

Communicable Disease Newsletter

Aiming for zero new infections, deaths and discrimination in HIV

A new “Regional Health Sector Strategy on HIV, 2011-2015”, has been endorsed by Member States of the WHO South-East Asia Region (SEAR). Through this Regional Strategy, WHO urges countries to achieve universal access to comprehensive HIV prevention, treatment and care and to contribute to health-related Millennium Development Goals (MDGs), particularly MDG 6 (combat HIV/AIDS, malaria and other diseases). The stated vision of the strategy is “zero new HIV infections, zero AIDS-related deaths and zero discrimination in a world where people living with HIV are able to live long, healthy lives.”

Since the first cases were reported in 1981, infection with human immunodeficiency virus (HIV) has emerged as the most formidable challenge to public health and development. In South-East Asia, the first few cases were reported in 1984. Today, South-East Asia has the second

highest burden of HIV in the world after sub-Saharan Africa. Although the overall adult HIV prevalence in the Region is below 1%, the total burden in terms of the absolute number of affected people is large — approximately 3.5 million people.

The past 20 years have seen unprecedented commitments to global, regional and national responses to HIV/AIDS. Significant progress has been made, such as a 31% reduction in the number of new infections between 2001 and 2009 in the Region. Achieving universal access has proven to be feasible, even in resource-constrained settings. New directions and opportunities for reaching the goal include more efficient and effective HIV approaches and technologies, the crucial contribution of civil society to services delivery and decentralization, the integrating of services and synergizing of health systems, such as



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strengthening links between HIV, TB, sexual, and reproductive health and maternal and child health.

However, much remains to be achieved. An estimated 1.3 million women aged 15 and above currently live with HIV in the Region. The estimated number of children living with HIV has increased by 46% during 2001 – 2009. Of the 448 million cases of sexually transmitted infections that occur globally, 71 million are in South-East Asia. Key challenges include late diagnosis of HIV; stigma and discrimination faced by people with HIV and most-at-risk populations; limited capacity of health systems; high prices of antiretroviral drugs, and lack of sustained financing.

The health sector can only overcome these challenges if it collaborates with other sectors in order to tackle the social, economic, cultural and environment issues that shape the epidemic and access to health services.

The goals are guided by principles that include tackling the social determinants of health that both drive the epidemic and hinder the response; protecting human rights and promoting gender equity; and integrating HIV and other health services.

The Regional Strategy has four strategic directions to achieve its goals:

- To optimize HIV prevention, care and treatment. This ensures that combined HIV-specific interventions are strengthened and expanded. These core programmes aim to enhance the quality, effectiveness and coverage of current HIV interventions and approaches, as well as to identify new HIV interventions on prevention, diagnosis, treatment and care.

- To strengthen strategic information systems for HIV and research, as information guides health policy, planning, resource allocation, programme management, service delivery and accountability. It is essential for action at all levels of the health system. As countries scale up their HIV response towards universal access, there is an increasing recognition of the need to invest in strategic information to guide programme planning and sustain national and international commitment and accountability.
- Strengthening health systems to ensure that the expanded response to HIV will build effective, efficient and comprehensive health systems in which HIV and other essential services are available, accessible and affordable. Systems need to be improved so as to create broad synergies and better health outcomes.
- Finally, fostering a supportive environment to ensure equitable access to HIV services. The health sector plays an essential role in fostering a supportive environment in the form of reducing HIV-related stigmatization and discrimination, and removing structural barriers to accessing HIV services. Linking of HIV and other key health areas is crucial for leveraging broader health outcomes. Such links are also important to ensure that the HIV response benefits from investments in other related health areas.

Dr Iyanthi Abeyewickreme
Regional Adviser, HIV Unit

Interview with Mr Y Sasakawa

Mr. Yohei Sasakawa, WHO Goodwill Ambassador for Leprosy Elimination, Chairman of The Nippon Foundation (TNF) and the Sasakawa Memorial Health Foundation (SMHF), has been a tireless crusader for leprosy-affected people. He attended the Global Leprosy Programme Managers' meeting in New Delhi, 28-29 September 2011.

Q. *The Nippon Foundation and the Sasakawa Memorial Health Foundation have been leaders in supporting leprosy elimination, through WHO as well as directly to the endemic countries. Why is leprosy so important to these organizations?*

R. Leprosy is important for us because in every man's life, there is nothing worse than being ill. There are thousands of diseases but with leprosy it's even sadder because even after being cured, there is terrible discrimination and they are not accepted by their neighbours. This has been there since the Old Testament, and in many cultures.

I take the issue seriously, as I know the true medical as well as the social negative impact, having travelled to over 120 countries on my mission.



- Q. *Now that leprosy has been eliminated as a public health problem at the national levels in South-East Asia, what are the next challenges?*
- R. I don't feel elimination is an end but a milestone to eradication. But is eradication possible? That is difficult to answer.

I have a metaphor for leprosy: a motorcycle. The "front wheel" is medical, and the "rear wheel" is the social aspect. We have been successful in the "front wheel" part, but we still have a tiny "back wheel". Only when the two wheels are balanced, can the motorcycle move forward.

In the 1980s, MDT (multi-drug therapy) was introduced, and India alone cured 11 million people. But were those treated and cured welcomed back into society as healthy people? NO. Their life is still very, very pathetic. Many still have to beg. Therefore, one of my missions is to ensure there is no more begging among leprosy-affected people here in India. Experts say, this is impossible. But we have to make a concerted effort for things to happen.

