may be attributed to increased awareness among the medical community and training to improve case management of dengue.

However, the WHO Regional Office for South-East Asia is monitoring trends closely to determine the burden of

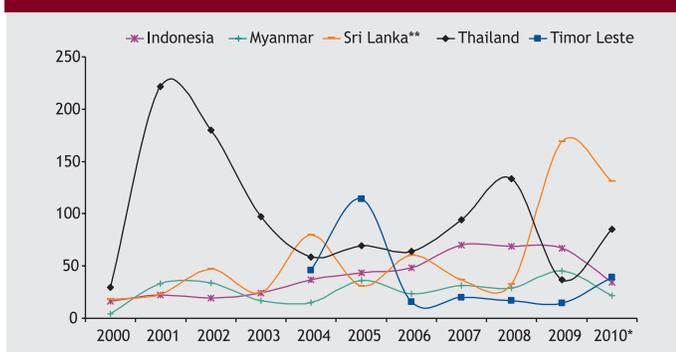
Table 1: Number of cases of DF/ DHF in the South-East Asia Region

Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010**
Bangladesh*	5,551	2,430	6,132	486	3,913	1048	2200	466	1153	474	76
Bhutan	0	0	0	0	2,579	11	116	86	73	351	16
DPR Korea	0	0	0	0	0	0	0	0	0	0	0
India*	650	3,306	1,926	12,754	4,153	11985	12317	5023	12561	15535	25725
Indonesia	33,443	45,904	40,377	51,934	79,462	95279	106425	157442	155607	156052	80065
Maldives	180	73	27	38	742	1126	2768	1680	1476	774	550
Myanmar	1,884	15,695	16,047	7,907	7,369	17454	11383	15285	14480	24287	11704
Nepal	0	0	0	0	0	0	25	3	6	30	2
Sri Lanka	3,343	4,304	8,931	4,749	15,463	5994	11980	7314	6555	35010	33599
Thailand	18,617	139,327	114,800	62,767	38,367	45,893	42456	62949	89626	25194	57948
Timor-Leste					434	1128	162	210	186	175	479
SEAR	63,668	211,039	188,240	140,635	152,482	179918	189832	250458	281723	257882	210164

*Only confirmed cases

** The reporting end dates in different countries are different. For some it is October and for others it is November 2010

Figure 4: : Incidence of reported DF/ DHF (including confirmed/ probable/ suspected cases) per 100,000 in selected Member States



dengue. Dengue is considered a public health priority by WHO and for this reason, a bi-regional SEARO / WPRO Asia Pacific Dengue Strategic Plan (2008–2015) has been developed in

consultation with Member States and development partners, as a first step in responding to the increasing threat. The plan aims to support countries to reverse the rising trend of dengue by enhancing their preparedness to rapidly detect, characterize and contain outbreaks, and to stop the spread to new areas. However much more needs to be done in terms of mobilizing human and financial resources, improving surveillance and response systems, and fostering a greater political will to tackle the threat effectively.

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Influenza (H1N1) 2009 in the post-pandemic period or inter-pandemic period

In April 2009 the World Health Organization declared the emergence of a novel influenza virus: a quadruple reassortant influenza A/H1N1 virus from North America. It rapidly spread around the world. In June 2009, the WHO Director-General declared the start of the first global pandemic of the 21st century.

WHO collaborated with Member States of all Regions to closely monitor the situation. Initially, contact tracing and case-based reporting was conducted to study the epidemiological characteristics of this novel virus, including assessment of who and how the people were being affected, risk factors associated with severe cases and deaths, and virological characteristics including drug resistance. As the pandemic progressed, the case count was found to be of limited use and a simplified monitoring system with reporting on four qualitative indicators, namely geographical spread, trend, intensity and impact on the health-care system, was introduced. On 10 August 2010, the Director-General declared that the pandemic was over; by then 18 449 deaths had been reported worldwide. In the SEA Region 76 302 cases and 2054 deaths had been reported.

The Director-General noted that in the post-pandemic period it was likely that the pandemic (H1N1) 2009 virus would continue to circulate as a seasonal virus for some years. Several Member States of the WHO South-East Asia Region continue to report cases of the pandemic virus; Sri Lanka is currently experiencing a second wave and India and Thailand continue to report cases each week although the trend is on a downswing.

