Intercountry Meeting of National Programme Managers for Kala-azar Elimination

Report of the Meeting
Behror, Rajasthan, India 1-2 September 2005

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Executive Summary

The intercountry meeting of National Programme Managers for kala-azar elimination was held at Behror, Rajasthan, India on 1-2 September 2005 to discuss the planning and implementation of kala-azar elimination programmes in Bangladesh, India and Nepal.

The specific objectives of the meeting were: (1) to review the progress so far in kala-azar elimination (2) to develop consensus on the guidelines to be used for the development of operational plans (3) to identify the steps for implementation and (4) to agree on a common framework for implementation including intercountry collaboration.

Elimination of kala-azar has been identified as a regional priority programme in response to the high-level political commitment articulated by the health ministers of Bangladesh, India and Nepal who signed a Memorandum of Understanding (MoU) calling for the elimination of kala-azar through intercountry cooperation. The Regional Technical Advisory Group (RTAG) constituted by the Regional Director, South-East Asia Region has reviewed the draft regional strategic framework for elimination of kala-azar and endorsed it. A meeting of the key partners comprising WHO/SEARO, WHO/HQs, TDR, World Bank, UNICEF, GTZ, Bill and Melinda Gates Foundation and Drugs for Neglected Diseases Initiative (DNDi) reached a consensus on the five strategic pillars for elimination of kala-azar and recommended preparation of operational plans by Bangladesh, India and Nepal.

The participants included Programme Managers and representatives from Bangladesh, India and Nepal, TDR, members from RTAG, WHO/SEARO, WHO Representative Offices from Bangladesh, India and Nepal and two temporary advisers. The Director, Department of Communicable Diseases, WHO/SEARO opened the meeting on behalf of the Regional Director. During the meeting, progress on kala-azar control/elimination was reviewed by the programme managers including the constraints, opportunities and the lessons learnt. Updates were provided on the diagnosis and treatment, planning of vector control and vector surveillance, communication for behaviour impact, disease surveillance and plans for monitoring and evaluation using a logframe approach. There was discussion on intercountry cooperation and cross-border collaboration through multi-country activities (MCA).
After reviewing the situation as well as, the recommendations of RTAG (2004) and the partners consultation (August 2005), the participants developed a framework for national operational plans and a road map for implementation. This would help them in refining the draft operational plans based on the operational guidelines and the regional strategic plan. The main thrusts of the kala-azar elimination programme were identified.

**Recommendations**

1. The elimination of kala-azar requires a favourable policy environment. It should be implemented as a part of healthy public policy with a focus on transmission risk reduction and surveillance.

2. The framework for the operational plan developed during the programme managers meeting should be completed and refined by the three endemic countries. The operational plan should include district-level planning with budgetary details and resource gaps. The operational plans should be used for mobilizing additional resources to fill the gaps.

3. Based on the operational plans, developmental work on standards, standard operating procedures (SOPs), training package for health care providers through intercountry meetings, national consultations and district planning is recommended. This should be followed by implementation in pilot districts through multi-country activities (MCA). An intercountry task force is recommended to oversee progress of work on elimination of kala-azar.

4. Since kala-azar affects contiguous geographical areas in the three endemic countries, multi-country activities are recommended for developing uniform way of diagnosis and treatment, vector control and use of comparable reporting formats and reporting system.

5. During implementation of the kala-azar elimination programme, harmonization with the private sector, NGOs and the corporate sector is recommended to maximize access to the programme by the poorest of the poor at risk of kala-azar. Concrete ways of involving the partners should be worked out and implemented.
A partners’ alliance or a partners’ forum may be considered to sustain partnerships in kala-azar elimination. This would enable mobilization of contributions based on their comparative advantage.

(6) In the first year the kala-azar elimination programme should be implemented in pilot districts. Each country should select at least one district. The pilot district should be selected in consultation with the national, state and district authorities. The experience in the pilot districts should be closely monitored and carefully documented. This should be shared with the other affected countries and serve as the basis for planning the scaling up of the elimination efforts.

(7) The main thrusts of the elimination programme should include universal accessibility to quality diagnosis and treatment with the emphasis on completion of treatment, monitoring of drug resistance, uninterrupted supply of quality drugs and diagnostics, disease and vector surveillance, transmission interruption through quality Indoor Residual Spray (IRS), strong programme management including monitoring, evaluation and supportive supervision, periodic reviews (internal and external), and solving the problems relating to migration and poverty.

(8) The programme should focus on behaviour change communication for impact. The behaviour impact includes early care seeking by the poor people, completion of treatment as advised by the health care providers and participation in transmission interruption efforts.

(9) The endemic countries should develop a network of institutions to undertake relevant operational and clinical research to complement the scaling up efforts. This would be useful in including the most effective interventions.
1. Background

The WHO Regional Director for the South-East Asia, Dr Samlee Plianbangchang, has identified elimination of kala-azar as a regional priority in response to the high-level political commitment articulated by the health ministers of Bangladesh, India and Nepal. He constituted a Regional Technical Advisory Group (RTAG) in 2004. At its first meeting in December 2004, RTAG reviewed the regional strategy framework for elimination of kala-azar and endorsed it. It recommended preparation of operational plans by Bangladesh, India and Nepal. The intercountry meeting of programme managers was organized to review the draft operational plans and revise them in accordance with the recommendations of the meeting of the partners that provided a consensus on the five pillars of interventions.