For example, in 2003, I visited UNHCR and met 27 experts, and none of them knew about leprosy-affected people and human rights. After that I visited UNHCR in Geneva every year to push for this. Last December,

192 Member States unanimously adopted a resolution to remove stigma and discrimination against leprosy-affected people. As the WHO Goodwill Ambassador for leprosy, I am thankful to the Heads of States for their support.

I must thank WHO, especially the SEAR Regional Director, Dr Samlee Plianbangchang, for his guidance and all-out support, in moving from the medical to the social aspect, to liberate people from stigma and discrimination and restore their dignity in society.

- Q. *As the WHO Goodwill Ambassador for leprosy, having visited so many leprosy-endemic countries, what is your advice to leprosy programme managers to tackle these challenges? Also, how can WHO regional offices and country offices best support the national programmes?*
- R. Under difficult conditions WHO country offices are doing very well. I have worked with many international organizations and I feel that WHO by far has very good relations with the governments they work with, and this is important. However, now a new issue is coming up. Some countries are decentralizing, which means more power to the local government. It's the local government who has the budget and decides how to use it. Appropriate advocacy at all levels, on the medical and social aspects of leprosy, is therefore essential.

Q. *What would your message be to improve awareness among the public about leprosy?*

R. Removing the stigma and discrimination associated with leprosy is a complex challenge, but we must not hold back our efforts.

First we must sensitize the international community on the human rights aspects. The second is to build general awareness and transform society's perception and understanding of leprosy. The third is to empower the people affected by leprosy so that they become the primary stakeholders in this medical, social and psychological fight against leprosy.

Q. *You have been working on stigma reduction and human rights of leprosy-affected people for many years now. Could you please share with us what, to you, have been your most significant achievements?*

R. I work with WHO, with governments of countries, with all the stakeholders, and I feel my success has been in building up this cooperation. I have been successful in getting 192 countries to accept the resolution

against stigma and discrimination against leprosy affected people. Now, we have to effectively use this resolution.

In India, where 70% of leprosy-affected people reside, I've been supporting the National Forum of India and started the Sasakawa India Leprosy Foundation to provide opportunity to leprosy-affected people.

For the elderly and severely disabled, I am now appealing to increase their pension. Then, elderly people can live in a safe environment, younger people and their children can lead a better life and there will be no more beggars from among the leprosy-affected and their families.

Interviewed by Dr Sumana Barua
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Communications Officer

Outbreaks and Public Health Emergencies

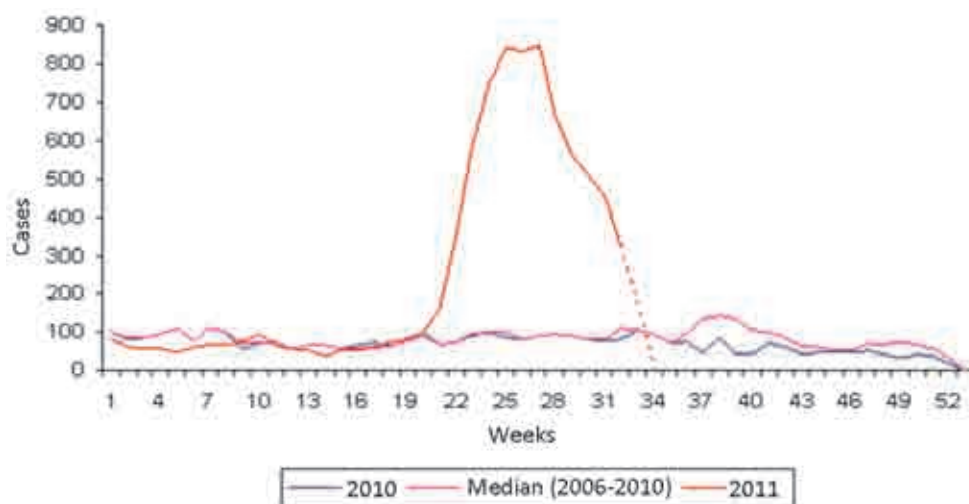
Hand Foot and Mouth Disease (HFMD) in South-East Asia

In South-East Asia, outbreaks of hand-foot-mouth disease (HFMD) have been reported from India, Indonesia, the Maldives, Sri Lanka and Thailand, but the status of HFMD in other countries in the Region is unknown. In the largest reported outbreak of HFMD in India, which occurred in Kolkata in 2007, more than 300 children were infected within four days. This disease has been of particular concern in the Region recently because Thailand has reported an unprecedented increase in the number of cases in the first half of 2011, totalling 8405 cases of HFMD with four deaths between January – August 2011. According to the Bureau of Epidemiology, the Central and Northern regions of Thailand had a high incidence with 86% of total cases registered as outpatients. An incidence rate of

194.21/ 100 000 population was reported from children below the age of five. The weekly distribution of HFMD cases in 2011 and the past five years is presented in Figure 1.

The epidemic of HFMD in South-East Asian countries in recent years clearly demonstrates the need to monitor the

Figure 1: Weekly distribution of HFMD cases, 2011 compared to 2010 and median (2006-2010), Thailand



Source: Bureau of Epidemiology, Ministry of Public Health, Thailand

emergence of this disease and establish a better surveillance system to facilitate early case detection and preventive action at the community level.