The H1N1 pandemic proved that investment in testing and preparing Pandemic Influenza Preparedness Plans (though

it was for a high mortality H5N1 scenario) significantly improved capabilities to diagnose and respond to public health emergencies. It also revealed how quickly health systems, laboratory diagnostic capacity and response capacity can be overwhelmed.

In this era of emerging and re-emerging infections when climate change and increasing human-animal interface provides the necessary conditions for the emergence of a novel virus, this pandemic should be viewed as an opportunity to further strengthen our surveillance, alert and response systems.

It is recommended that Member States:

- Maintain monitoring for severe acute respiratory infections through routine respiratory disease surveillance (including SARI and ILI surveillance) supplemented with strengthening laboratory capacity.
- Undertake assessments to broaden preparedness plans to address emerging and re-emerging infections as required under the International Health Regulations (IHR) 2005 and bolster preparedness at subnational levels
- Strengthen response capacity by investing in health infrastructure and self-reliant systems for the production of pharmaceuticals such as antivirals and vaccines.
- Develop the necessary human resource capacity.
- Undertake research on effectiveness of non-pharmaceutical public health measures such as regular handwashing, and disseminate communication messages in accordance with local sociocultural and contextual factors.

Continue to support WHO in ensuring global health security through transparency in sharing relevant information for “public good” and building a system which is built on human values, honesty, trust and scientific principles.

(The authors thankfully acknowledge the contributions made by Member States of the SEA Region in sharing their data, situation and response with WHO SEARO).

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Unusual outbreak of human anthrax in Bangladesh

On 18 August 2010 media reported an outbreak of anthrax in Sirajganj district, followed by six more outbreaks in Sirajganj and Pabna districts. A team from the Institute of Epidemiology, Disease Control and Research, the International Centre for Diarrhoeal Disease Research, Bangladesh and the World Health Organization (WHO) investigated the epidemiological, clinical and exposure history of suspected human and animal illnesses. Of 168 identified cases, 146 were interviewed. All cases had typical skin lesions of cutaneous anthrax and were treated with ciprofloxacin for at least 10 days. All had a history of either slaughtering sick animals or handling raw meat of sick animals or being present at slaughtering sites. Among 65 sick animals identified, 43 (66%) were cattle and 22 (34%) were goats or sheep. Twenty three of them were slaughtered. Ninety per cent of the dead animals were disposed in water or in an open field.

The Bangladesh government issued a red alert on 5 September due to the unusual anthrax outbreak in human and animal populations. From 18 August - 4 October 2010, 607 cases were reported from 12 districts, with no deaths. In April-June 2010, 44 such human cases had been reported. In contrast, the first detailed investigation of human anthrax outbreak in Bangladesh in 2009 had reported 55 cases.

Actions taken

- Increased mass awareness through media and public announcements.
- Setting up anthrax checkpoints at cattle markets.
- Improved vaccination coverage of cattle by proper implementation of the vaccination campaign and building awareness among farmers.
- Formation of a task force, including ministries, dealing with health, livestock and local government.
- Orientation of physicians and field health workers of the affected districts on identification, reporting and treatment of anthrax under WHO assistance.

Socioeconomic impact

The anthrax outbreak was a disaster for farmers in northeastern Bangladesh, a dairy pocket area. Bangladesh exported hide and leather worth of US\$ 460 million in 2009. Beef consumption and prices plummeted after media coverage, which reported 66



people being infected in one day in one affected district. The consequent sharp fall in cattle slaughter and limited supply of hides seriously affected the 60 tanneries employing more than 70 000 workers.

Recommended actions

- Develop national strategy for prevention and control of anthrax.
- Establish strong coordination mechanism between the public health and animal health sectors.
- Intensify surveillance and reporting of anthrax in animal and human populations.
- Carry out operational research for behaviour change communication.
- Carry out mass immunization of cattle in outbreak areas before the monsoon.
- Introduce compensation schemes for farmers for cattle that died of anthrax to prevent slaughter of diseased or sick animals and improve reporting.

Conclusion

Human anthrax is an emerging zoonotic disease problem in Bangladesh. It is likely that anthrax is endemic in northwestern Bangladesh and is currently assuming epidemic proportions. The current outbreak is the biggest in the country's history. Globally, concern over anthrax was high after 2001. Most of the cases presented with cutaneous anthrax, but the likelihood of intestinal anthrax cannot be ruled out.