2. Opening session

Dr Jai P Narain, Director CDS, WHO/SEARO welcomed the participants and said this was an important meeting, since it followed a partners’ meeting which reached a consensus on the five pillars of the kala-azar elimination strategy. There was political commitment at the highest level to facilitate collaborative work amongst the endemic countries. It was important to determine the burden of kala-azar and examine the factors that would facilitate elimination. There were unique features of the disease that favoured elimination; there was an opportunity to expand the elimination programme because of the new technologies. The programme should address the needs of the poorest of the poor living in the remote areas to access the health system and bridge the existing gaps through strengthening of the health systems. He said the three endemic countries had resolved to eliminate kala-azar by 2015. This opportunity should not be missed. A regional strategy framework was discussed and endorsed in the partners’ meeting which concluded on 31 August 2005.

Dr Narain said the challenge for the countries was to implement the strategies through an operational plan at the district level with support from
the state and the central government. The plan should be need based and not fund based. The resources could be mobilized to complete the job. The participating countries were committed to implement the programme and national sources had already been committed. These can be increased based on the projected needs and gaps, be added. A coherent approach was needed for the proposed phased implementation. Since the disease affects contiguous areas, it should be considered as the problem of a single, geographical area and not a three-country problem. This would require multi-country activities with a uniform way for diagnosis and treatment, vector control and comparable reporting formats and reporting system. WHO was fully committed to provide technical and other support.

3. **Introduction of the participants**

Dr Mahmudur Rahman, Director Institute of Epidemiology Disease Control and Research (IEDCR), Bangladesh was nominated as the chairperson, Dr Das Gupta, National Vector Borne Disease Control Programme (NVBDCP), India as co-Chairperson and Dr AB Joshi, Tribhuvan University, Nepal as the Rapporteur of the meeting. List of participants is given in Annex 1. The agenda of the meeting is given in Annex 2.

4. **Objectives**

The general objective was to discuss the planning and implementation of the kala-azar elimination programme in Bangladesh, India and Nepal.

**Specific objectives**

- To review the progress so far in kala-azar elimination
- To develop consensus on the guidelines to be used for the development of operational plans
- To identify the steps for implementation
- To agree on a common framework for implementation including intercountry collaboration.
4. Progress in national kala-azar elimination

4.1 Bangladesh

The progress in Bangladesh was reviewed by the Programme Manager, Dr Mostafa Kamal. Bangladesh reports nearly 10,000 cases each year and the estimated prevalence rate is 45,000 cases. Reporting is done only by the government institutions and this is also incomplete. The strategy is early diagnosis and prompt treatment. Diagnosis is based on aldehyde test and SAG is used for treatment. At present there is very little resistance to this drug. DDT is effective but is not used now since the stocks have been exhausted and the national policy does not permit its use. The alternative is to use pyrethroids. However, the costs of pyrethroids is high and therefore IRS is not used widely. Disease and vector surveillance is done by the government institutions only and there is a lot of scope for improvement. The government has signed a MoU, and a core group constituted by the government has drafted the national strategic plan for elimination of kala-azar by the year 2015. It is proposed to undertake phase IV trials for miltefosine. A study on disease burden is nearing completion. A steering committee is being formed and linkages are proposed between IEDCR, NIPSOM and three medical colleges. The government is also exploring partnership with JICA.

Discussion points

- In Bangladesh one district that is surrounded by kala-azar endemic districts is free of the disease. The possible explanation is that the rivers change their course and as a result of reclamation, new houses are built. Where there is flowing water, there is little chance for breeding while where there is stagnation, the possibility of vector breeding increases. A study should be undertaken to find a satisfactory explanation.

- Miltefosine has not been registered in Bangladesh. Intercountry mechanisms are proposed to be used to facilitate the process. The drug registration process is approved in principle but an application from the manufacturer is required and a technical committee has to recommend it for approval.

- The efficacy of ITNs should be shown by evidence before including it as an intervention in the programme. Kalanets are
being used and appear promising. Where kala-azar is a problem, people use the nets even though the conditions may not be friendly for their use. The efficacy of ITNs varies between 37-50%. This issue should be addressed while refining the operational plan since there are limitations in the widespread use of Indoor Residual Spray because of the high costs involved. Stratification is needed and entomological expertise has to be mobilized for cost effective IRS. Where malaria and kala-azar coexist, Indoor residual spray (IRS) for effective control of both the diseases.

- ‘RK 39’ should be adopted since this is a more reliable test than the aldehyde test. However, its efficacy under field conditions has to be established before recommending its widespread application in the programme.
- For surveillance, it is important to identify the reporting units, the reporting formats and reporting system.
- For effective Communication for Behavioural Change (BCC), there is a need for preparing a credible and robust communication strategy.
- Partnerships in the form of Public-Private mix is required. Partnerships are also required with NGOs and community self-help groups at the local level. District level committees may also be considered as a mechanism.
- The draft operational plan should be revised and refined after careful consideration of the recommendations of the meeting.

