



DCD

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Disease elimination and eradication: where are we?



extremely important factor.

Disease elimination is defined as the elimination of either infection or disease. Elimination of infection is the disappearance of transmission of an infection from an area, small or large, within a country, region or continent, such that it ultimately becomes free of infection, as in elimination of measles. Elimination of disease is the reduction of case transmission to a pre-determined very low level at which the disease is no longer a public health problem, as with leprosy and neonatal and maternal tetanus elimination. After elimination is achieved, disease prevention and control efforts should actively continue in order to maintain elimination status. Interruption of the control measures will result in re-emergence of the infection or the disease in previously free area(s).

Disease eradication is defined as irreversible cessation of transmission of the causative agent through extermination

of this causative agent from all countries of the world. When a disease is eradicated, the infection disappears from the world, no further cases of the disease occur anywhere and continued control measures are unnecessary.

Global goals for elimination and eradication of disease are built on the experience gained from the successful eradication of smallpox in 1977. At present, the global and regional targets for communicable disease elimination and eradication include: poliomyelitis eradication by 2005 (regional and global

target); dracunculiasis eradication by 2009 (regional and global target); leprosy elimination by 2005 (regional and global target); maternal and neonatal tetanus elimination by 2005 (regional and global target); measles elimination by 2010 (regional target); and lymphatic filariasis elimination by 2015 (regional target). Three of these targets were set for the end of 2005 (eradication of poliomyelitis and elimination of filariasis and maternal and neonatal tetanus).

Dracunculiasis eradication

Sudan is the only country in the Region endemic for dracunculiasis. During 2005, 5569 new cases of dracunculiasis were reported, compared with 7266 cases in 2004. The northern states of Sudan were free from local transmission of dracunculiasis. East Equatoria was the most highly endemic of the 10 states

The ultimate objective of any communicable disease control programme is the elimination, and then the eradication, of the targeted disease. The possibility of elimination or eradication of a disease, however, depends on identifying the various factors related to its occurrence, as well as the availability and implementation of effective prevention and control strategies. The political environment, which defines the political commitment, availability of resources and international support, is also an

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in southern Sudan, with 70% of reported cases. The percentage of contained cases was around 4% due to high movement of displaced populations in southern Sudan. A large number of cases were reported from previously inaccessible areas in southern states.

In 1990, three countries (Pakistan, Sudan, Yemen) were endemic for dracunculiasis. In 2005, only one country (Sudan) remained endemic.

Lymphatic filariasis elimination

In 2004, Egypt completed five rounds of mass drug administration (MDA) with diethylcarbamazine and albendazole for a target population of 2.5 million people in 163 villages. Microfilaraemia and antigenaemia surveys confirmed interruption of lymphatic filariasis transmission in 153 villages. In 2005, 40 villages with a population of 0.8 million continued to receive MDA. Yemen completed four rounds of MDA with ivermectin and albendazole in all endemic areas in 2005. Monitoring of the efficiency of the MDA will be done in sentinel sites. Mapping of lymphatic filariasis was completed in 141 administrative units in 6 states in Sudan. Mapping activities will be continued in other states during 2006.

In 2000, one endemic country (Egypt) was implementing MDA. In 2005, two endemic countries (Egypt, Yemen) were implementing MDA.

Leprosy elimination

By 2000, the goal of elimination of leprosy as a public health problem was achieved in all endemic countries at the national level. By 2005, the target to eliminate leprosy at subnational levels was achieved at the first administrative levels in all countries and at the second administrative level in all countries except Egypt, Somalia and Sudan. The next priority for the national programmes is to sustain the progress achieved through integration of leprosy activities within available primary health care systems.

In 1995, 7 countries had leprosy prevalence higher than 1 per 10 000 population at subnational level (Afghanistan, Egypt, Morocco, Pakistan, Somalia, Sudan, Yemen). In 2005, only 3 countries still had prevalence higher than 1 per 10 000 population at subnational level (Egypt, Somalia, Sudan).

Maternal and neonatal tetanus elimination

In 1989, the World Health Assembly adopted the goal of elimination of neonatal tetanus (NNT) by 1995, defined as less than 1 NNT case per 1000 live births in every district.

In 1990, 4666 NNT cases were reported in the WHO Eastern Mediterranean Region. However, because of the weak surveillance system in several countries, WHO estimated the number of NNT deaths in the Region to be much higher, around 56 000, with NNT death rates varying from less than 1% of live births in the 6 countries of the Gulf Cooperation Council to more than 5% in Pakistan, Somalia and Sudan (with rates in the remaining 14 countries from 1% to 5% live births). A regional action plan was therefore developed for the 17 countries with estimated NNT death rates higher than 1%, focusing on three main strategies: immunization of women of childbearing age with at least two doses of TT vaccine, provision of clean delivery and strengthening of NNT surveillance.

By 1995, substantial achievements were made in the Region, with 16 countries reaching less than 1 NNT case per 1000 live births in every district. The remaining countries were Afghanistan, Egypt, Iraq, Pakistan, Somalia, Sudan and Yemen. The global goal was not achieved, mainly because of the situation in these countries and others in the WHO African, South-East Asian and Western Pacific Regions. It was therefore decided to postpone the global elimination goal to 2005 and to change it from elimination of NNT to elimination of MNT (maternal and neonatal tetanus).