HFMD is usually a self-limiting illness, common across Asia, that mainly affects children under the age of 10. It is considered an “emerging/ reemerging disease” in countries of the South-East Asia Region. HFMD is caused by a group of enteroviruses of the Picornaviridae family. The virus is transmitted through the faeco-oral route. Symptoms include fever, sores in the mouth and a rash with blisters. It

can sometimes be fatal if complications such as meningo-encephalitis, pneumonia and myocarditis occur. Severe cases of HFMD have been associated with infection with a type of virus called enterovirus 71 (EV71). Currently, there is no specific antiviral treatment for HFMD and no vaccines to prevent HFMD infection.

Dr G.N. Gongal
Scientist

Disease Surveillance and Epidemiology Unit

Progress Update

Kala-azar elimination in Bangladesh, India and Nepal

Eliminating kala-azar in Member countries of the WHO South-East Asia Region is relevant for achieving the Millennium Development Goals (MDGs). Kala-azar is present in 109 districts in Bangladesh, India and Nepal and the target for elimination is less than 1 case per 10 000 population at the district level by 2015. The disease affects primarily the poor, and aggravates poverty. Elimination of the disease will help in the mitigation of poverty in the affected areas, and contribute to achieving MDG 1 which is to eradicate extreme poverty and hunger.

There are several reasons why kala-azar elimination is possible:

- It is confined to limited areas in three countries.
- It has unique epidemiology.
- There is only one vector (*Phlebotomus argentipes*).
- Humans are the only reservoir for the vector.
- An effective, relatively safe oral drug is available (Miltefosine).
- A rapid diagnostic test is available for use in field conditions (rK39).
- Effective vector control is possible with indoor residual spray (IRS).
- Strong political will and commitment has been demonstrated by these three countries.



With elimination as the target, the Regional kala-azar Strategy focuses on:

- Reducing kala-azar, including in the vulnerable, poor and unreached populations in endemic areas.
- Reducing case-fatality rates from kala-azar.
- Reducing cases of post-kala-azar dermal leishmaniasis and interrupting transmission of kala-azar in endemic areas.
- Improving effectiveness of programme management.
- Capacity building.
- Effective disease and vector surveillance.

- Ensuring early diagnosis and complete treatment.
- Disease prevention and control by integrated vector management, impregnated nets, indoor residual spray with community contribution.
- Preventing the emergence of kala-azar/HIV/TB co-infections.
- Operational research.
- Early diagnosis and complete treatment.
- Integrated vector management and vector surveillance.
- Effective disease surveillance through passive and active case detection.

- Social mobilization and building partnerships.
- Clinical and operational research.

There has been substantial progress in the development of effective treatment for kala-azar. It has been found that a single dose of the drug Lipid Amphotericin B (10 mg/kg) has a cure rate of around 95%. In 2009, the Regional Technical Advisory Group for kala-azar recommended this as the best drug for the elimination programme.

Dr A.P. Dash
Regional Adviser

Dr S.K. Bhattacharya
Vector-Borne and Neglected Tropical Diseases Unit

Viral hepatitis in the WHO South-East Asia Region

Viral hepatitis is a serious public health problem in the WHO South-East Asia Region. In the next ten years, it is predicted that more than five million people in the Region will die of the disease and its consequences. The disease strikes people at their most productive age, adding to the economic cost for both the family and the country.

Four viruses commonly cause the vast majority of hepatitis infections: hepatitis A, B, C and E. The estimated number

of deaths in the Region associated with viral hepatitis and its complications exceeds the mortality estimates for malaria, dengue and HIV/AIDS combined. Every year, an estimated 8.98 million cases of hepatitis, and 585 800 deaths, occur in the WHO South-East Asia Region. Of these, 400 000 cases and 800 deaths are due to hepatitis A; 1 380 000 cases and 300 000 deaths due to hepatitis B; 500 000 cases and 120 000 deaths due to hepatitis C and 6 500 000 cases with 160 000 deaths and 2700 stillbirths are due to hepatitis E. In addition, due to the high cost of treatment and care, hepatitis adds to the economic burden of millions of people and the healthcare system.



Recognizing the seriousness of the problem, the World Health Assembly adopted a resolution (WHA63.18) in May 2010, calling for comprehensive prevention and control of viral hepatitis. On 7–9 June 2010 WHO SEARO organized an informal consultation on viral hepatitis in the Region to consider the recommendations of the WHA resolution. The meeting concluded with a consensus that there is an urgent need to raise awareness about hepatitis B and C as serious health problems in all countries of the Region. This is because chronic hepatitis B and C infections are among the leading causes of preventable deaths in South-East Asia. It is estimated that 100 million people with chronic hepatitis B infection and 30 million people with chronic hepatitis C infection live in the Region. Hepatitis A and E are also serious problems. The WHO South-East Asia Region bears half the global burden of hepatitis E. The high number of cases of acute hepatitis E virus (HEV) in the Region, (with high mortality, particularly in infected pregnant women), and the trend of an increasing

number of hepatitis A virus (HAV) infection outbreaks, are both significant causes for concern.