4.2 India

Dr C.K. Rao, NPO, WHO Representative Office of India, presented a review of the kala-azar elimination programme in India on behalf of Dr P.L. Joshi, Director, National Vector-Borne Diseases Control Programme, India. Though in general, kala-azar is under control, the trend is rising since 2002. About 20,000 cases are reported to the programme each year. The change in situation is resulted due to the intensity of interventions. The reported cases increase when the control efforts are relaxed. Trends of reported cases for the affected districts were presented. The national policy recommends the elimination of kala-azar by 2010. A two-pronged strategy
is proposed. This comprises of vector control and parasite elimination. This strategy will be supported by Behavioural Changes Communication (BCC), intersectoral coordination, operational research, monitoring and supervision. Geographical Information System (GIS) technology will be started in collaboration with the malaria control programme in four districts. Validation studies are in progress. New guidelines are proposed for use in capacity development. Activities have been planned for implementation which will be phased. Phase IV miltefosine trials have been completed and the drug has been registered. It is proposed to progressively enhance the use of new drugs and diagnostics. DDT will be used for IRS. Surveillance will be intensified and revamped with increasing stress on active surveillance. Though the budget approved is about 50 million USD during the next five years, the gap identified is 55 million US Dollars.

**Discussion points**

- Access to diagnosis and treatment of kala-azar is an important issue. The health facilities providing diagnosis and treatment include community health centres. This should be made available in the primary health centres for increasing access. In Bangladesh, the programme should consider union health facility and in Nepal district health facility.

- Phase IV trials with miltefosine have shown good adherence to treatment and adequate sensitivity and specificity of ‘rk 39’. This was possible since the efforts and follow-up in a phase IV trials are well supported and adequately resourced. However, the usefulness of the interventions have to be proven in programme setting. Therefore, it is recommended that early diagnosis and complete treatment (miltefosine to be used in the pilot districts) needs to be provided in pilot districts during the preparatory phase. This should be intensively monitored to document the constraints and opportunities. These efforts should be combined with vector control measures, surveillance and BCC. The services should be provided as a package. The pilot district experience will be invaluable in expanding and scaling up the programme during the attack phase. During this period of implementation in the pilot districts other districts can continue to use the current recommendations of the programme.
The kala-azar elimination programme will be a part of the World Bank project of vector-borne disease control and collaboration of other partners like the Gates Foundation will be solicited. A mission has been fielded to develop the plans and the proposals. After its approval, it is proposed to roll over the plan for all the vector-borne diseases. Cross-cutting interventions are going to be included under the programme.

4.3 Nepal

Dr M.B. Bista, Director Epidemiology and Disease Control Division, Nepal, presented the operational plan for kala-azar elimination. Twelve districts, all of them located across the international border are affected. About 2000 cases are reported each year and there is a rising trend. A national coordination committee has been formed, miltefosine has not been registered yet, and ‘rk 39’ has been introduced. In the operational plan, ‘rk 39’ is proposed to be used and expanded. Two regional kala-azar elimination centres, and three reference centres to support the elimination programme will be established. Manpower constraints, however, are serious. In the vector control efforts, it is proposed to use IRS in 70%, ITNs in 20% and environmental management in 10% population in the affected districts. Surveillance will be revamped and Early warning alert and response system (EWARS) strengthened. The priorities for operational research have been identified. It is proposed to organize a workshop to discuss implementation research with support from TDR in December 2005. Nepal proposes to undertake partnership with the private sector and NGOs. The experience with social mobilization is useful and it will be taken forward through BCC with the support of local partnerships at the district level. Partners identified are the World Bank, USAID, WHO, JICA and local governance. The estimated budget is 28 million USD and the projected gap is about 23 million USD. During the pilot phase the shortfall is 0.5 million USD.

Discussion points

- The treatment failure rate is about 5% in Bangladesh, 60% in northern districts of Bihar in India and 20-25% in Nepal. Because of the treatment failure rate and the toxicity of Sodium Antimony Gluconate (SAG), it is important to introduce the safe
and effective oral drug, miltefosine. At the same time, monitoring of drug resistance should be undertaken.

- Shortage of manpower and the poor capacity of the health system are serious constraints. This needs to be corrected and supported by capacity development through implementation of the plans for linkages and support from regional kala-azar elimination centres and reference centres.

- Miltefosine has not yet been registered but efforts are being made to speed up the process of registration.

5. Diagnosis and complete treatment

Dr S.K. Bhattacharya, Director, National Institute of Cholera and Enteric Diseases (NICED), Kolkata, identified issues relating to early diagnosis and complete treatment of kala-azar at different levels of the health system in the government sector using India as an example. At the outreach facilities and the subcentre levels, the diagnosis of kala-azar is based on case definition by health workers and health volunteers. Suspected cases are to be sent to the facilities where diagnosis can be established on the basis of screening test ‘rk 39’. Cases conforming to the case definition and having ‘rk39’ positive are to be treated. The facilities at this level should also have the first-line drugs for kala-azar, TB, and leprosy. The cases who do not respond and a certain proportion of cases 3-5% (for validation) should have the diagnosis confirmed by bone marrow or splenic aspirate examination for the parasite. Besides the first line drugs, these facilities should have rescue drugs, and treatment facilities for HIV. The supply and drugs needs were identified for each facility. Case reporting is to be done on a monthly basis to the district and once every three months from the district to the state. Yearly reporting was recommended to the national authorities and WHO. A similar system is required for diagnosis, treatment and reporting of cases of Post kala-azar dermal lesions (PKDL). The supply and equipment needs for each level of facility should be determined. It is important to ensure that these facilities are also equipped and capable of managing coinfections (TB and HIV). Efforts are needed to make the system to complete the treatment in the largest proportion of kala-azar cases.
**Discussion points**

- Complete treatment is necessary to achieve the elimination of the parasite. To ensure complete treatment, the programme should consider the use of treatment cards, blister packaging of the first-line drug, and follow-up of patients. Developing a test that reflects cure from the disease is an important research issue.

