

The reported and estimated data suggest that five countries – Bhutan, Maldives, DPR Korea, Sri Lanka and Thailand – have achieved the target of elimination of neonatal tetanus, i.e. less than 1 case per 1000 live births. The high risk area approach, considered to be critical for the elimination of this disease, has been promoted in all countries. However, the Region continues to account for 30% of the world's reported cases of neonatal tetanus.

Neonatal tetanus

On comparison of the estimated number of measles cases during the pre-immunization period and during 1995, there is a reduction of about 67% in the measles cases in the Region. Special immunization campaigns against the disease were introduced in urban high-risk areas. However, the countries of South-East Asia continue to account for 30% of the world's reported measles cases. Due to incomplete surveillance data, however, there is gross under-estimation of measles cases.

Measles

The measles vaccination coverage of children under one year of age in the Region has been maintained above 80%. Supplementary measles vaccination campaigns were conducted in selected towns and districts in Bangladesh, Bhutan, India and Nepal.

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Control of Other Communicable Diseases

There has been a dramatic expansion of activities relating to diphtheria, pertussis and childhood tuberculosis in the Member Countries. Immunization coverage for these diseases in the Region as a whole has been sustained at 80%. WHO continues to give priority to increasing immunization coverage in all critical regions/districts. Childhood immunization with hepatitis B has

Vaccine-preventable diseases

**Diarrhoeal
and Acute
respiratory
diseases
control**

been introduced in Bhutan, Indonesia, Maldives and Thailand and selectively in some states in India.

Bangladesh, DPR Korea, India, Indonesia, Myanmar and Thailand are producing some of the EPI vaccines. Of these countries, *India, Indonesia and Thailand are the only ones that have reached the level of sustainable supply of quality vaccines and these countries alone have adequate national vaccine control bodies, although their functions are not yet optimal.*

In order to protect the ozone layer, CFC-free refrigerators are replacing the use of conventional refrigerators. In addition, WHO is encouraging the use of solar energy for cold chain systems in some of the Member Countries.

Considerable progress has been made in all the target Member Countries in the control of acute respiratory infections (ARIs) and diarrhoeal diseases. In December 1995, WHO sponsored an intercountry review meeting of programme managers, which was held in Yangon, Myanmar. At this meeting, which was attended by CDD and ARI programme managers from Bangladesh, India, Indonesia, Myanmar and Nepal, it was agreed that, while training and other activities should be continued with greater vigour, it was also necessary to pay attention to the quality of training, monitoring and supervision in order to assure that clinical management improves and, thus, mortality rates due to these diseases are reduced.

An intercountry training course for training of trainers of prominent NGOs from Bangladesh, India, Indonesia and Nepal was held in Pokhara, Nepal. The training material for this course was a regional adaptation of the material developed by WHO/HQ. It was later refined and will be used to train government and NGO trainers in SEAR countries.

To evaluate the performance of health workers, the ARI and CDD programmes have developed a health facility survey protocol which was used to conduct three surveys in Bangladesh (ARI)

and Indonesia (ARI and CDD) in 1995. These surveys showed that although much progress had been made by these programmes, there were certain weaknesses in health workers' management of ARI and diarrhoea cases.

Integrated management of childhood illnesses (MCI), which includes management of diarrhoea, ARIs and undernutrition, was identified as a priority area in several Member Countries. During 1995, Indonesia and Nepal prepared, with the assistance of WHO consultants from SEARO and headquarters, comprehensive plans for integrated management of childhood illnesses. These plans have now been approved by the governments. WHO will include these countries as 'first-use' countries for MCI. Three representatives from Indonesia and Nepal were trained in the first consultant clinical course in Addis Ababa in 1995 and one more was trained in May 1996. Areas for implementation of MCI have been selected and WHO material is being adapted and revised for local use.

WHO continued to provide technical assistance and support to Member Countries mainly in the areas of preparing internal evaluations, developing revised plans of action and facilitating training activities. Financial support for control efforts was also provided.

Technical assistance was provided to Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand in the development of national plans for tuberculosis control and in the preparation of a manual based on the revised TB strategy. The joint programme reviews conducted in Indonesia, Nepal and Thailand during 1994-1995 had a positive impact in that they led to the development of revised national tuberculosis programmes (NTPs) through strengthening of weak areas and according of higher national priority and increased resources to TB programmes. WHO also provided technical support to the World Bank funded tuberculosis projects in Bangladesh and India in the drafting of project documents and in monitoring the pilot project sites.

Tuberculosis

Emerging diseases

An Intercounty Meeting of National TB Programme Managers in South-East Asia Region was organized in Thailand in 1995 to review the WHO policy and strategy for tuberculosis control; to finalize a document on the strategic plan for tuberculosis control in South-East Asia Region, and to develop a work plan for its implementation. In November 1995, a workshop was held in Nepal to develop a core of resource personnel in the Region who will have the necessary skills to strengthen NTPs of their own countries and be available to provide consultancy services to other countries.