In 1996, the regional plan of action was revised to focus on the seven remaining countries using an acceleration strategy, the high-risk approach. In this approach, all high-risk districts for MNT were identified in all remaining countries, using a standardized algorithm developed by WHO and UNICEF, and plans were made to conduct at least three rounds of tetanus toxoid vaccination campaigns targeting all women of childbearing age, in addition to improving surveillance activities and clean delivery services.

National action plans were developed in the seven remaining countries, but implementation varied from one country

to another. Despite all the joint support provided by WHO and UNICEF, only one of the seven countries, Egypt, reached the elimination goal. However, Afghanistan, Iraq, Sudan and Yemen have made good progress for the past 5 years and are currently close to elimination, with only a small number of districts that have not yet reached the elimination goal. In 2005, 802 MNT cases were reported by 21 countries (no report was received from Somalia to date), with 518 cases (65%) from Pakistan, 94 from Sudan, 58 from Egypt, 46 from Yemen and 39 from Afghanistan.

Measles elimination

In 1997, the Regional Office established a goal to eliminate measles by 2010. The regional strategy for measles elimination includes:

- High routine measles vaccination coverage (>90% in all districts) among children aged 1 year
- One-time, nationwide mass immunization campaign or catch-up campaign targeting all children
- Second opportunity for measles immunization either through periodic follow-up campaigns every 3–5 years targeting all children born since the last campaign or achieving >95% routine coverage with a second dose of measles vaccine
- Case-based surveillance for measles with laboratory confirmation of disease
- Optimal case management of children with acute disease.

Raising coverage with at least one dose of measles-containing vaccine (MCV) is a key element of the elimination strategy. In 2005, MCV coverage was 82%, leaving an estimated 2.8 million children who were not vaccinated. More than 90% of these unvaccinated children reside in Afghanistan, Iraq, Pakistan, Somalia, Sudan and Yemen. In 2005, Afghanistan, Iraq, Sudan and Yemen made considerable progress in increasing coverage, and it is anticipated that this progress will continue. Pakistan is working with the polio infrastructure to strengthen routine EPI and it is anticipated that progress will be made there as well. Long-term plans to strengthen EPI in Somalia and south Sudan are under development.

Over the past year, catch-up campaigns have been implemented in Djibouti, Somalia, south Sudan and Yemen, with

Pakistan and Morocco the only countries that have yet to conduct a catch-up campaign. Pakistan is planning pilot campaigns in the autumn and will conduct a national campaign in 2007. Morocco is planning a phased approach for catch-up vaccination through school-based vaccine programmes. Since 1999, more than 111 million children have been vaccinated in catch-up campaigns. Based on campaign results, surveillance data and routine EPI coverage, there has been more than a 50% reduction in measles mortality since 1999 (table 1).

Despite the considerable progress, measles remains a leading cause of death among children less than 5 years of age in the Region. Of the 17 countries that have implemented the full elimination strategy, several countries continue to experience measles outbreaks. Most recently Lebanon has experienced repeated outbreaks with increasing magnitude in 2006. Most of the patients in this outbreak are unvaccinated children less than 10 years of age, suggesting that both the "catch-up" and "keep-up" part of the measles elimination strategy in Lebanon needs to be revisited. Similar outbreaks have also occurred in Saudi Arabia and the Syrian Arab Republic, emphasizing the importance of surveillance in refining the elimination strategy at country level.

While the remaining countries experience low levels of measles virus transmission, none have achieved elimination. It is likely that most sporadic cases identified in these countries are imported; however, surveillance systems need to be strengthened to document this.

Table 1: Estimated regional deaths due to measles, 1999–2004

Year	Estimated deaths
1999	102 000
2000	105 000
2001	89 000
2002	59 000
2003	58 000
2004	46 000

Malaria-Free Initiative: Arabian Peninsula and North Africa

In 2004, a strategy of expansion of malaria-free areas, including the Arabian Peninsula and North Africa, was adopted as part of the Regional Office's vision for expansion of disease-free areas. Saudi Arabia and Yemen are the only two countries in the Arabian Peninsula that still have local malaria transmission; the other 5 countries have eliminated malaria or are very close.

In Saudi Arabia, after a comprehensive situation analysis and feasibility study, an elimination strategy was developed in 2004 with the goal of malaria elimination by 2010. Implementation of the strategy has resulted in a significant continuous decrease in malaria cases (204 indigenous cases reported in 2005). Coordination with Yemen in cross-border malaria activities and establishment of border health posts for screening and treating migrants are important activities (table 2).

Yemen, with 900 000 estimated malaria cases and 60% of population at risk, is the main challenge for realizing this goal. However, in areas where the programme has been strengthened, successful results are being obtained. This success is evident in the

experiences of Socotra Island, which is very close to achieving malaria-free status, and Tihama region, which had had a significant decrease in malaria prevalence (table 3).