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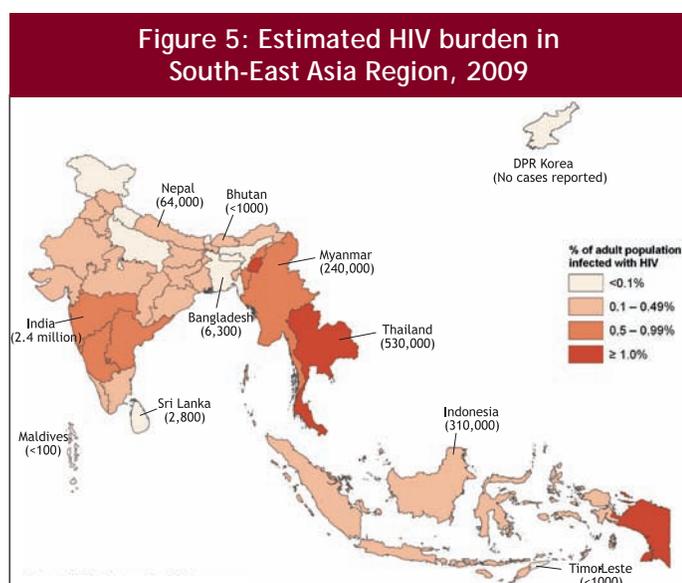
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Progress Updates

HIV/AIDS in the South-East Asia Region— status update 2010

The number of people living with HIV/AIDS (PLHIV) in SEAR has remained constant at an estimated 3.5 million since a year ago. The numbers vary widely between countries (Figure 5), with five countries – India, Thailand, Myanmar, Indonesia and Nepal – accounting for the majority of cases. In this Region, more than a third of PLHIV are women – in contrast, globally, women account for little more than half. The number of new infections fell by 31% from 2001 to 2009 indicating the halting and reversing of the HIV/AIDS epidemic in the Region.



Unsafe sex and injecting drug use are the main drivers of the epidemic in South-East Asia. HIV infection rates are much higher (up to 50 times in some cases) among high-risk populations, i.e. sex workers and their clients, men who have

sex with men, and injecting drug users. The Region also carries about 15% of the global burden of HIV/TB.

With increased feminization of the epidemic, and onward transmission of the virus to their children, the number of children living with the disease has grown from an estimated 89 000 in 2000 to 130 000 in 2009. Thailand's perinatal HIV transmission rate had decreased to less than 3% due to high coverage of prevention of mother-to-child transmission (PMTCT) interventions and effective triple antiretroviral prophylaxis. Myanmar has also significantly increased PMTCT coverage. Despite these achievements, overall in the Region only 34% of pregnant women have access to PMTCT. Further progress will be driven by increasing coverage of PMTCT services in India which accounts for 75% of the HIV-infected pregnant women needing prophylaxis or treatment.

Important accomplishments in combating HIV/AIDS in the Region include high levels of condom use among sex workers and clients leading to reduction in HIV prevalence among sex workers in Thailand and south India; 100% screening of transfused blood preventing hundreds of thousands of TTIs; launch of the elimination of congenital syphilis programme in four countries; ten-fold scale up of ART programme with 577 000 people with advanced HIV infection receiving ART by the end of 2009.

In addition, substantial progress has been made in expanding surveillance systems in the Region. Key challenges include continuing stigma and discrimination faced by PLHIV and most-at-risk populations (MARPs), limited capacity of health systems, high prices of antiretroviral drugs and lack of sustained finances.

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WHO-FAO-OIE Collaboration in animal-human-ecosystems interface in the South-East Asia Region

A major global challenge is the spread of infectious diseases that emerge (or re-emerge) from the interface between animals and humans and the ecosystems in which they live. Severe Acute Respiratory Syndrome, avian influenza (H5N1) and Nipah virus are classical examples. This is a result of the exponential growth in human and livestock populations, rapid urbanization, rapidly changing farming systems, closer integration between livestock and wildlife, forest encroachment, changes in ecosystems and globalization

of trade in animal and animal products. The avian influenza (H5N1) outbreak since 2003 has clearly demonstrated the need for close collaboration between human and animal health sectors, i.e. a holistic, multidisciplinary approach. This concept provides a framework for preventing emerging infectious diseases of animal origin, instead of simply responding to them once they have occurred.