Viral hepatitis must be given greater priority in terms of resources, technical effort and activities in all Member countries of the WHO South-East Asia Region. Good surveillance is essential to detect cases early. Infant immunization coverage for hepatitis B must reach levels greater than 95%. It should be mandatory for all blood and blood products to be screened for hepatitis B and C. The quality of hepatitis testing in public and private laboratories must be monitored. Finally, there should be widespread public awareness campaigns, targeted at health and social workers as well as the general public, to increase awareness about the risk of hepatitis. WHO will lend its full support for the implementation of all of these initiatives.

Dr Alex Andjaparidze

Disease Surveillance and Epidemiology Unit

Sri Lanka and Maldives march towards elimination of lymphatic filariasis

In the WHO South-East Asia Region, nine countries are endemic for lymphatic filariasis. Programmes for elimination of this disease involve implementing Mass Drug Administration (MDA) with two drugs – Diethyl Carbamazine and Albendazole. In 2007 and 2009 respectively, Sri Lanka and the Maldives stopped MDA after completing five rounds, when microfilarial (mf) rate was reduced to less than 1%. Following the recommendation of the Regional Programme Review Group for Elimination of Lymphatic Filariasis (RPRG-ELF) 2010, WHO-SEARO initiated the process of verification of LF elimination in these two countries by sending an expert mission to Sri Lanka and the Maldives. This mission completed the first step of the process of verification of post-MDA activities as per the revised WHO (2011) guidelines, on 12–26 June 2011.

The team undertook immunochromatography (ICT) card testing, examined old cases of LF disabilities and analyzed the available trend data. In Sri Lanka and the Maldives, a total of 419 schoolchildren aged 6-7 years were tested with ICT cards for detecting microfilarial infection (as per the revised guidelines). None were found positive, indicating the absence of transmission of LF infection in the community in those islands.

Sri Lanka:

Sri Lanka was the first country in the world to start a national anti-filariasis campaign (AFC) in 1947. The campaign focused on vector control, case detection and treatment. With the introduction, in the late 1990s, of mass treatment with a single dose of DEC and subsequently of two-drug therapy, along with vector control measures, LF was effectively controlled in the country.

In 2002, Sri Lanka initiated the WHO – recommended two-drug therapy (MDA) in eight endemic districts covering a population of 11 million, after a pilot campaign in Colombo district in 2001. The vector control measures were continued.



The programme initiated post-MDA surveillance activities including xenomonitoring, after stopping MDA in 2007.

Maldives:

The Maldives has an estimated 298 842 people living in 201 inhabited islands in six regions and 19 atolls. Even in 1952, many islands in five atolls surveyed reported a 30–55% endemicity rate for filariasis. The national control programme was launched in 1969, followed by atoll – level action in 1974. The microfilaria (mf) rate declined from 18.5% in 1950 in many of the islands to less than 1% by 2003 and to zero by 2008 due to vector control, case detection and treatment. Only Fonadhoo Island was qualified to receive MDA in 2003 and it was introduced in 2004 for a population of 2000. The island completed five rounds of MDA in 2008 and stopped in 2009.

The WHO expert mission made the following recommendations:

(1) The mission placed on record its appreciation of the efforts of the Government of Sri Lanka and Maldives and

their commitment to eliminate lymphatic filariasis in the country and also approved stopping of the MDA in 2007 and 2009 respectively.

- (2) The mission urged the programme to initiate all activities recommended for post-MDA surveillance (according to the revised WHO guidelines of 2011) and submit a report of these activities to the RPRG in 2012.
- (3) The mission recommended the initiation of steps to compile the Dossier that will be required for the certification process.
- (4) The mission recommended continuing all the morbidity management activities and exploring integrated approaches for disability management (with leprosy disability management).

Dr A.P. Dash
Regional Adviser

Dr C.R. Revankar
Vector-Borne and Neglected Tropical Diseases Unit

Asia Pacific Strategy for Emerging Diseases (APSED): strengthening preparedness in the regions

The Asia Pacific Strategy for Emerging Diseases, a unique bi-regional strategy developed by the South-East Asia Region and the Western Pacific Region of WHO, was initially launched in 2005. The development of APSED was greatly influenced by a number of events in the Asia Pacific region, including the emergence of SARS (Severe Acute Respiratory

Syndrome), outbreaks of avian influenza A (H5N1) in birds and poultry, associated with cases of human infection, as well as the adoption and anticipated entrance into force of the revised International Health Regulations (2005). The Strategy provides a framework for Member States, WHO and partners to work together in building capacity to face the growing threats posed by emerging diseases. Through APSED, over the past five years, considerable progress has been made in the Region towards strengthening the core capacities needed to prevent, detect and respond to threats posed by emerging diseases.



However, the spread of pandemic influenza H1N1 (2009) tested our public health and health care systems, revealing strengths and weaknesses. Based on past experiences and lesson learnt from the pandemic, APSED (2010) was developed through consultative and collaborative processes during 2009-2010. It has a broader reach in relation to core capacity requirement for implementation of International Health Regulations (IHR 2005) and recognizes diversity in existing

capacity levels across countries. The Strategy also addresses concerns about strengthening surveillance and response systems to meet the specific needs of smaller countries such as Bhutan, the Maldives and Timor-Leste.

While APSED (2010) continues to focus on emerging diseases, it also seeks to maximize the benefits already achieved by widening its scope to include other acute public health threats and by identifying additional areas of synergy and special situations to which the Strategy can make important contributions. APSED (2010) has therefore expanded its scope to include eight “focus areas”:

- (1) Surveillance, risk assessment, and response
- (2) Laboratories
- (3) Zoonoses
- (4) Infection prevention and control
- (5) Risk communications

- (6) Public health emergency preparedness
- (7) Regional preparedness, alert and response, and
- (8) Monitoring and evaluation.