Facilitators, who were earlier trained in WHO-sponsored regional workshops, now conduct training courses in their respective countries. In the area of research, WHO continued to technically support some of the ongoing operational research studies in Member Countries. India, Nepal and Thailand from the Region are taking part in the WHO Global Project on Anti-tuberculosis Drug Resistance Surveillance studies.

Communicable diseases continued to dominate the disease pattern in all the countries of the Region. The best defence against new, emerging and re-emerging infectious diseases is prevention, early detection and effective control measures. Effective surveillance is essential for early action to prevent and control epidemics. An intercountry meeting on New, Emerging and Re-emerging Infectious Diseases was held in SEARO, August 1995, to identify strategies and approaches for effective control of these diseases. It recommended reviewing and strengthening epidemiological services and surveillance systems to provide early warning, strengthening laboratory capacities and developing rapid response mechanisms. This meeting was followed in June 1996 by an intercountry symposium on the prevention and control of selected communicable diseases with epidemic potential. Recommendations were developed at this symposium for formulating operational guidelines for use in the countries for early diagnosis, proper case management and prevention and control of these diseases

and for establishing a networking system for exchange of epidemiological and other relevant data.

Cholera, caused by the El Tor strain, has been reported from all the countries in the Region, except DPR Korea. A new strain, now labelled *V. cholerae* O139 and first reported in October 1992, rapidly spread to many countries in South-East Asia as well as to countries in other WHO regions. The new strain, which almost completely replaced the O1 El Tor strain in 1993, however, largely disappeared from the countries in 1995.

SEARO participated in an interregional meeting held in Geneva in December 1995 to revise the International Health Regulations which will facilitate the exchange of information on cholera and other diseases of international concern without fear of any restrictions being imposed on the reporting countries.

WHO continued to support countries in the prevention and control of the most frequently observed zoonotic diseases such as rabies, anthrax, toxoplasmosis, cysticercosis, plague and food-borne diseases. A number of national workshops were held for the development of strategies for rabies control programmes. Large-scale dog vaccination programmes and improved post-exposure treatment of humans have been promoted in Indonesia, Sri Lanka and Thailand. Nationals from India, Indonesia, Sri Lanka and Thailand were trained in the prevention and control of zoonotic diseases.

WHO assisted the training of six Indian nationals in laboratory diagnosis and production of diagnostic reagents for plague at WHO collaborating centres, enabling the country to produce sufficient quantities of test-kits for conducting regular serological testing of rodents for predictive surveillance and for laboratory diagnosis of plague in the countries of the Region. In March 1996, WHO conducted a training workshop on laboratory diagnosis and surveillance of plague at Yogyakarta, Indonesia,

Cholera

Zoonoses

Antimicrobial resistance

where scientists from Indonesia, Myanmar, Nepal, Sri Lanka and Thailand participated.

A consensus meeting of participants from all Member Countries was held in December 1995 for setting up a Gonococcal Antimicrobial Sensitivity Programme (GASP) in SEAR with the objective of monitoring the testing of gonococcal antimicrobial sensitivity. Establishment of a network of laboratories would promote not only the broad programme objective of monitoring antimicrobial resistance, but would also go a long way in the prevention of spread of STDs, including AIDS, by selecting effective therapy.

Dengue/ dengue haemorrhagic fever (DHF)

Dengue/DHF continues to persist in many countries of the Region. This infection is a notifiable disease in Indonesia, Myanmar, Sri Lanka and Thailand. India is also planning to include dengue/DHF in the list of reportable diseases. In October 1995, WHO organized a regional consultative meeting on Prevention and Control of Dengue/DHF in New Delhi. It reviewed the present situation and developed a revised strategy and plan of action for prevention and control of this infection at national and regional levels. As a result of the recommendations of this meeting, WHO fielded a short-term consultant in Myanmar, who assisted nationals in the preparation of a revised national strategy and a proposal for extrabudgetary funding for dengue/DHF prevention and control. Development of a training module for case management of DHF and dengue shock syndrome (DSS) is under way. Designation of the Children's Hospital in Bangkok, Thailand, as a WHO collaborating centre for case management of dengue/DHF/DSS has been initiated.

WHO continued to provide support for clinical trials of dengue vaccine for children, which has been developed by Mahidol University, Bangkok. The terms of reference of the Technical Advisory Committee for the preparation of protocols for the Phase III field trials of dengue vaccine and a review and analysis of results are being finalized.