There is a growing acceptance of this concept and usage. The International Ministerial Conference on Animal and Pandemic Influenza held in Hanoi in April 2010 reiterated the need to move forward and adopt the holistic, multi-disciplinary approach at country-level. Since the scope, priority and

approaches are different in human public health and animal health institutions, an integrated and/or coordinated approach for its implementation is necessary. Veterinary public health service is rudimentary in most developing countries and it is estimated that USD 1.3 billion will be required annually to implement this approach till 2020.

WHO is one of the contributors in developing a strategic framework for reducing risks of infectious diseases. Multiple donors and partners are also supportive. FAO, OIE and WHO are working together on a regional cooperation project funded by the European Commission in collaboration with ASEAN and SAARC. Similarly the USAID-funded 'IDENTIFY' Project, coordinated by WHO, FAO and OIE at the Regional level, aims to strengthen surveillance and laboratory capacities of Mekong-basin and Gangetic-basin countries. WHO-SEARO has been providing technical support to Member States in the following areas in line with the Regional Strategic Framework for Prevention and Control of Zoonoses and the recommendations of the Regional Zoonoses Meeting held in November 2007 in Jakarta:

- Encourage countries to establish an intersectoral coordination mechanism;
- Create a forum to share information and best practices;
- Establish networking of epidemiology and laboratory units;
- Promote joint training programmes for animal and human health professionals.

The WHO Regional Offices for South-East Asia and the Western Pacific have jointly formulated the Asia-Pacific Strategy for Emerging Diseases (2010) which advocates for strengthening coordination between animal health and public health sectors for prevention and control of emerging diseases under zoonoses framework.

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Tuberculosis Control in the South-East Asia Region shows steady progress

Countries in the South-East Asia Region have continued to make steady progress with tuberculosis (TB) control (Figure 6). The number of notified TB cases has been steadily increasing with more than two million TB patients initiated on treatment in the Region during 2009. Based on data from National TB programmes in Member States in 2009, nine

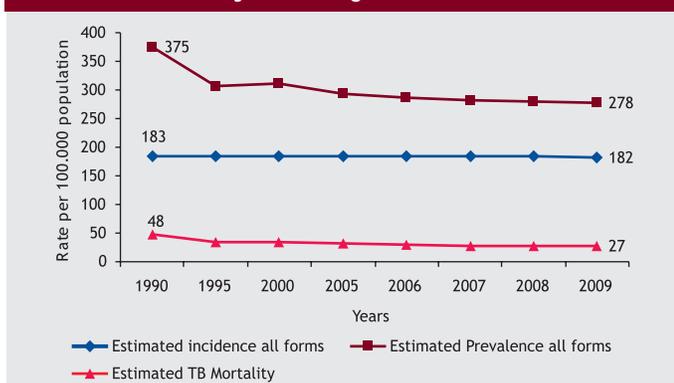
countries in the Region have now achieved or surpassed the 85% treatment success target; the overall treatment success rate achieved in the Region as a whole was therefore 88%, close to the current target of 90%. Major achievements during the year were the establishment and scaling up of interventions for TB/HIV, multidrug-resistant TB and further expansion of private and public partnerships for the provision of TB care in Member States. As a result of on-going efforts, TB prevalence and mortality rates have declined by almost a third as compared to the baseline in 1990, while a slower decline in incidence continues to be maintained.

Many community-based interventions are in place in the Region and such approaches are increasingly being incorporated into routine service delivery by national programmes.

Attention toward advocacy, communications and social mobilization (ASCM) is also increasing across the Region.

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Figure 6: Estimated TB prevalence, incidence and mortality: SEA Region, 1990-2009



NewsBytes

Informal consultation to develop a guideline for review of National Pandemic Strategic Responses in SEAR Member States

From 22-24 November 2010, the Disease Surveillance and Epidemiology unit of WHO-SEARO held an informal consultation in the Regional Office to develop a guideline to facilitate the review of National Pandemic Strategic Responses in Member States of the Region. To date, within the Region, only Thailand has undertaken a systematic review of their pandemic response and made this report available. At the consultation in Delhi, the methods and process of the Thailand review were presented as well as a summary of the lessons learned.