APSED (2010) provides a framework for the establishment of policies by Ministries of Health, agencies working on emerging diseases in animal health sectors, food safety authorities, and departments concerned with the management of other public health emergencies. Development agencies, donors and other partners are also strongly encouraged to use this framework to prioritize support to countries and thus maximize the efficient use of resources.

Dr Richard Brown
Regional Adviser

Dr G.N. Gongal
Scientist

Disease Surveillance and Epidemiology Unit

Malaria programme review in Bangladesh

A review of the National Malaria Control Programme (NMPC) in Bangladesh was carried out on 20 – 30 June 2011 jointly by a team of national and international experts. The objective of the review was to conduct a comprehensive assessment of the programme, its structure, policies and strategies, operations,

partnerships, achievements, and impact on malaria. The review methodology consisted of examining programme reports and pertinent scientific literature, discussion with NMCP officials and its principle partners, field visits to some of the endemic districts, interviews with key stakeholders, including endemic communities, and analysis of data from the national database and those received from the districts during the field assessments.

Malaria is endemic in 13 of the 64 districts of Bangladesh, with over 80% of cases and deaths being reported from the three hill tract districts (Bandarban, Rangamati and Khagrachari), and Cox's Bazar. In 2010, the country reported 55 873 cases of malaria — 93% being due to *P. falciparum* — and 37 malaria deaths.

The country received two grants from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM): one in 2007 (Round 6), with which began the scaling up



of malaria control interventions, and another in 2010 (Round 9) to further expand intervention coverage. Malaria control operations are largely supported financially by the GFATM, but also by the Health, Nutrition and Population Sector (HNPS) Programme, and technically by WHO. Since 2007, malaria control services have expanded vastly. This has been achieved due to a collaboration between the Ministry of Health (MoH) and a consortium of 21 non-governmental organizations (NGOs) led by BRAC, which has led to the establishment of an effective network of community-level

intervention delivery programmes. The scale-up of key interventions which began in 2007 and 2008 is now showing impact — malaria incidence and deaths are decreasing, according to national data.

Dr Leonard Ortega
Regional Adviser

Dr Mushfiqur Rahman
Technical Officer
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Building a Regional network of Civil Society Organizations (CSOs) for TB

When the Stop TB Department of the World Health Organization (WHO) convened a consultation of selected civil society organizations at WHO headquarters in Geneva, Switzerland on 30 September – 1 October 2010, the meeting participants noted limited involvement of civil society organizations and the almost total absence of organizations of TB patients in global and national responses to TB, despite the acknowledgment of their crucial role at all levels, reflected in WHO policies and guidelines. Some of the action points recommended for WHO include:

- Develop global, regional or country-specific roadmaps to engage civil society organizations in TB prevention, care and control efforts;
- Include civil society organizations in its global and regional TB policy and programme guidance development processes and decision-making bodies;
- Capacity building (e.g., training) and technical support for national civil society organizations to promote their involvement in national TB control activities.

The TB Unit of WHO SEARO has taken a lead in involving the TB community in the Region and, in the past few years, has provided space for representatives of Civil Society Organizations (CSOs) to be involved, including ensuring their inputs in meetings with the TB National Programme Managers in the Region.

To strengthen the regional response to TB control through civil society engagement, a need was felt for a regional network of CSOs that SEARO could continue to engage with. It was agreed that the first step would be to build a database profiling

the CSOs in the region that work on community-based TB care. It was also felt that documenting stories, experiences and best practices of effective engagement from the region would be beneficial, with a plan to have a consultation of the National Programme managers and CSOs in early 2012.

Summary of findings of four countries:

Four countries in the Region initiated work to build a database of CSOs focussed on community-based TB care.

Bangladesh: Organisational profiles for 18 CSOs have been collated. Case studies and best practice summaries have also been collected. Photographs from some programmes have also been received.

Nepal: Organizational profiles for 12 CSOs have been collated. The CSOs are from seven different districts. Case studies and best practice summaries have also been collected, as well as photographs of some of the programmes.

Sri Lanka: Organization profiles for four CSOs have been collated. Case studies and best practice summaries as well as some photographs of the programmes have been collected.

Bhutan: Nine CSOs were contacted but their work on TB is limited.

Next Steps

CSOs in India, Thailand and Indonesia will be profiled in the next phase, and the CSOs in the remaining countries of the Region in the final phase.

Dr K. Hyder
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Tuberculosis Unit

First person

Life with lymphatic filariasis – associated disabilities



E., now 70 years, was a strapping young man in an island in the Maldives, looking forward to a full life of farming and fishing, when, at the age of 20, he developed fever. Initially, he didn't take it seriously – after all, everyone gets fever, and then it gets better, and he was fit and healthy. Little did he know that his life was about to change forever. For, after the fever, his feet began to swell. His family, relatively well-to-do, took him to Kerala, India, for treatment. "I was treated with tablets for six months," he recalls. His fever subsided, but the swelling on the feet – the most visible sign of lymphatic filariasis – has remained with him all his life. Now seventy, he has no regrets, he has a large, 10-member family, but wonders what life would have been like without his swollen feet.

legs are swollen, making it difficult for her to move easily. She sought treatment when she initially developed fever ten years ago, and was admitted to a health facility and began DEC treatment. The treatment destroyed the worms that caused the disease, but her disfigurement remains. "Initially it was difficult, but I'm glad that now people are aware of lymphatic filariasis, so they no longer discriminate against people like me," she said.