Prevention of reintroduction of malaria to malaria-free areas is an important objective of the malaria-free initiative. Malaria-free countries of the Arabian Peninsula (Bahrain, Kuwait, Oman, Qatar and United Arab Emirates) still have the malaria vectors and receive a number of imported cases annually. A strong programme for vector monitoring and epidemiological surveillance is needed to prevent re-establishment of local malaria transmission. The wide spread of parasite and vector resistance and the re-emergence of other vector-borne diseases (e.g. Rift Valley Fever, leishmaniasis, Crimean–Congo haemorrhagic fever, dengue) are additional factors which require an intercountry and subregional approach for control and elimination of malaria and other vector-borne diseases.

In March 2006, Deputy Ministers of Health of GCC countries met in Cairo to discuss mechanisms for supporting the malaria control programme in Yemen to achieve the goal of malaria elimination by 2015.

Table 2: Reported autochthonous malaria cases, 2000 and 2005 in countries targeting elimination

Country	Reported autochthonous cases	
	2000	2005
Iran, Islamic Republic of	19 716*	12 792
Iraq	1860	47
Morocco	3	0
Oman	6	0
Saudi Arabia	4736	204
Syrian Arab Republic	6	0

* Epidemiological classification of cases started only from 2002. This figure is the total reported cases; more than 70% of them are autochthonous

Table 3: Malaria prevalence in selected areas, 2000 and 2005

Area	Prevalence (2000)	Prevalence (2005)
Socotra island (Yemen)	54.8%	0.1%
Khartoum state (Sudan)	155 per 10 000 population	10 per 10 000 population

In 2005, the four North African countries including Morocco of the Eastern Mediterranean Region reported the occurrence of imported malaria and no local transmission.

However, in Algeria (a member of the African Region) there are autochthonous cases, and in Egypt there are also unofficial reports of residual transmission in Fayoum. Achieving the goal of a malaria-free North Africa by 2010 will require interregional coordination between the African and Eastern Mediterranean Regions, strengthening national malaria surveillance systems for early and reliable detection and effective treatment of all malaria cases and strengthening integrated vector management.

Tuberculosis elimination initiative in countries of the Gulf Cooperation Council

Elimination is the ultimate aim in tuberculosis control. The global vision is to achieve the elimination, or reduce the incidence, of smear positive tuberculosis to 1 case per 1 million population by 2050. As a global precedent, the six countries of the Gulf Cooperation Council (GCC) jointly started an innovative Tuberculosis Elimination Initiative. The Initiative aims at reducing the incidence of smear positive tuberculosis to the level of the elimination phase, or 1 per 100 000 population, among national populations

by 2010. The countries developed national plans and started implementing activities. Other countries with low incidence like Jordan also joined the Initiative.

The interim target of the Initiative was to reduce the incidence of smear positive tuberculosis to 3 cases per 100 000 population by 2005. Bahrain, Kuwait and Jordan reached the target. Oman reduced incidence to close to 4 per 100 000. Incidence in Qatar and

Saudi Arabia was still around 7 per 100 000 population (table 4). The common challenge is the stagnation, without significant decline, of incidence. High quality implementation of DOTS activities is needed, along with focus on the control of infection. Modern technologies such as molecular epidemiology are useful to understand transmission patterns of tuberculosis and to identify and address high-risk groups.

Table 4: Incidence of smear positive tuberculosis in countries, 2004

Country	Pulmonary smear positive rate per 100 000 population
Afghanistan	29
Bahrain	10
Djibouti	139
Egypt	7
Iran, Islamic Republic of	7
Iraq	12
Jordan	2
Kuwait	10
Lebanon	4
Libyan Arab Jamahiriya	15
Morocco	40
Oman	6
Pakistan	22
Palestine	0
Qatar	9
Saudi Arabia	7
Somalia	81
Sudan	34
Syrian Arab Republic	8
Tunisia	9
United Arab Emirates	1
Yemen	17
Regional average	18

Outbreak News

Updates on avian influenza in the Eastern Mediterranean Region

The avian influenza outbreak is expanding in an unprecedented way all over the world. In the Eastern Mediterranean Region, the highly pathogenic avian influenza (HPAI) virus strain H5N1 has been isolated in 10 countries, including Gaza strip of occupied Palestine territory, since the last quarter of 2005. Countries that have reported the HPAI strain H5N1 are:

- **Kuwait:** A case in a migratory bird was reported and confirmed as H5N1. No cases among domestic poultry were reported (dead end).
- **Islamic Republic of Iran:** A case in some migratory birds in the northern part of the country. No cases among domestic poultry were reported (dead end).