The main rationale behind developing this guideline is that a careful review of national responses to the recent pandemic will provide critical information to support revision of national pandemic plans. It can also help to provide a clear picture of the most important technical areas that need to be strengthened to ensure capacity for more effective responses in the future. It is hoped that the guideline will help to ensure a structured and consistent approach to such assessments - as well as encourage countries to share their lessons learned, best practices and examples of strong regional collaboration.

The Guideline is expected to be completed by January 2011.

Shortage of Streptomycin for Treatment of Tuberculosis

The Global Drug Facility (GDF) anticipates a temporary shortage of quality-assured Streptomycin, drug used during the intensive phase of the re-treatment of tuberculosis cases and National TB programmes in the Region are advised to consider different temporary solutions: a) shift existing in-country drug stock of Streptomycin between treatment centres to cover re-treatment cases until the supply situation improves; b) buy Streptomycin from other sources, for example, use of government funds, however quality assurance criteria for the selection of anti-TB medicines and manufactures must be adhered to as per the national procurement requirements; c) temporary use of 3HREZ/5HRE regimen for re-treatment cases until the shortage of quality assured Streptomycin is resolved.

For GDF recipient countries, which includes all SEAR Member States the current problem means that over the next eight to 12 months, Streptomycin will be available i) in limited quantities; ii) require longer lead times for delivery (8 -10 months) and iii) be more costly (35-50USD per 50 vials) compared to the present. Therefore, the National TB programmes are advised to plan far in advance for the next procurement cycle and to ensure availability of sufficient funds to cover the increased cost of retreatment (Category II) cases. The most up-to-date GDF prices could be found at www.stoptb.org/gdf/drugsupply/drugs_available.asp

Workshop on Malaria Treatment Policy and Drug Resistance Monitoring in SEA Region Countries, Bali, Indonesia 15-17 September 2010

The rapid increase in antimalarial drug resistance over the past few years is a big setback to effective malaria control. Therefore, drug efficacy and proper clinical management is being more intensely



monitored to detect changing patterns of resistance early, and revise national malaria treatment policies accordingly.

With artemisinin-resistance spreading from the original foci at the Thai-Cambodia border there is an urgent need to reactivate the drug resistance monitoring network in the non-Mekong belt countries. A regional workshop was organized to this end in Bali, Indonesia, on 15-17 September 2010. The workshop was attended by officials of seven non-Mekong countries, namely Bangladesh, Bhutan, India, Indonesia, Nepal, Sri Lanka and Timor-Leste. The objective of the meeting was "to update and revitalize the therapeutic efficacy studies and drug resistance monitoring for strengthening the treatment of malaria in participating countries".

Discussions focused particularly on 'Lessons learnt from Mekong Region on artemisinin resistance and its containment project on the Cambodia-Thailand border'. The consensus was that each country should have a final country workplan on drug resistance and conduct drug resistance monitoring in 2011. A follow-up meeting is planned in 2012 to review the outcome of these activities. WHO will provide technical and financial support.

World AIDS Day observed in SEA Region

A wide range of activities across Member States of the WHO South-East Asia Region marked the observance of World AIDS Day on 1 December 2010. Many of them highlighted this year's theme, 'Universal access and human rights'.



In the WHO Regional Office for South-East Asia, Deputy Regional Director Dr Poonam Khetrpal Singh released, on behalf of Regional Director Dr Samlee Plianbanchang, the document *HIV/AIDS in South-East Asia: Progress Report 2010*. At the programme, Dr Iyanthi Abeyewickreme, Regional Adviser, HIV/AIDS, provided an overview of the situation in the Region. Dr Sangay Thinley, Director, Communicable Diseases, summarized the way forward.

Two articles on prevention of mother-to-child transmission (PMTCT) of HIV/AIDS by the Regional Director were also published in two leading English language newspapers in the Region: the *Hindustan Times* (India) and *Bangkok Post* (Thailand).

Activities in Indonesia, India and Nepal focused on the issue of mother-to-child transmission, which also encompasses larger issues of gender, stigma, and universal access to HIV testing and care. The WHO country offices distributed topical posters and the planner; *Stay Safe, Protect Your Baby and Stay Healthy* on VCT, PMTCT and drug resistance issues. In the Maldives, awareness programmes included workshops to sensitize religious leaders, mobile text messages sent to police officers, and rock concerts on the theme of HIV/AIDS.