WHO continued implementation of the regional plans of prevention and control of viral hepatitis in Member Countries. WHO assisted Bhutan to develop a national strategy and a proposal for extrabudgetary funding for hepatitis B prevention and control. Assistance was provided to India in the preparation of a protocol for a demonstration project of hepatitis B vaccination. Myanmar has developed hepatitis B vaccine and field trials are under way. In DPR Korea, Indonesia, Maldives and Thailand, hepatitis B vaccination was introduced within the framework of EPI in limited areas. During 1995-96 it was extended to more provinces. Large-scale production of hepatitis B vaccine has been started in DPR Korea and Indonesia. Mandatory screening of blood and blood products for hepatitis C virus infection was introduced in Thailand.

WHO provided technical support to Member Countries in outbreak investigation, control and containment measures for epidemics of hepatitis E virus infection.

Japanese encephalitis continues to be a disease of significant public health priority in India, Nepal, Sri Lanka and Thailand. Cases have also been reported in Bangladesh and Myanmar. In Indonesia, in addition to the serological evidence of circulation of JE virus, a few clinical cases have also been reported in 1995. The human immunization strategy to control JE successfully is being used in Sri Lanka and Thailand. A mass vaccination campaign was introduced in 30% of the provinces in Thailand. WHO provided technical information to the endemic countries and helped in the procurement of JE vaccine.

The Regional Office continued to assist the Member Countries in the planning, implementation and evaluation of AIDS prevention and control activities. These included formulation of medium-term AIDS control plans; organization of external programme reviews; assistance in training and strengthening of national capacities; promotion of STD/AIDS prevention and care activities to be integrated into primary health care; development of guidelines

Viral hepatitis

Japanese encephalitis (JE)

AIDS and sexually transmitted diseases

and technical materials, and facilitating the supply of equipment, reagents, condoms and HIV test-kits. To enhance political commitment at country level for urgent response to the HIV/AIDS pandemic and promote STD/AIDS education in schools, advocacy materials in the form of videos and printed texts were developed. In addition, support was provided to the ASEAN Secretariat, Jakarta, to develop its HIV/AIDS work programme; to the Asian Institute of Migration, Bangkok, for developing an information base on HIV and population movement, and to the Royal Thai Government for organizing the 3rd International Conference on HIV/AIDS in Asia and the Pacific in Chiang Mai in September 1995.

To promote and share appropriate HIV prevention and control strategies and interventions, intercountry meetings were held which included: HIV/AIDS, STD Surveillance and Data Management (Bangkok, December 1995) and Monitoring Gonococcal Antimicrobial Susceptibility (New Delhi, December 1995). The annual meeting of National AIDS Programme Managers to exchange programme experiences and to share innovative ideas and approaches suitable for the Region was held in Jakarta in November 1995. The Regional Office also organized a consultation in Thailand in September 1995 for staff and consultants of the WHO Global Programme on AIDS (GPA) to brief them on AIDS programme management.

The Regional Office developed and distributed a document entitled 'Information, Education and Communication -- A Guide for AIDS Programme Managers'. More than 8000 copies of a SEARO booklet 'Understanding and Living with AIDS' were distributed. A training guide on counselling was prepared after pretests in India and Nepal. The 'AIDS Home Care Handbook', developed by WHO/HQ, was revised during a consultation, field-tested in four Member Countries to make it suitable for regional use, and distributed to national programmes and NGOs in the Region. Support was provided to countries in developing a continuum of care models and in integrating comprehensive HIV/AIDS care and support into primary health care.

In line with the Global Malaria Control Strategy, the current national efforts are concentrated on early diagnosis and prompt treatment of malaria through the PHC system; implementation of selective transmission control activities; prevention and control of epidemics and extensive capacity building to support the above activities, and upgrading of operational research.

The Regional Intercountry Consultative Meeting of National Programme Managers held in SEARO in March 1995 had set a target to achieve 25% reduction in the 1995 level of malaria mortality in the high-risk groups by 1999. The impact of malaria on health in areas close to international borders became an important issue.

To achieve the above target, WHO continued to support Member Countries in the assessment of malaria control programmes, development of extensive training facilities, coordination of action in border areas, and upgrading their capabilities in operational/applied research. Two border meetings, involving five endemic countries, were organized in August and December 1995, which resulted in initiation of cooperation and enhanced coordination of malaria control activities in adjoining areas. WHO organized workshops for trainers in Bangladesh and Bhutan on the management of severe malaria, which was followed by a series of national workshops. An intercountry workshop on planning and implementing vector control for malaria, organized by WHO in December 1995 in Bangalore (India), made recommendations on policy and guidelines in vector control, strengthening of research in vector biology and control, and the need to establish firm partnerships with other sectors, including private enterprises and NGOs, for effective and sustainable control of malaria and other disease vectors. The World Bank continued to assist Bangladesh in the vector-borne diseases programme. Myanmar received assistance from UNDP in malaria control.

It is estimated that almost 55 million people are infected with lymphatic filariasis in the Region. There was no change in the situation during the reporting period.