To avoid infection, do not touch or approach dead birds

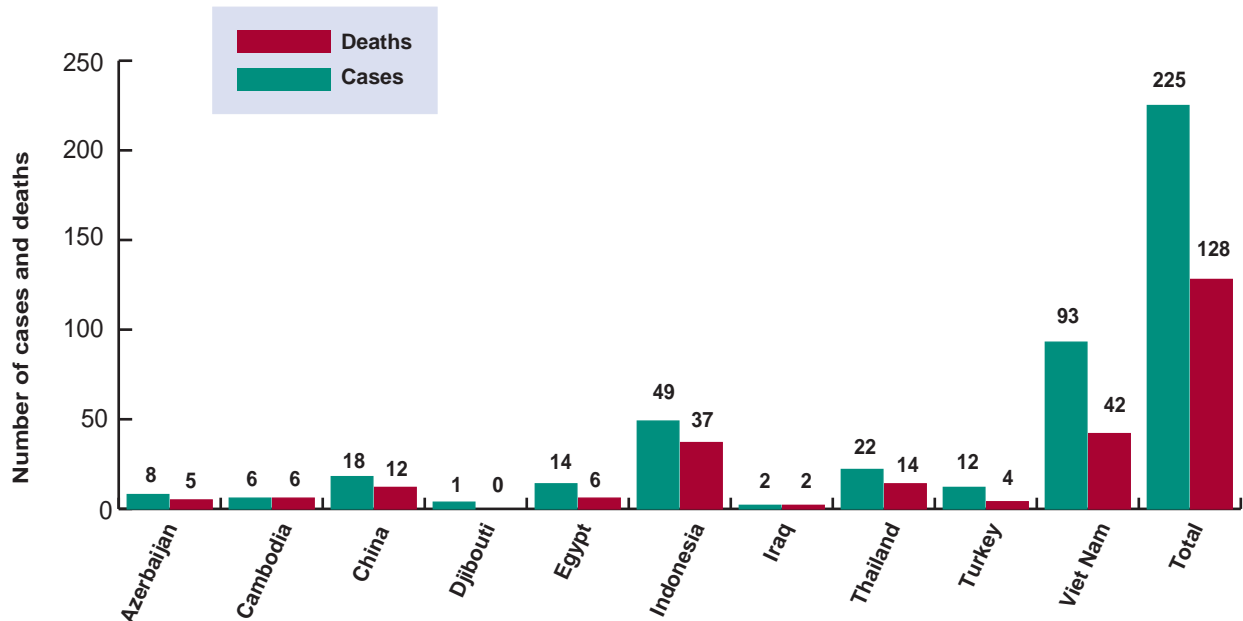


- **Iraq:** HPAI virus, H5N1, was isolated from sick poultry in Northern Iraq. Two human cases were confirmed and died. On 27 March 2006, two more suspected H5N1 cases (siblings) were reported, one of whom died. The source of infection for both was probably the same. However, these later cases were not confirmed as H5N1-positive, keeping the total confirmed human cases two.
- **Egypt:** Wide spread of disease in poultry occurred as of 17 February 2006. Fourteen (14) human cases (12 not related and 2 siblings) have been confirmed, with 6 deaths. Four of the human cases had close contact with infected birds, in particular slaughtering and defeathering of sick poultry. All the human cases were confirmed locally in the National Public Health Laboratory and the U.S. Naval Medical Research Unit Number 3 (NAMRU-3), a WHO collaborating centre for influenza.
- **Afghanistan:** Confirmed HPAI cases in poultry were reported in three different regions of Afghanistan. Six human cases with clinical symptoms were suspected, with two deaths. These were not confirmed as H5N1-positive.
- **Pakistan:** Pakistan reported avian influenza due to low pathogenic avian influenza virus (H5) early this year. The quality of laboratory results is uncertain, as specimens were not retested in a reference laboratory. A joint World Bank and World Health Organization mission was conducted during first half of April 2006 to assess the situation and to respond to the avian influenza outbreak. H5N1 viruses were isolated in Sihala on 16 April 2006 and Terlai on 20 April 2006. No human cases were confirmed for H5N1 in Pakistan.

- **Jordan:** HPAI cases were diagnosed in poultry on 23 March 2006. One human case, diagnosed as H5N1-positive on 30 March, travelled with symptoms from Egypt. The patient was cured and discharged on 10 April 2006.
- **Palestine:** Cases were diagnosed in poultry in Gaza Strip in late March 2006. Only one human case was suspected but tested negative for H5N1.
- **Sudan:** Avian influenza virus H5N1 was reported in poultry in Khartoum and Jazeera states in mid April 2006. A WHO mission was sent to Khartoum on 18 April 2006 to assess and respond to the outbreak. One suspected human cases was admitted to a hospital in Khartoum. Laboratory results showed that all specimens from poultry and humans were negative for H5N1.
- **Djibouti:** One human case was confirmed with H5N1 on 11 May 2006. A group of experts was deployed to assist the Government of Djibouti to respond to the ongoing outbreak of avian influenza in poultry and to investigate the human case and its possible contacts.

Globally, 225 human cases have been confirmed with H5N1 infection up to 6 June 2006 (see figure below). Of these cases, 74 occurred during 2006. A total of 17 confirmed human cases of highly pathogenic avian influenza occurred in 3 countries of the Region, namely Djibouti (1 case, 0 deaths), Egypt (14 cases, 6 deaths) and Iraq (2 cases, 2 deaths). The global case fatality rate of the highly pathogenic avian influenza strain of the virus is 57%.