For F., a 63 year old widow, in a family of four, it was more difficult, as both her



H., 65, an active fiercely independent, spirited woman, did not realize, twenty years ago, that the swelling on her legs indicated lymphatic filariasis. But she was concerned, and sought treatment, in the island health centre in the capital Male, as well as with private doctors. She underwent treatment for three months. Although her disability due to lymphatic filariasis is permanent, she tries not to let it interfere with her life, and insists on doing all her chores herself. The local health centre also helps her in taking care and washing and keeping her feet clean. "I am happy, people around me are good," she says.



Dr C.R. Revankar
Vector-Borne and Neglected Tropical Diseases Unit

Dr Supriya Bezbaruah
Communications Officer

NewsBytes

Tenth International Conference of AIDS in the Asia Pacific (ICAAP)

The ICAAP is organized every two years and brings together key stakeholders for addressing the AIDS epidemic in the Asia Pacific Region including HIV positive networks and communities and key affected population groups. It provides a platform to review progress, share lessons learnt and discuss the way forward. The tenth ICAAP with the theme “*Diverse Voices United Action*” was held in Busan, South Korea, 26–30 August 2011. It covered five plenary sessions, 47 oral sessions, 11 symposia and 34 satellite meetings, 28 skill-building workshops and 1000 poster presentations. Around 3000 participants from 64 countries attended.

The conference was inaugurated with a distinguished panel including the President of Fiji and the Health Minister of the Republic of Korea. WHO SEARO collaborated in three sessions: “Elimination of new Pediatric Infections in the Asia Pacific”, “Treatment 2.0 in the Asia Pacific” and “The Health Sector Response to the needs of MSM and Transgenders”. There were country and civil society presentations and representations in all three symposia.

The issues discussed during the course of the conference ranged from updates on basic science research, ongoing trials, newer technologies like “treatment as prevention”, sustainable financing, role of regional players like ASEAN, role of communities, trade agreements and their effect on access to treatment, role of religious and faith based groups and innovative approaches to prevention, care and treatment for HIV. The poster exhibition brought together an enriching display of various interventions in the countries of the Asia Pacific Region.

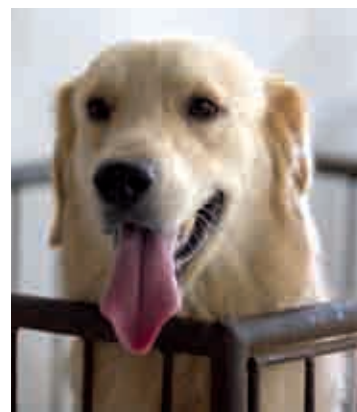
First APSED Technical Advisory Group (TAG) meeting

The first APSED Technical Advisory Group (TAG) meeting was held in Manila on 25 – 28 July 2011. WHO WPRO and SEARO workplans associated with each of the eight focus areas defined in the Strategy (i.e., surveillance, risk assessment and response; laboratory; zoonoses; infection control; risk assessment; public health emergency planning; regional surveillance and response; and monitoring and evaluation) were reviewed and endorsed. Member States were requested to continue their planning process to develop or finalize national workplans for emerging diseases and public health emergencies, in line with the APSED (2010) workplan. The meeting recommended that WHO Regional Offices should

work in consultation with partners to implement a regional workplan focussing on priority activities requiring regional coordination. A parallel meeting of international partners was also held, and they strongly endorsed the strategy and affirmed their ongoing support for implementation of this new strategy.

Regional strategic framework for elimination of human rabies transmitted by dogs in the WHO South-East Asia Region

An informal consultation was organized in Bangkok on 13-14 June 2011, by SEARO in collaboration with the WHO Collaborating Center for Research and Training on Viral Zoonoses, Chulalongkorn University. The objective was to finalize a draft “Regional strategic framework for elimination



of human rabies transmitted by dogs in the WHO South-East Asia Region”. The draft document had been prepared by the National Centre for Disease Control, a WHO collaborating centre for Rabies Epidemiology. This document was discussed in detail during the consultation and many useful comments and suggestions were incorporated. This framework focuses on public health issues and advocates for ministries of health to work with the animal health sector, local governments and non-governmental organizations to control rabies at the source of origin, i.e., dogs infected with rabies.

Guidelines for prevention and control of Nipah virus infection

Nipah virus encephalitis is an emerging zoonotic disease of public health significance. Bangladesh and India reported the first outbreaks of Nipah virus encephalitis in the WHO South-East Asia Region in 2001. Since then, outbreaks of Nipah virus encephalitis have been reported almost every year in Bangladesh. A draft guideline for prevention and control of this disease was therefore developed by WHO SEARO with the inputs of regional experts.