In Timor-Leste, President Jose-Ramos Horta gave his first televised speech on World AIDS Day, highlighting the importance of the issue. A film, *Diamonds*, on HIV positive women, was televised nationally. Other awareness initiatives included a comic book on the issue and quiz contests. In Thailand, among other activities there were exhibitions organized by the Ministry of Public Health, and stage performances conducted in Jatujak Park in Bangkok. In Sri Lanka too, health officials and the

public participated in an AIDS Day walk in Colombo, and street dramas were enacted.

In Bangladesh, President Zillur Rahman and Prime Minister Sheikh Hasina issued separate messages on the day's eve. Health and Family Welfare Minister Dr AFM Ruhul Haque addressed a seminar on "Universal access and human rights". The WHO Bangladesh Country Office distributed posters and planners for 2011 provided by the HIV Unit in SEARO and shared the message of the Regional Director with local stakeholders.

21st SEAR National AIDS Programme Managers' Meeting

The 21st Meeting of AIDS Programme Managers was held from 26 -28 October 2010 and was attended by 29 participants from 9 of 11 SEAR Member States and 20 WHO staff from HQ, country offices and the Regional Office.

Overall, countries in the South-East Asia Region have made substantial progress in the response to the HIV epidemic in the past five years resulting in a slow but consistent decline in new HIV infections every year. Still, much remains to be done. In 2009, an estimated 220 000 individuals were newly infected with HIV. HIV transmission rates remain unacceptably high among populations engaging in high-risk behaviours, namely sex workers, men who have sex with men and injecting drug users. The majority of the HIV-infected people are unaware of their HIV status and more than half do not receive treatment. Two out of three HIV-infected pregnant women do not receive prophylactic antiretroviral therapy resulting in a large number of children being born with HIV each year. Addressing these issues will require overcoming many challenges.

The following were the recommendations made.

1. Reduce HIV transmission among populations with the highest transmission rate. Remove barriers to access to health services by advocating for repealing discriminatory laws and reducing stigma.
2. Review and revise current national guidelines for PMTCT with the goal of reducing perinatal HIV transmission and moving towards elimination of paediatric HIV by increasing access to quality PMTCT services for pregnant women.
3. Strengthen efforts through effective collaboration at all levels to scale-up the implementation of the three “T’s” (i.e. infection control, intensified case detection and isoniazid preventive therapy) in line with international recommendations.
4. Ensure timely access to treatment by effective linkages between testing, counselling and treatment centres. Invest in building health systems and human resources to increase the implementation capacity for scaling-up HIV interventions.
5. Strengthen STI surveillance and HIV case reporting systems.
6. Review and revise current national guidelines for ART for adults and children in order to expand access and improve the quality of treatment services, with a particular focus on preventing loss to follow-up and integrating ART with complementary programmes such as maternal-child health and STI management.
7. WHO to provide technical support in the identified areas.

Leprosy-affected persons in the SEA Region have a key role to play in community awareness on leprosy

The WHO South-East Asia Region has become the first Region where leprosy-affected people will play a key role in the efforts to further reduce the disease burden, by sensitizing individuals and the community and helping to identify the key issues and challenges. In this way, they could be the bridge between the affected people and the community on one hand, and policy-makers, programme managers and society at large on the other hand.

The WHO Enhanced Global Strategy and the Operational Guidelines for Further Reducing the Disease Burden Due to Leprosy (2011–2015) have been adopted by the Member States of the SEA Region. In accordance with the new strategy, guidelines are being prepared to strengthen the participation of persons affected by leprosy in leprosy services. WHO drafted and finalized these two documents through the active involvement of persons affected by leprosy.

Two affected persons, Dr P.K. Gopal, of the National Forum of Persons Affected by Leprosy in India, and Mr Adi

Yosep of PerMaTa in Indonesia, shared their experiences to sensitize programme managers at the Meeting of National Leprosy Programme Managers (of the SEA Region) in Colombo, Sri Lanka, on 27–29 July 2010. As Mr Adi Yosep put it, “active participation of individuals affected by leprosy can bring about lasting and tangible changes in perceptions, policies, programmes, priorities and procedures. Their involvement can lead to country-specific definitions and standards of the quality of service to be provided”.