- For the first-line drug an alternative to miltefosine is important since miltefosine cannot be used in early pregnancy and has to be used with caution in females of child-bearing age. Paromomycin can be a good candidate drug but it has to be registered.

- For the diagnosis and treatment of PKDL, linkages should be developed with dermatologists and treatment regimens recommended. The motivation of the affected person to complete the treatment is also an important consideration.

- A parallel health system in the private and NGO sector should be considered (clinics, nursing homes and hospitals) and linkages developed since a large proportion of patients seek treatment from these facilities and providers. The issue of Public-private mix is important and was endorsed. A meeting should be hold to engage the private practitioners and should be a part of the plan in the pilot district. For cross-border issues, uniform guidelines need to be developed and applied.

- Strengthening the capacity of private providers and NGOs at different levels is important since a large proportion of patients of kala-azar do not come to the government health facilities for diagnosis and treatment.

- Since kala-azar affects the poorest amongst the poor, treatment should be free in the government and private sectors. Additional provisions may have to be made to support referral, meet the nutritional requirements and provide compensation for the loss of wages.

- In order to increase access, facilities for diagnosis and treatment should be brought closer to the people. Awareness should be increased through the outreach system in which health care volunteers and especially women volunteers have an important role to play, participating following up on the treatment advised.
6. **Planning vector surveillance and vector control**

Planning vector surveillance and vector control for kala-azar was summarized by Mr N.L. Kalra, temporary adviser, WHO/SEARO. IRS is the mainstay of vector control. The target for coverage is 80% with good quality of insecticides. The spraying should be done in two rounds, the first one should be completed before the transmission season while the timing of the second round should be adjusted according to the transmission pattern. Planning is the key to the success of IRS. The existing data base for the last three years should be used to assess the needs and to plan the households to be covered. GIS and RS technologies are important but require development of capacity and resources for implementation. It is important to plan IRS taking PHC as a unit. The equipment needs for each spray team, and the quantity of insecticide required should be calculated according to the area to be sprayed. This is worked out on the basis of the number of households, the number of rooms to be sprayed and any other surfaces to be covered. The composition of spray teams was described and training needs reviewed. It has been observed that only 50-60% of the target is achieved and to achieve an impact, a mop-up round becomes necessary. IRS should include the number of households and the number of rooms sprayed and the population covered. Monitoring and evaluation including vector surveillance should be an integral part of IRS operations for it to be effective and for tracking the progress of performance.

**Discussion points**

- Amongst the various elimination strategies, vector control is the most expensive and is also resource-intensive. For maximal returns, vector control should be carefully and thoroughly planned and implemented. The activity should be monitored for processes and outcomes and to track the progress.

- Vector eradication is not possible since the vector is in abundance but kala-azar elimination is possible if the strategy of parasite elimination is combined with vector control supported by effective surveillance of the disease and the vector.

- Larval control measures are difficult to implement and the focus of the programme should be on the adult population because of the biological advantage and the fragile nature of the vector.
Prioritization in selection should be done on the basis of the reported cases during the preceding three years. IRS should be continued for a period of five years.

Coverage of the targeted households with effective insecticides is the aim of vector control. Mopping-up operations are important and need the cooperation of the village panchayats, village developmental committees, and self-help groups.

7. Communication for behaviour impact (COMBI)

Communication for behaviour impact and community participation was discussed by Dr A.B. Joshi, RTAG member, Nepal. Communication for behaviour impact and community participation is one of the five strategic pillars of the kala-azar elimination programme. It can succeed if there is adequate support of other strategies viz. early diagnosis and complete treatment, surveillance and vector control. Behavioural Changes Communication (BCC) or Information, Education and Communication (IEC) is also a part of other communication programmes for behaviour change. Other programmes that involve the community include leprosy elimination, polio eradication, TB control, poverty reduction and HIV control. Therefore, linkages are necessary for BCC to be successful. BCC has two distinct components (1) Advocacy with key decision makers, partners and leaders and (2) Mobilization of the community at the district level and below to participate in the elimination efforts. The target audience, the objectives, the strategies and message-mix are different for the above strategies of BCC. The objectives should be clearly defined and the impact identified. Following this it is important to define the strategies and communication channels to be used. The message mix should target the poorest amongst the poor. Media, newspapers and, reading material may have very limited impact on this group of the population. On the other hand, radio, interactive opportunities, folk and local events of interest to the audience are likely to be more effective. One-to-one communication is a very important component of BCC for which is the health care providers and health care volunteers should be responsible. To be effective BCC interventions, have to be carefully planned with provision of adequate resources. They should be guided by social scientists and communication experts who should be involved right from the planning stage. It is also necessary to provide for monitoring and evaluation of the BCC and for an assessment of its impact. In Nepal, a project experience was described.
relating to the BCC experience. This included a study of knowledge and behaviour. Identification of strategies and, development of a number of messages and strategies to deliver them to the target population was carried out.

**Discussion points**

- The strategy for BCC should be included in the operational plan and integrated with elimination efforts and with other related programmes.

- An agreed terminology for BCC should be used. There are several possibilities to be considered e.g. COMBI, Behaviour change communication. However, IEC is not appropriate. The process of developing the materials should be undertaken only after completion of planning of COMBI/BCC. This should be based on the objectives and agreement on the expected impact. The ten steps for COMBI should be used if this strategy is adopted.