Cumulative number of confirmed human cases of highly pathogenic avian influenza (H5N1) reported to WHO (December 2003 to June 2006)

Epidemiological Analysis

Neglected diseases and mass drug administration

Neglected tropical diseases include a group of chronic infectious diseases affecting the most impoverished populations living in low-income countries where they account for tremendous disability and human suffering. Although medically diverse, neglected diseases impose a great burden of morbidity on populations, profoundly affect economic development and childhood education and are often associated with great stigma. Almost all neglected diseases can be controlled using low-cost technologies that are safe, rapidly effective and easy to administer in resource-poor settings. Human helminthiasis, such as schistosomiasis, ascariasis, hookworm infections, trichuriasis, lymphatic filariasis and onchocerciasis, are part of a group of neglected diseases which often overlap in areas with unsafe water and poor sanitation, inadequate nutrition and lack of access to health services. The burden of these infections can be prevented through delivery of

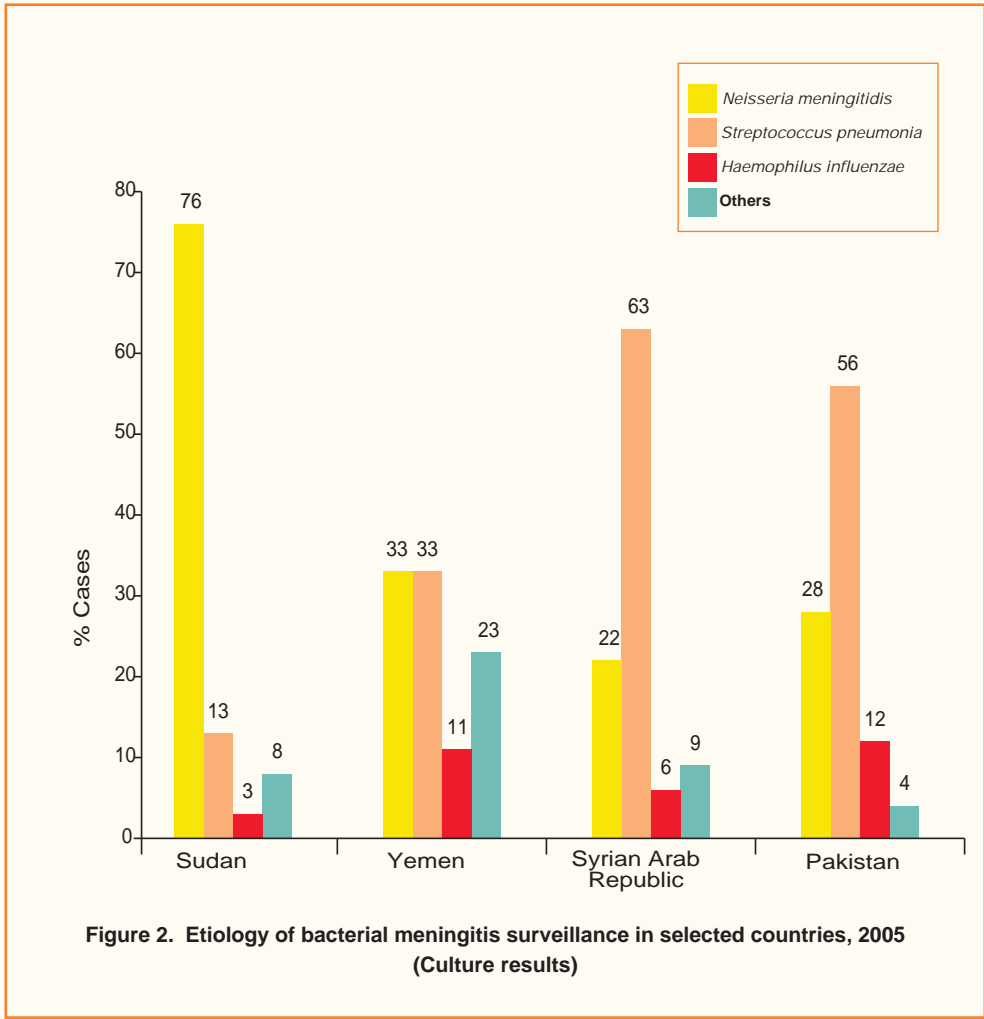
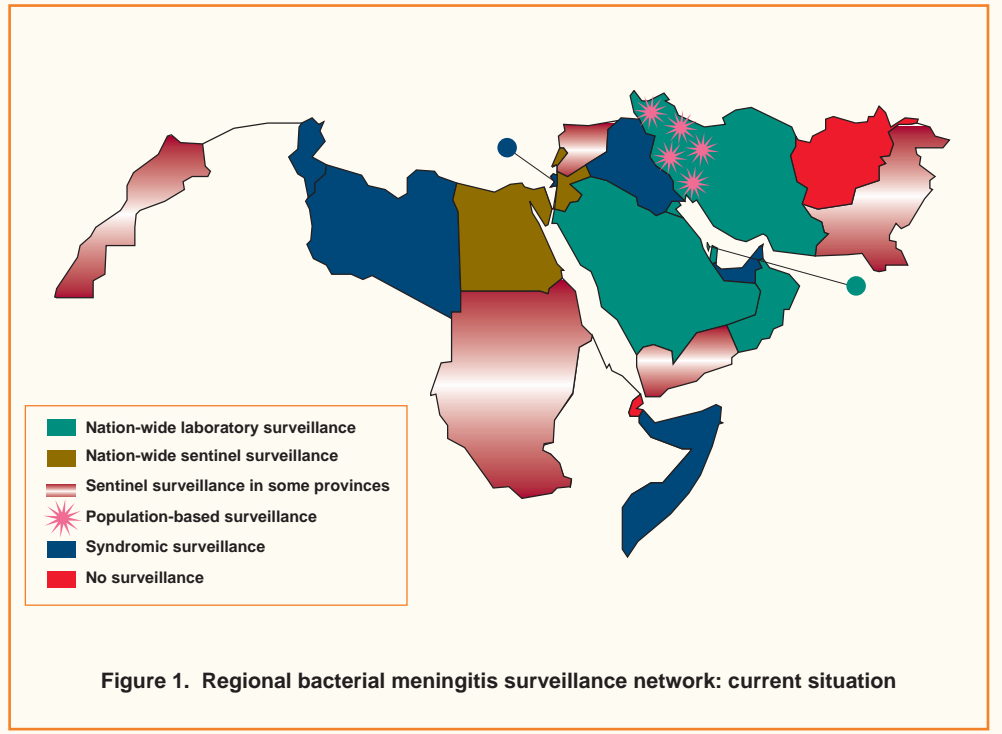
population-wide chemotherapy of quality drugs at regular intervals throughout their lives. A limited number of drugs (praziquantel, albendazole and/or mebendazole, and ivermectin or diethylcarbamazine) can be used to target those diseases. Some drugs are donated by international pharmaceutical companies and provided free to those in need. Each drug has an excellent safety record and drug adverse reactions are minimal and transient. In practice, both infected and uninfected people are treated in community programmes. Preventive chemotherapy interventions can be incorporated into existing health care programmes. Campaigns targeting children, such as vitamin A distribution, vaccination, mother-and-child health days or school health programmes can be used as an approach for regular drug administration. Community-wide drug distribution programmes utilizing existing health systems, community-based approaches or both, such as those for control of