One of the main recommendations at the Meeting of National Leprosy Programme Managers held in Colombo was that “National programmes will further improve their ongoing efforts to strengthen the participation of persons affected by leprosy in leprosy services”.



Dr P.K. Gopal, of the National Forum of Persons Affected by Leprosy in India, lighting the candle during the opening ceremony of the Meeting of National Leprosy Programme Managers in Colombo in July 2010.

In most Member States of the SEA Region, community awareness on leprosy and workshops on empowerment by the persons affected have taken place through the support of and in the presence of the WHO Goodwill Ambassador for Leprosy Elimination, Mr Yohei Sasakawa, and other dignitaries. In India, for example, leprosy-affected people have been working with a group of Members of Parliament and other top policy-makers and opinion leaders with the aim of improving the standards of living of the affected people.

GFATM Round 10: A Summary

The Global Fund Board has approved all 79 Round 10 proposals recommended by the Technical Review Panel (TRP), at a cost of US\$ 1.73 billion over the first two years and US\$ 4.72 billion over five years. This makes Round 10 the third largest round ever, after Rounds 8 and 9 respectively. These decisions were made at the Fund’s 22nd Board meeting held on 13–15 December in Sofia, Bulgaria.

Sufficient funding will be available to cover all Round 10 proposals that the TRP recommended for approval. The Board has also not required that budgets be reduced.

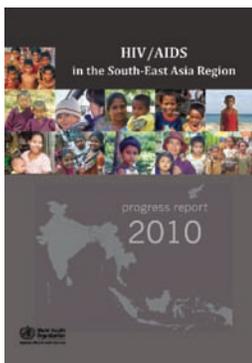
Salient features of R-10

- The TRP reviewed 150 proposals: 78 for HIV/AIDS, 48 for TB, and 24 for malaria.
- The average approved proposal has a two-year cost of US\$ 22 million, down from US\$ 26 million in Round 9, but still double the US\$ 11 million average cost of the first seven rounds.
- Fifty three per cent of eligible proposals submitted in Round 10 were approved. Malaria proposals were most successful, with 79% approved (as against 54% for TB proposals and 44% for HIV/AIDS).
- HIV/AIDS had more proposals approved (34) than either TB (26) or malaria (19). In dollar terms, approved HIV/AIDS proposals accounted for 47% of the total cost, malaria at 34% and TB at 20%.
- The best-performing region was East Asia and the Pacific, with approval rates of 75%, 65% and 78% in Rounds 8, 9 and 10, respectively.
- Twenty five of the 78 HIV proposals requested funding from the dedicated funding stream for most-at-risk-populations (MARPs), which was newly created for Round 10. The total two-year funding request under this stream was US\$ 99 million. The TRP recommended 12 of these proposals, with a two-year cost of US\$ 47 million.
- Of the 150 eligible proposals, 52 (35%) planned to implement dual-track financing, with principal recipients from both the governmental and nongovernmental sectors.
- Eight of the 12 proposals in the WHO South-East Asia Region were approved, in categories 1, 2 or 2B. Of these, three were for TB (Indonesia, Thailand and Bangladesh), three in HIV (Timor-Leste, Nepal and Thailand) and two for malaria (Thailand and Timor-Leste).

Change in Director for CDS

After more than five years of successfully leading the Department of Communicable Diseases, Dr Jai Narain has now moved as Director, Department of Sustainable Development and the Environment (SDE) at SEARO. He has been succeeded by Dr Sangay Thinley as Director, Department of Communicable Diseases (CDS), since 1 October 2010. Dr Thinley was formerly Director, Health Systems Development at SEARO.

New publications



HIV/AIDS in the South-East Asia Region: Progress Report 2010

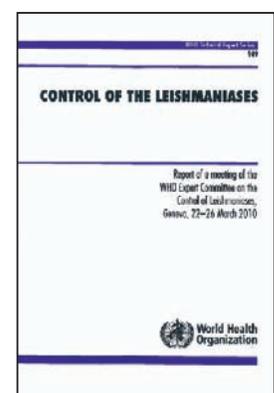
This progress report presents the current status of HIV/AIDS in the South-East Asia Region based on latest surveillance and programme data reported by Member countries. The report highlights the progress made in the prevention and control of HIV in the Region and lists challenges and future priorities. Unique programmatic achievements of each member country are elaborated under the Country Best Practices section. The information in this report could be useful to a wide audience including HIV programme managers in the Region and around the world, donors, policy makers as well as researchers in the field of HIV/AIDS.