- The education department and the local artistes have a lot of potential in contributing to the success of COMBI/BCC.

- The elimination programme should be well packaged. Logos and slogans are important and can be developed through national/state competitions.

- A course is proposed to be organized by the WHO Mediterranean Centre in October. This can be a very important input for kala-azar programme.

- Evaluation and behavioural surveillance are an integral part of COMBI/BCC. Key indicators to track progress of performance need to be identified.

8. **Disease surveillance, reporting, monitoring and evaluation and research**

Disease surveillance, reporting, monitoring and evaluation, and operational and clinical research was presented by Dr M.K. Bannerjee,
RTAG member, Senior Public Health Administrator, Nepal. There are a number of constraints in surveillance that need to be addressed. People suffering from kala-azar either do not seek care or approach the private health care providers who do not report the disease. Passive surveillance is based on the reports of cases and deaths in hospitals. The diagnosis and treatment is not uniform. There is no system for feedback. Active surveillance is done by observing a kala-azar fortnight once a year in India. Nepal carried out active surveillance once in one district. Passive surveillance at the beginning of the elimination programme should be the mainstay. It comprises reporting of probable cases, deaths and treatment failures which is disaggregated by the age and sex reporting should be done once a month to the district in an agreed reporting format. The district should share it with the state every quarter and the consolidated report should be shared with the national programme and WHO annually. The reports should be used for feedback and for planning. Kala-azar should be made a notifiable disease. Active surveillance should be done annually to start with and then intensified as the programme moves into the attack phase. The reports should be accurate, complete (including zero reporting) and timely. Validation should be done through sentinel surveillance and periodic surveys.

To track the programme performance, a monitoring and evaluation framework should be developed comprising verifiable input, output and outcome indicators. Mapping of current monitoring and evaluation should be followed by development of capacity. The resources needed should be included in the operational plan. Monitoring and evaluation as well as surveillance should be built into the pilot districts. This would facilitate the development of realistic plans during the attack phase. Monitoring and evaluation should include monitoring of drug, diagnostic and insecticide quality and monitoring of drug and insecticide resistance. This may be initiated as an operational research project during the preparatory phase and should be expanded as surveillance sites during the operational phase. Important subjects identified for operational and clinical research include validation of disease burden, role of ITNs in transmission reduction, the role of housing design in interrupting disease transmission, socio-economic impact of kala-azar, a study of treatment failure and how to increase the compliance to treatment, the trial of combination drugs, treatment of coinfections like TB, HIV, the diagnosis and treatment of PKDL, study of vector and insecticide resistance and vector bionomics.
Discussion points

- The surveillance of kala-azar should conform to the expectation of Health Management Information System (HMIS) or Integrated Diseases Surveillance Programme (IDSP) in the country. At the same time, the special needs of elimination should be the responsibility of the kala-azar elimination programme.
- The minimum indicators in the programme should include the monitoring and evaluation of selected impact indicators identified for BCC.
- Surveillance should be linked to feedback to be able to bring about improvements in programme performance and programme monitoring.

9. Intercountry cooperation, cross-border collaboration

Kala-azar affects contiguous districts in Bangladesh, India and Nepal. Its elimination should be through joint efforts of the three countries. The MoU signed between the three countries supports intercountry collaboration. WHO multi-country activities and RTAG, with efforts to establish linkages and networking, are important mechanisms to be used. During the pilot phase, the countries should consider selection of contiguous districts across the international borders to gain experience in cross border collaboration. While there is free movement through the border between India and Nepal, for India and Bangladesh visas and passports are required. Therefore, the customs and police departments have to be involved. Cross-border meetings of the district officers are important to facilitate cross-border collaboration. The existing barriers and problems should be identified and addressed. If meetings cannot take place because of legal constraints, this can be overcome by electronic communication or through telephone or other means. Regular information exchange can help to overcome many constraints.

10. Follow-up on development of operational plans and a roadmap for implementation

The kala-azar problem is old, but the disease has to be eliminated. It is a good candidate for elimination. A historic landmark was achieved on
18 May 2005 with the signing of an MoU for elimination of kala-azar by the three endemic countries. The WHO Regional Director for South-East Asia is committed to support the elimination of the disease as part of his regional commitment. A RTAG has been established and it met in December 2004. A consensus was reached at a partners’ meeting to contribute to the elimination efforts. Important landmarks include the following:

- RTAG established
- Regional strategic framework developed, discussed and endorsed by RTAG.
- Consensus reached on the five pillars for implementing the strategy in partners’ consultation
- Agreement on developing common framework of implementation reached
- Inputs made for the preparation of micro plans and operational plans
- The framework for an operational plan was developed during the intercountry programme managers meeting at Behror. This is attached as Annexure III.
- The specific steps and the timeplans will be developed through national and district level consultations to fill the gaps.

11. The way forward

- Conducting situational analysis at the country level to learn from experience in demonstration pilot districts
- Advocating at the country level – in the states and in the districts
- Establishing the national steering committee and task force
- Constituting working groups within the Directorate General of Health Services
- Finalizing the operational details on the five pillars for demonstration districts and for expansion to other affected districts
- Preparing of the annual operational plans
Training of manpower and setting up laboratory services
Organizing the service delivery at all static health facilities and in the community for making the diagnosis, using the drugs, revamping surveillance and Indoor Residual Spraying activities
Fostering partnerships with NGOs and the private sector through consultations and engaging with the partners especially at the district level
For economy of scale, there should be bulk purchase and then channelization based on the needs. This can be worked out through multi country mechanisms with support from WHO.
Proposed elimination have been summarized in Annex 3.