lymphatic filariasis and onchocerciasis, may also be used to expand preventive chemotherapy interventions. Programme managers, in consultation with target communities, can identify the most suitable methods for drug delivery and administration. Multiple treatment protocols can be consolidated into a single schedule indicating drugs, target population and timing. Long-term preventive chemotherapy must be accompanied by monitoring of coverage, impact on morbidity and drug effectiveness.

Need for disease surveillance to guide new vaccines introduction: regional surveillance networks

Diarrhoeal diseases and acute respiratory infections continue to be the major killers of children under 5 years in the Region. Several effective new vaccines against this group of illnesses are currently available or are in the pipeline, including Hib, pneumococcal and meningococcal conjugate vaccines as well as rotavirus vaccines. Conjugate Hib and pneumococcal vaccine have shown significant reduction of the burden of disease when used in routine childhood vaccinations. Despite this fact, Hib vaccine was introduced to only half the countries in the Region, constituting together only 16.7% of the infants in the Region, and pneumococcal vaccine was introduced by Qatar only. The Regional Office is establishing regional laboratory-based surveillance networks for assessment of burden of rotavirus gastroenteritis, bacterial meningitis, pneumonia and other invasive Hib and pneumococcal disease in countries of



the Region. The networks aim at generating reliable data on the burden of disease caused by these organisms and on the suitability of the new vaccines for the locally circulating strains, in order to provide evidence for decision-making on the need for and suitability of the new vaccines.

Launched early 2004 to study the burden of Hib, pneumococcal and meningococcal meningitis, the bacterial meningitis surveillance network is expanding to cover an increasing number of countries. The standard operating procedures of the network specify culture as the gold standard confirmation test. In addition to identifying the causative organism, culture allows identification of the circulating serotypes as well as studying antibiotic sensitivity pattern. Through the network, the Regional Office and the regional reference laboratory at NAMRU-3 are supporting several countries in selecting the appropriate sentinel sites, training the local teams on laboratory and epidemiological surveillance including data management, provision of supplies and equipments where needed, quality assurance and quality control, and further characterization of the circulating strains. With such

support, sentinel surveillance was established in: 4 hospitals in Khartoum, Sudan; 6 hospitals in 5 governorates in Yemen; 4 hospitals in 4 provinces in Pakistan; and 7 hospitalas in 5 governorates in the Syrian Arab Republic. Sentinel surveillance is ongoing in 7 sites in Egypt as well. Population-based surveillance is now covering 5 sites in the Islamic Republic

of Iran and routine laboratory-based surveillance is covering most of that country. Five sentinel sites in Morocco and 4 sites in the Libyan Aran Jamahiriya are expected to start bacterial meningitis surveillance activities in May/June 2006, and ongoing activities in Sudan will be expanded to cover 3 additional states (Figure 1). Data generated from the

network in participating countries show that laboratory-based surveillance is feasible with commitment and effort (Figure 2).

Surveillance of invasive Hib and pneumococcal diseases is being expanded to cover pneumonia and meningitis. Two sentinel sites were selected in Pakistan, one sentinel site in each of Morocco, Syrian Arab Republic and Yemen, as well as one population-based site in the Islamic Republic of Iran are expected to start surveillance of pneumonia in addition to ongoing bacterial meningitis surveillance activities.