Control of Leishmaniases

This report makes recommendations on new therapeutic regimens for visceral and cutaneous leishmaniasis, on the use of rapid diagnostic tests, details on the management of Leishmania/HIV co-infection and consideration of social factors and climate change as risk factors for increased spread.

Recommendations for research include the furtherance of epidemiological knowledge of the disease and clinical studies to address the lack of an evidence-based therapeutic regimen for cutaneous and mucocutaneous leishmaniasis and post-kala-azar dermal leishmaniasis (PKDL).

This report not only provides clear guidance on implementation but should also raise awareness about the global burden of leishmaniasis and its neglect. It puts forward directions for formulation of national control programmes and elaborates the strategic approaches in the fight against the leishmaniases. The committee's work reflects the latest scientific and other relevant developments in the field of leishmaniasis that can be considered by Member States when setting national programmes and making public health decisions.



Surveillance corner

Avian Influenza in South-East Asia Region, 2010

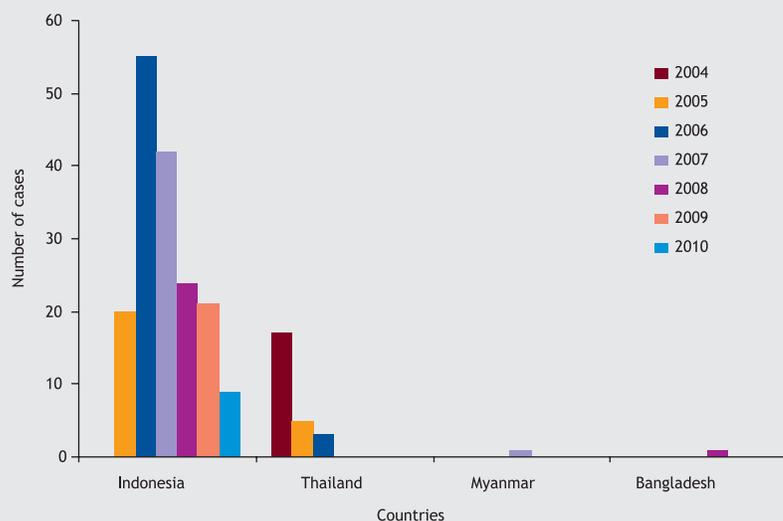
Outbreaks of highly pathogenic avian influenza were reported in 2010 among poultry in Bangladesh, Indonesia, India, Myanmar and Nepal. Strategic culling and poultry vaccination policies have been adapted and implemented by Indonesia. Other Member States of the Region have carried out depopulation of poultry during outbreaks.

So far, Bangladesh, Indonesia, Myanmar and Thailand have reported laboratory confirmed human cases of avian influenza A (H5N1) as shown in Fig. 7. Indonesia reported 171 human cases of avian influenza A (H5N1) with 141 deaths since July 2005. Thailand has reported 25 cases with 17 deaths from 2004 to 2006. Myanmar reported its first human case in 2007 and Bangladesh reported its first human case in 2008. Both cases in Bangladesh and Myanmar have since recovered.

The South-East Asia Region has reported a total of 198 human cases of avian influenza A (H5N1) with 158 deaths since 2004. The region has contributed 39% of global human cases of avian influenza A (H5N1) with a case-fatality rate of 80%.

Indonesia continues to report human cases with a high case-fatality rate since 2005, which is a matter of public health concern. The case-fatality rate of reported human cases in Indonesia was 78% in 2010 compared with 90% in 2009. The number of reported human cases is progressively decreasing in last four years. All confirmed cases were reported from provinces in the Java, Sumatra, Sulawesi and Bali. On average, a larger number of cases are detected in January than other months of the year. The majority of human cases were due to direct contact of humans with infected poultry or contaminated environments. There are a few instances where limited human-to-human transmission of the virus could not be ruled out, but there have not been large clusters of human cases. There were 12 clusters of avian influenza infection in Indonesia, but relatively few of these occurred after 2006 and none till in 2010.

Figure 7: Reported human A (H5N1) cases, South-East Asia Region, 2004-2010



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Design, pre-press support and layout: TPD

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