12. Main thrusts of kala-azar elimination programme

Universal accessibility to treatment
Uninterrupted supply of quality drugs and diagnostics for elimination of the parasite
Transmission interruption through IRS which is the mainstay of vector control
Raising public awareness amongst the population at risk
Establishing a strong M&E mechanism at each level
Strengthening programme management
Periodic assessment and evaluation, both internal and external
Intercountry collaboration for sharing of lessons learnt and maximizing the outputs at the country level
Addressing the problems of migrants and those who are outside the scope of the elimination programme. This subject should be a part of qualitative research. These should be considered as refractory areas. Imported cases can also be a problem. These may also be because of migration. As surveillance improves it should be able to detect the imported cases. This should become a part of the surveillance system.
13. Recommendations

- The elimination of kala-azar requires a favourable policy environment. It should be implemented as a part of healthy public policy with a focus on transmission risk reduction and surveillance.

- The framework for the operational plan developed during the programme managers meeting should be completed and refined by the three endemic countries. The operational plan should include district-level planning with budgetary details and resource gaps. The operational plans should be used for mobilizing additional resources to fill the gaps.

- Based on the operational plans, developmental work on standards, standard operating procedures (SOPs), training package for health care providers through intercountry meetings, national consultations and district planning is recommended. This should be followed by implementation in pilot districts through multi-country activities (MCA). An intercountry task force is recommended to oversee progress of work on elimination of kala-azar.

- Since kala-azar affects contiguous geographical areas in the three endemic countries, multi-country activities are recommended for developing uniform way of diagnosis and treatment, vector control and use of comparable reporting formats and reporting system.

- During implementation of the kala-azar elimination programme, harmonization with the private sector, NGOs and the corporate sector is recommended to maximize access to the programme by the poorest of the poor at risk of kala-azar. Concrete ways of involving the partners should be worked out and implemented. A partners’ alliance or a partners’ forum may be considered to sustain partnerships in kala-azar elimination. This would enable mobilization of contributions based on their comparative advantage.

- In the first year the kala-azar elimination programme should be implemented in pilot districts. Each country should select at least one district. The pilot district should be selected in consultation
with the national, state and district authorities. The experience in the pilot districts should be closely monitored and carefully documented. This should be shared with the other affected countries and serve as the basis for planning the scaling up of the elimination efforts.

- The main thrusts of the elimination programme should include universal accessibility to quality diagnosis and treatment with the emphasis on completion of treatment, monitoring of drug resistance, uninterrupted supply of quality drugs and diagnostics, disease and vector surveillance, transmission interruption through quality Indoor Residual Spray (IRS), strong programme management including monitoring, evaluation and supportive supervision, periodic reviews (internal and external), and solving the problems relating to migration and poverty.

- The programme should focus on behaviour change communication for impact. The behaviour impact includes early care seeking by the poor people, completion of treatment as advised by the health care providers and participation in transmission interruption efforts.

- The endemic countries should develop a network of institutions to undertake relevant operational and clinical research to complement the scaling up efforts. This would be useful in including the most effective interventions.
Annex 1

List of participants

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## Annex 2

### Programme

#### Day 1 Thursday, 1 September 2005

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.00–08.30</td>
<td>Registration</td>
<td></td>
</tr>
<tr>
<td>08.30–09.00</td>
<td>Remarks by CDS</td>
<td>Dr Jai P. Narain, CDS, WHO/SEARO</td>
</tr>
<tr>
<td></td>
<td>Objective of the Meeting</td>
<td>Dr Chusak Prasittisuk, VBC, WHO/SEARO</td>
</tr>
<tr>
<td></td>
<td>Introduction of Participants</td>
<td>Dr Chusak Prasittisuk</td>
</tr>
<tr>
<td></td>
<td>Appointment of Chairperson and Rapporteur</td>
<td>Dr Jai P. Narain</td>
</tr>
<tr>
<td></td>
<td>Administrative Announcements</td>
<td>Dr Chusak Prasittisuk</td>
</tr>
<tr>
<td>09.00–09.40</td>
<td>Progress in national Kala-azar elimination programme – Bangladesh</td>
<td>Dr A.T.M. Mustafa, Programme Manager, Bangladesh</td>
</tr>
<tr>
<td>09.40–10.00</td>
<td>Discussion</td>
<td>UNICEF Representative</td>
</tr>
<tr>
<td>10.00–10.30</td>
<td>Group Photograph Tea/Coffee</td>
<td></td>
</tr>
<tr>
<td>10.30–10.50</td>
<td>Progress in national kala-azar Elimination programme – India</td>
<td>Dr P.L. Joshi, Programme Manager, India</td>
</tr>
<tr>
<td>10.50–11.15</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>11.15–11.35</td>
<td>Progress in national Kala-azar Elimination programme – Nepal</td>
<td>Dr Mahendra Bahadur Bista, Director, EDCD, DHS, Nepal</td>
</tr>
<tr>
<td>11.35–12.00</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>12.00–12.30</td>
<td>Early diagnosis at different levels of the health system including reporting system</td>
<td>Dr S.K. Bhattacharya, Member of RTAG, India</td>
</tr>
<tr>
<td>12.40–13.00</td>
<td>Discussions and recommendations</td>
<td></td>
</tr>
<tr>
<td>13.00 – 14.00</td>
<td>Lunch break</td>
<td></td>
</tr>
<tr>
<td>14.00 – 14.30</td>
<td>Complete treatment at different levels, including report and follow-up</td>
<td>Dr S.K. Bhattacharya, Member of RTAG, India</td>
</tr>
</tbody>
</table>
### Day 1 (Thursday, 1 September 2005)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker/Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.30–15.00</td>
<td>Discussion and recommendation</td>
<td></td>
</tr>
<tr>
<td>15.00–15.30</td>
<td>Vector control and vector surveillance planning for vector control operations</td>
<td>Mr N.L. Kalra, Temporary Adviser, WHO/SEARO</td>
</tr>
<tr>
<td>15.30–15.45</td>
<td>Tea/Coffee break</td>
<td></td>
</tr>
<tr>
<td>15.45–16.30</td>
<td>Discussions and Recommendations</td>
<td></td>
</tr>
<tr>
<td>16.30–17.00</td>
<td>Meeting of the Core Group</td>
<td>WHO Secretariat</td>
</tr>
</tbody>
</table>