Establishment and expansion of the Eastern Mediterranean Rotavirus Surveillance Network (EMRSN) is ongoing. Necessary supplies, reagents and equipment were procured and standard operating procedures were developed for the network. An intercountry training workshop was conducted to train epidemiology and laboratory focal points and finalize the standard operating procedures. The network now covers 6 countries in the Region, namely, Egypt, Islamic Republic of Iran, Morocco, Oman, Pakistan and Tunisia. More countries will join the network later in 2006 (Figure 3). Although the network is in its nascence, preliminary data generated by it show that the burden of rotavirus gastroenteritis in the Region is substantial (Figure 4).

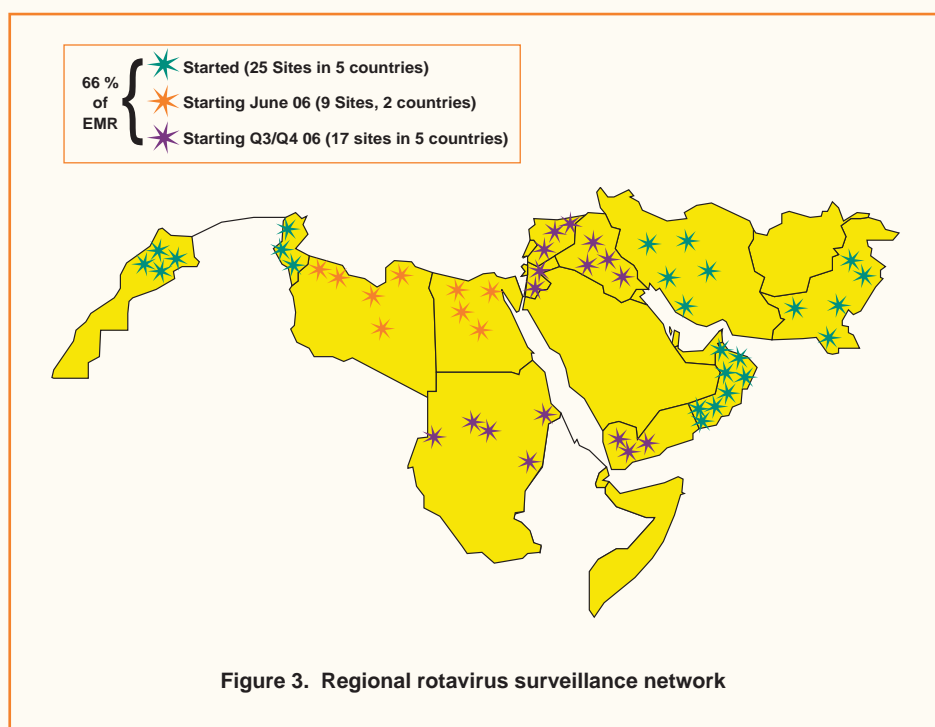


Figure 3. Regional rotavirus surveillance network

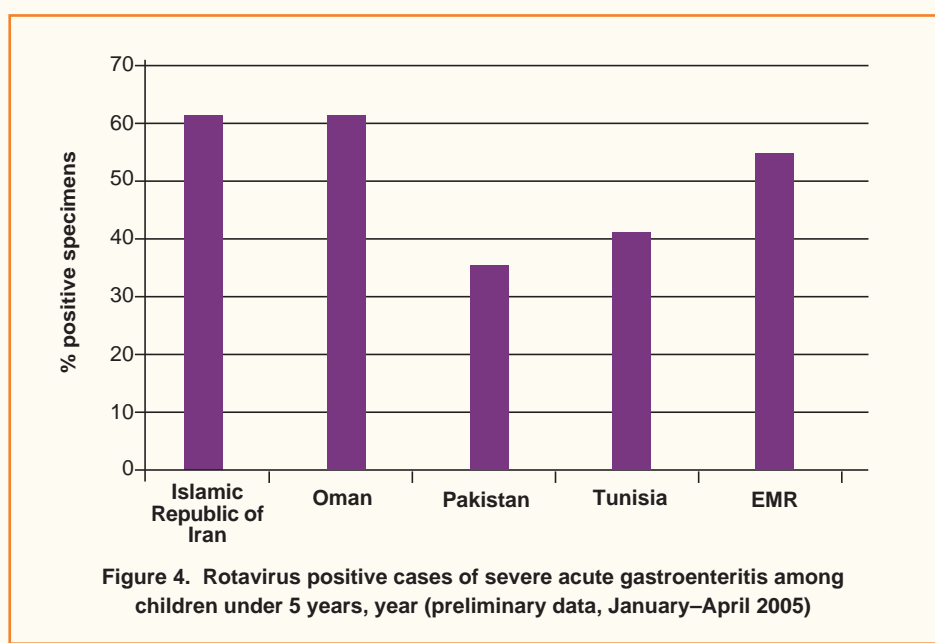


Figure 4. Rotavirus positive cases of severe acute gastroenteritis among children under 5 years, year (preliminary data, January–April 2005)