An informal consultation was subsequently held in Bangkok on 15 – 16 June 2011 to discuss and finalize the draft guidelines. Leading experts from International Centre for Diarrhoeal Disease Research Bangladesh (ICDDR)B

and the Institute of Epidemiology, Disease Control and Research (IEDCR), Bangladesh, the National Institute of Virology, Pune, India, the WHO Collaborating Centre for Research and Training on viral zoonoses, Chulalongkorn University Thailand, and the Ministry of Health and Family Welfare, Government of India, participated. The consultation provided a valuable forum to interact and share knowledge and experience. Dr Henry Wilde of Chulalongkorn University highlighted the need for such guidelines to strengthen preparedness for outbreaks of emerging infectious diseases. Suggestions for improvements were made and WHO SEARO was commended for taking the initiative as the guidelines will also be useful for other regions.

Addressing MDR-TB challenges

While WHO surveys show multidrug-resistant tuberculosis (MDR-TB) rates as increasing, and XDR-TB cases confirmed in 58 countries, less than 6% of MDR-TB cases are treated appropriately. This is due to several factors, including complicated treatment and inappropriate diagnosis; long and toxic treatment; limited availability of quality-assured drugs for MDR-TB treatment and wide availability of non-quality assured drugs; high cost of the treatment; and fragmented anti-TB drugs market. To address some of these issues, the second anti-TB drug manufacturers meeting organized by the Global Drug Facility (GDF) took place in New Delhi, India on 29-30 August 2011. Over 100 participants attended, including representatives from established as well as new anti-TB drug manufacturers from India. The meeting discussed global shortages of quality assured first (Streptomycin) and second line anti-TB drugs (mostly injectable) and the cost escalation of treatment for MDR-TB. The need for enhancing production capacity in the Region and motivating potential drug suppliers to increase the production of quality-assured drugs was suggested. Moreover, there are now opportunities to transform the market through consolidation of demand;

harmonization of quality standards; availability of new diagnostic technologies; initiatives to engage the private sector (e.g., WHO PPM concept); regulation of anti-TB drugs use. Enhancing support to the manufacturers in accessing quality-assured Active Pharmaceutical Ingredients (API) through establishing an API bank, provision of free of charge assistance in preparation of dossiers for the WHO prequalification programme, in addition to volume consolidation and accurate forecasting, should lead to increased number of quality assured products in the market.

Bi-regional response to drug-resistant malaria

Dr Samlee Plianbangchang, Regional Director, World Health Organization, South-East Asia, delivered the opening address in the Third International Task Force (ITF) Meeting for the Strategy for the Containment of Artemisinin Resistant Malaria Parasites in South-East Asia Project, Bangkok, Thailand, on 13-15 September 2011. The ITF monitors and provides technical guidance for the project to contain the spread of artemisinin resistant parasites in Cambodia and Thailand. The project, mainly funded by the Bill and Melinda Gates Foundation (BMGF), has been implemented since 2009. In his speech, Dr Samlee highlighted that “the spread of ‘malaria resistant to ACT’ is another important threat to international health security especially in the poor and underprivileged population groups.” He reiterated WHO’s commitment to “continue its best in providing full support to countries in their efforts to control, and even to eliminate malaria. This commitment of WHO will also be extended particularly to strengthening ‘intercountry collaboration’, this is with special attention to disease surveillance and disease management at the border areas.”

In addition to ITF members, the meeting participants included representatives from Cambodia, Thailand, China, Lao PDR, Vietnam, Myanmar, Indonesia, and Bangladesh as



well as from development agencies, implementing partners and WHO. The ITF meeting was followed by a one-day meeting wherein the participants agreed to continue the bi-regional response against drug resistant malaria beyond Cambodia and Thailand under the continuing leadership of WHO.

Strategic communication to the media on emerging infectious diseases

The mass media is probably the single most important source of health information for the general public, shaping public opinion, and influencing policymakers and donors, so it is important that media reports of outbreaks and emerging infectious diseases are accurate. Therefore, an informal media consultation was held on 26 May 2011 in Delhi, India, to develop a tool for identifying key issues for improved health reportage on emerging infectious diseases. The focus was on countries considered 'hotspots' for emerging infectious diseases i.e., Bangladesh, Bhutan, India, Myanmar, Nepal, Thailand, as well as Indonesia which has recently suffered outbreaks of avian influenza, dengue and other EIDS.

In the workshop, both technical experts and journalists expressed what they expect from each other, followed by discussions on how to meet these expectations. Among the recommendations were:

- (1) Regular, ongoing meetings between health experts/WHO and key, national level media on health issues, needs and constraints faced.
- (2) During health emergencies, the prompt availability of a health spokesperson at all times for quotes, regular briefings, updated information for the media.
- (3) Wider use of internet technologies to bridge the information gap in a fast-moving situation, including social media, sms alerts, virtual press conferences, voice

recordings at a preset phone number with the updated information accessible from anywhere.

- (4) More trainings and field visits for journalists.
- (5) Emphasis on the "human" and social aspects of health developments.

WHO supports mission for dengue prevention and control in the Maldives

In 2011, the Maldives had the worst outbreak of dengue in five years, with over 2400 cases and 12 deaths. Significantly, while earlier outbreaks of dengue were primarily in the capital Male, this year almost half the cases reported were from the islands.

WHO assisted the Maldives by supporting two missions on 18 – 22 September 2011. The first mission was led by Prof. Siripen Kalayanaroj of the WHO Collaborating Centre for Case Management of Dengue at the Queen Sirikit National Institute of Child Health, Thailand. Prof. Siripen and her team provided training on clinical case management of dengue to clinicians at the Indira Gandhi Memorial Hospital, Male. This week-long training was well received by clinicians and other health staff from Male and the islands including staff from private hospitals.