### Day 2 (Friday, 2 September 2005)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker/Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.30–09.00</td>
<td>Communication for Behavioural Impacts and community participation</td>
<td>Dr Anand B. Joshi, Nepal, Member of RTAG</td>
</tr>
<tr>
<td>09.00–09.30</td>
<td>Discussion and recommendation</td>
<td></td>
</tr>
<tr>
<td>09.30–10.00</td>
<td>Disease surveillance, reporting, monitoring and evaluation, operational and clinical research</td>
<td>Dr Manas Banerjee, Nepal, Member of RTAG</td>
</tr>
<tr>
<td>10.00–10.30</td>
<td>Discussions and Recommendations</td>
<td></td>
</tr>
<tr>
<td>10.30–10.45</td>
<td>Tea/Coffee break</td>
<td></td>
</tr>
<tr>
<td>10.45–11.15</td>
<td>Programme management, Operational Plans</td>
<td>Dr Vijay Kumar, Temporary Adviser, WHO/SEARO</td>
</tr>
<tr>
<td>11.15–13.00</td>
<td>Discussion and Recommendations</td>
<td></td>
</tr>
<tr>
<td>13.00–14.00</td>
<td>Lunch break</td>
<td></td>
</tr>
<tr>
<td>14.00–14.30</td>
<td>Follow-up on Development of Operational Plan and Roadmap</td>
<td>Dr Manan Bangali, WR Office, Bangladesh</td>
</tr>
<tr>
<td>14.30–15.30</td>
<td>Discussions and Recommendations</td>
<td></td>
</tr>
<tr>
<td>15.30–15.45</td>
<td>Tea/Coffee</td>
<td></td>
</tr>
<tr>
<td>15.45–16.30</td>
<td>Conclusions and Recommendations</td>
<td>Chairman</td>
</tr>
<tr>
<td>16.30–16.45</td>
<td>Closing session</td>
<td></td>
</tr>
</tbody>
</table>
# Annex 3

## Operational plan for implementation during planning phase

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Areas identified for planning</th>
<th>Steps</th>
<th>Time-frame</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Management</td>
<td>National Task Force/Kala-azar Coordination Committee – at ministerial level – Secretariat (advisory)</td>
<td>– Formation: Chair</td>
<td>December 2005</td>
<td>WHO/Country/District/Academy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– List of members (partners)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>– approval by the ministry</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>– twice a year meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working group – at DG level – Secretariat</td>
<td>Formed and held 1st meeting Quarterly meeting</td>
<td></td>
<td>December 2005</td>
<td>Country</td>
</tr>
<tr>
<td>Registration of miltefosine</td>
<td>– application forwarded – approval received</td>
<td></td>
<td>By Dec 2005</td>
<td>WHO/Country</td>
</tr>
<tr>
<td>Revision of strategic plan Operational plan consistent with regional meeting</td>
<td>– revise national plan – prepare microplans for demonstration district – national meeting with partner,</td>
<td></td>
<td>By Dec 2005</td>
<td>National, state and district</td>
</tr>
<tr>
<td>GIS/RS/Health mapping technology</td>
<td>– capacity development – implementation</td>
<td></td>
<td>Early 2006</td>
<td>MCA-SEARO</td>
</tr>
<tr>
<td>Infrastructure: health facilities and human resources by category</td>
<td>– inventorization – identification of needs at different levels – project based and hiring policy</td>
<td></td>
<td>Dec 2005</td>
<td>Country</td>
</tr>
<tr>
<td>Consultation with poverty alleviation fund or programmes</td>
<td>Meeting in which agencies involved with poverty alleviation programmes at different levels will be invited to participate</td>
<td></td>
<td>March 2006</td>
<td>Country</td>
</tr>
</tbody>
</table>
### Strategies

<table>
<thead>
<tr>
<th>Areas identified for planning</th>
<th>Steps</th>
<th>Time-frame</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning at national level with regional and district participants Microplanning – at district level</td>
<td>Meeting with district staff in the districts selected for pilot</td>
<td>March 2006</td>
<td>Country</td>
</tr>
<tr>
<td>Indicators – for each pillar developed (piloted in demonstration district)</td>
<td></td>
<td>June 2006</td>
<td>WHO/Country</td>
</tr>
</tbody>
</table>