**Special
Programme for
Research and
Training in
Tropical
Diseases (TDR)**

Major endemic foci of visceral leishmaniasis are reported in border areas between India, Bangladesh and Nepal. A declining trend was reported from a total of 52 974 cases and 727 deaths to 33 343 cases and 408 deaths during 1993 and 1994 respectively.

The TDR activities and research in the Region focused mainly on malaria, filariasis, leprosy and leishmaniasis. With regard to malaria, TDR sponsored in 1995-1996 studies on drug resistance (Myanmar, Thailand); malaria vaccines development (India); health financing of malaria programmes (Thailand); vector control strategies (Sri Lanka, Myanmar), and drug regimen compliance (Myanmar). With regard to lymphatic filariasis, studies to test new drug regimens such as amocarzine (India) and to evaluate foot care, DEC and penicillin were conducted to develop new strategies in morbidity control (India). Use of impregnated bed-nets and curtains, in combination with chemotherapy and vector control, is also a part of the cost-effective strategies being currently investigated in the Region (Sri Lanka). The economic affordability of filariasis control interventions is the subject of several on-going research projects (India), and a workshop in this regard was conducted at the Vector Control Research Centre, Pondicherry, India, in March 1996. Rapid assessment procedures are also being investigated for better understanding of the epidemiology of filariasis (India). Field studies on leprosy focused on the sociological impact of the disease on women patients (India). Field trials of new drug regimens containing ofloxacin are being conducted in India and Myanmar and a multicentric study on the prevention of mycobacterial diseases through the molecular approach was initiated in India in 1995. Recognizing the need for better drugs and diagnostic tests, regional studies on visceral leishmaniasis focused on immunotherapy (India), new drug regimens (India) and simple diagnostic tests usable under field conditions (Nepal).

Collaboration between TDR/HQ and selected governments in the Region is now being strengthened in regard to strategic

projects, such as the long-term financial and technical partnership in the development of the genome project (physical and genetic mapping of the genes of the TDR target parasites), and new drugs discovery and screening using novel approaches, such as combinational chemistry and molecular biology.

A regional TDR linkage grant for research training, approved in June 1993, is still operational and involves three countries (Myanmar, Sri Lanka, Thailand). In SEAR, Nepal has been recently selected for intensified TDR support.

The major area of WHO's collaboration in the prevention of blindness (PBL) continued to be the promotion of primary eye care using the PHC network, and control of avoidable blindness through restorative interventions such as eye camps, outreach services and strengthening of referral facilities. Support was provided for conducting training courses on primary eye care for persons in charge of health posts and school teachers in Nepal. In Myanmar, a community-based eye restoration project was recently formulated in Mandalay, and a model primary eye care project in Sintgaing was continuing its expansion in other areas with the production of relevant IEC materials and conduct of training courses for health assistants and eye care personnel.

In India, a massive cataract control project, supported by the World Bank, was launched by organizing operation camps, training courses and institutional strengthening. WHO supported the country for developing a recording and reporting system for monitoring the progress of PBL programmes at the district level.

Despite all-round efforts to control blindness, its prevalence, particularly due to cataract, does not appear to be decreasing significantly. This has necessitated undertaking a review exercise on the existing strategies and approaches. With support from AGFUND, several countries in the Region, including Bangladesh, Nepal and Myanmar, conducted review workshops, the results of which were utilized at a Regional Workshop on Assessment of National Programmes for Prevention of Blindness in April-May

Prevention of blindness and deafness

1996. Apart from this, an in-depth evaluation of the impact of the PBL programme on eye health status is under way in Nepal.

As regards prevention of deafness and hearing impairment, efforts are being made to ascertain the magnitude and aetiological pattern of the problem through a multicentric study in four selected countries of the Region. WHO assisted in the development of a manual on primary ear care for physicians and medical assistants working at the PHC level in Thailand.

16 Control of Noncommunicable Diseases

Control of non- communicable diseases

Serious efforts towards an integrated approach to the control of noncommunicable diseases (NCD) were started in the Region with an intercountry workshop in October 1995. Integration is supposed to cover three aspects: first, the formation of core groups of specialists from various concerned fields, e.g. cardiology, oncology, endocrinology, rheumatology, etc., in order to jointly develop curriculum modules for various levels of health care; second, the apportionment of tasks to various levels of care; and, third, addressing jointly the risk factors which are the common cause of several noncommunicable diseases such as smoking, dietary habits, sedentary lifestyles, etc.

Oral health

The oral health programme continued to centre around the prevention and control of the two most predominant oral diseases – caries and periodontal diseases. Major approaches to dealing with these conditions are promotion of primary oral health care, introduction of appropriate public oral health measures such as water fluoridation, and development of affordable dental restoration technologies. With WHO's support, the primary oral health projects, started initially in a few townships in Myanmar, have