The main objective of the second mission, led by Dr Chusak Prasittisuk, was to assist in social mobilization as well as to assist with a draft strategic plan for dengue prevention and control, based on the Asia Pacific Dengue Strategic Plan (2008-2015). The team met over 15 stakeholders, including the construction industry association MACI, Ministry of Education, Ministry of Housing and Environment, Local Government Authority (who coordinate the island councils), Male Municipal Corporation, GMR (airport and port health), and health corporations, NGOs like the Maldivian Red Crescent. The key message expressed was "dengue prevention and control is everyone's responsibility".

On 22 September, over 20 participants from different organizations and Ministries attended the one-day Stakeholders Meeting to discuss their role in preventing and controlling dengue and this was included as part of the draft national strategic plan for dengue.



Strategic plan for kala-azar in Bangladesh

A rise in the number of kala-azar cases in 30 districts in Bangladesh has raised concern. Recently, the Health Ministry revised its national guidelines on the parasitic disease and adopted a strategic plan to tackle it. Almost 60 per cent of the kala-azar patients can be found in two Upazillas of Mymensingh — Trishal and Fulbaria.

New Appointments in the Department

Dr Richard Brown has been appointed Regional Adviser, Disease Surveillance and Epidemiology from 1 June 2011.

Dr Khurshid Alam Hyder has been appointed Regional Adviser, Tuberculosis from 9 May 2011.

Dr Rui Paulo de Jesus has been appointed Regional Adviser, Communicable Disease Control from 23 May 2011.

New publications

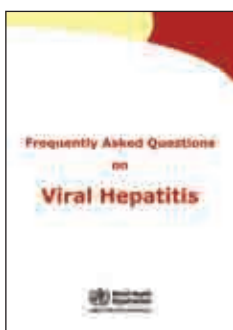


Comprehensive guidelines for the prevention and control of dengue

Dengue is the fastest emerging arboviral infection with major public health consequences, particularly in South-East Asia. This revised and expanded edition of the Comprehensive guidelines is intended to provide guidance to national and local-level programme managers, public health officials, health practitioners, laboratory personnel and others, on planning, implementation, monitoring and evaluation, and strengthening response to dengue prevention and control.

Viral Hepatitis in the WHO South-East Asia Region

Viral hepatitis affects nearly nine million people in South-East Asia, and causes more than half a million deaths annually. This publication provides an analysis of viral hepatitis South-East Asia, and ways to meet this immense public health challenge.

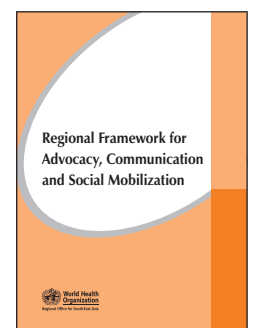


Frequently Asked Questions: Viral Hepatitis

This publication answers some basic questions on viral hepatitis in the South-East Asia Region.

Regional Framework for Advocacy, Communication and Social Mobilization

This publication provides a roadmap for increasing an understanding of tuberculosis among policy-makers and the public, and promoting key behaviour change for controlling the disease.



Surveillance corner

Avian influenza in the WHO South-East Asia Region

In 2011, outbreaks of highly pathogenic avian influenza have been reported among poultry in Bangladesh, Indonesia, India and Myanmar.

The South-East Asia Region has reported a total of 210 human cases of influenza A (H5N1) with 166 deaths, since 2004, until October 2011. As much as 37% of global human cases of A (H5N1) have occurred in this Region.

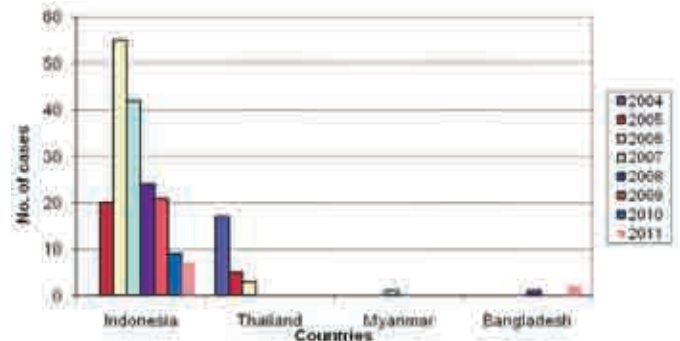
Until 31 October 2011, Bangladesh, Indonesia, Myanmar and Thailand have reported laboratory confirmed human cases of avian influenza A



(H5N1) as shown in Figure 2. Indonesia reported 181 human cases of influenza A (H5N1) with 149 deaths since July 2005. The number of reported human cases has been progressively decreasing in the last five years.

A statement recently made by FAO indicated emergence of a new variant of Influenza A/H5N1 (described as H5N1 Clade 2.3.2.1) in Indochina and its potential to spread among poultry populations, and elicited considerable media interest. The WHO Global Influenza Surveillance and Response System had earlier recognized this new clade in February 2011. H5N1 viruses continue to evolve, especially in areas where they are endemic in poultry. Human cases of influenza A(H5N1) infection remain rare and sporadic events, occurring mostly in areas where H5N1 viruses circulate regularly in poultry. There is currently no evidence that the newly evolved clade is more transmissible or pathogenic in humans.

Figure 2: Reported human cases of influenza A (H5N1), South-East Asia Region, 2004-2011 (Jan-Oct)



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