### Early diagnosis and treatment

| | | July 2006 | WHO/Country |
| | | Nov. 2006 | Country with support from WHO |
| | | June 2006 | Country / WHO |
| | | | Country and WHO |
| | | | WHO / Country |
| | | | WHO / Country |
| | | | TDR, ICMR |
### Strategies
- **Linkage with dermatologists and hospital physicians**
  - Private/NGOs sector, according to agreed criteria identified
  - Consultation to identify strategies for public-private mix
  - Strategy for poor and marginalized population
    - Identification of targeted population
    - Mapping
    - Comm. based interventions
  - Country to initiate activities
  - WHO and Partners
  - Country and WHO to develop guidelines and criteria

<table>
<thead>
<tr>
<th>Areas identified for planning</th>
<th>Steps</th>
<th>Time-frame</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linkage with dermatologists and hospital physicians</td>
<td>Country to initiate activities</td>
<td>Nov-Dec 2006 Early 2006</td>
<td>Country</td>
</tr>
<tr>
<td>Linkage with dermatologists and hospital physicians</td>
<td></td>
<td></td>
<td>Country</td>
</tr>
<tr>
<td>Private/NGOs sector, according to agreed criteria identified</td>
<td>WHO and Partners</td>
<td>Nov 2006</td>
<td>Country / WHO</td>
</tr>
<tr>
<td>Consultation to identify strategies for public-private mix</td>
<td></td>
<td></td>
<td>Country / WHO</td>
</tr>
<tr>
<td>Strategy for poor and marginalized population</td>
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<td></td>
<td></td>
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<tr>
<td>- Identification of targeted population</td>
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<td></td>
<td></td>
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<tr>
<td>- Mapping</td>
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<td></td>
<td></td>
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<tr>
<td>- Comm. based interventions</td>
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</tr>
<tr>
<td>Development of the software with geographic referencing</td>
<td>Country to initiate and collaborate with WHO</td>
<td>July 2006</td>
<td>Inter-country</td>
</tr>
<tr>
<td>Development of the software with geographic referencing</td>
<td></td>
<td></td>
<td>WHO / Country</td>
</tr>
<tr>
<td>Training – case reporting, data management</td>
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<tr>
<td>Surveillance System – IDSP or ad-hoc</td>
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<tr>
<td>Data management unit at all levels</td>
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<tr>
<td>Inventory of reporting sites</td>
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<tr>
<td>Unit of reporting</td>
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<tr>
<td>Uniform reporting formats</td>
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<tr>
<td>Core indicators</td>
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<td></td>
<td></td>
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<tr>
<td>Additional indicators</td>
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<td></td>
<td></td>
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<tr>
<td>Frequency of reporting</td>
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<td></td>
<td></td>
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<tr>
<td>Supervision and quality control</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Flow of information</td>
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<td></td>
<td></td>
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<tr>
<td>Feedback – bulletin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing of information from lowest level through national channel to WHO, web-based</td>
<td></td>
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<tr>
<td>Integrated Vector management</td>
<td>Country and WHO</td>
<td>Sep 06</td>
<td>WHO / Country using MCA</td>
</tr>
<tr>
<td>Stratification of the spraying areas</td>
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<td></td>
<td></td>
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<tr>
<td>GIS/mapping</td>
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</tr>
<tr>
<td>- Round one: February–March</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Round two: August–September</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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Intercountry Meeting of National Programme Managers for Kala-azar Elimination

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Page 25
## Strategies for Planning

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Areas identified for planning</th>
<th>Steps</th>
<th>Time-frame</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Microplan</td>
<td>Guidlines, Community participation and BCC, Roster of human resource by category, Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Procurement of insecticides, Spraying equipment, Repair and maintenance of equipment, Implementation plan, Supervision and monitoring, Reporting of coverage, Entomological evaluation, ITNs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>− Operational research, Improved home management, − kalanet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Mobilization</td>
<td>Documentation of available information, BCC impact objectives in consultation with social scientist and communication experts, Inventory of existing BCC materials and methods, Mapping of resources at different levels − e.g. micro-financing, Development of BCC package − advocacy and others, Strategy for implementation − message mix, Development of logo and slogan, District societies/committee, Village/community multi-sectoral committee, Community-based programmes by district and villages</td>
<td>Country and WHO</td>
<td>Sept 2006</td>
<td>WHO/Country – using MCA</td>
</tr>
<tr>
<td>Strategies</td>
<td>Areas identified for planning</td>
<td>Steps</td>
<td>Time-frame</td>
<td>Responsibilities</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>Operational Research</td>
<td>Inventory of partners on ORs Inventory of available documents Inventory of experts (multidisciplinary) Plans for capacity development Linkages and networking amongst research groups and with programme Community-based interventions</td>
<td>Country and WHO</td>
<td>Oct. 2006</td>
<td>WHO / Country / TDR</td>
</tr>
<tr>
<td>Cross-border initiatives</td>
<td>Identify areas country-wise responsible for supporting programme Components: Resource mobilization Operations research Areas of collaboration Migration – case management Information exchange</td>
<td>Country and WHO</td>
<td>Late 2006</td>
<td>WHO / Country / Partners Using MCA</td>
</tr>
</tbody>
</table>