News In brief

Actions for life towards a world free of tuberculosis

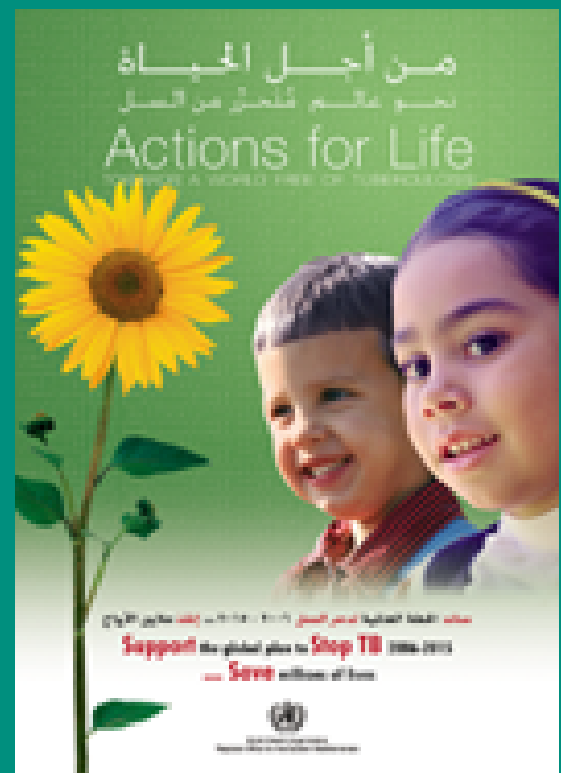
This year, the slogan of World Tuberculosis Day 2006 is “Actions for life; towards a world free of tuberculosis”. “Actions for life” is a call for people to act, commit, collaborate, achieve, invest, treat, reach, innovate, advocate and to have hope in the fight against tuberculosis.

This year and for the next 10 years to come, all our efforts and actions in the Region will be synchronized with the global efforts with the aim that one day, soon, we all live in a world free of tuberculosis.

World Tuberculosis Day represents a great opportunity to open dialogues with policy-makers, communities and affected people about the role of each member of the society in the fight against a totally preventable and curable disease that is still responsible for the deaths of more than 140 000 people in the Region every year. As stated by Dr Hussein A. Gezairy, WHO Regional

Director for the Eastern Mediterranean, in his message for the occasion, “World Tuberculosis Day is one of many occasions on which we get the opportunity to raise our voices and take actions to stop further unnecessary human suffering. What we need to do on World Tuberculosis Day and further beyond the day is to make a strong call for actions. Actions to advocate for more political commitment, to increase public awareness and knowledge about tuberculosis and to mobilize resources much needed to sustain the tuberculosis control efforts in the Region for the coming 10 years”.

It is worth mentioning that this year’s theme for World Tuberculosis Day was inspired by the Global Plan to Stop TB, 2006–2015. The Global Plan which was launched by President Obasanjo of Nigeria, Mr Gordon Brown, the British Chancellor of the Exchequer, and Mr



Bill Gates of the United States, at Davos, Switzerland in January 2006, sets out a comprehensive assessment of the actions and resources needed to implement the Stop TB strategy in the next 10 years.

More information about World Tuberculosis Day 2006 and the Global Plan to Stop TB can be found at: www.emro.who.int/stb

Small Grants Scheme funds 31 proposals in tropical and other communicable diseases

During its last meeting in Cairo, the Selection Committee of the EMRO/TDR Small Grants Scheme for Operational Research in Tropical and Other Communicable Diseases accepted 31 projects from 9 countries of the Region: Islamic Republic of Iran (8), Egypt (6), Sudan (4); Afghanistan (4), Pakistan (3) Somalia (2), Yemen (2), Morocco (1) and the Syrian Arab Republic (1).

The selection of research priorities was based on the challenges facing disease control programmes. In the area of HIV/AIDS and sexually transmitted diseases, the topics included behavioural studies of high risk groups, voluntary counselling and testing, interventions to improve preventive behaviour, and studies determining the prevalence and determinants of sexually

transmitted diseases and health seeking behaviour of the patients.

With regard to malaria, the selected topics included studies evaluating new approaches for implementing malaria home management, interventions to increase coverage with intermittent presumptive treatment and insecticide-treated bednets among pregnant women, impact of integrating malaria control activities with the Basic Development Needs (BDN) programme, and cost-effectiveness of pre-season treatment of the gametocyte reservoir in areas with unstable malaria transmission.

The selected projects in the area of tuberculosis were mainly evaluating the impact of different types of public-private mix on case detection

and studying the predictors of non-compliance to treatment on mortality from tuberculosis.

Three projects studying the prevalence of hepatitis B and C and their determinants among barbers and their regular clients were supported from three high burden countries. A project evaluating the knowledge, attitudes and practices of the high-risk groups and the general population to the avian influenza outbreak was also supported.

Regarding vaccine-preventable diseases, three projects were accepted: one in meningitis and two in rubella. In the area of tropical diseases and zoonoses, four projects were supported in rabies, leishmaniasis, leprosy and the distribution and behaviour of leishmaniasis and malaria vectors.

Epidemiological Information

Reported cases of priority communicable diseases in the Eastern Mediterranean Region January-December 2005

Country	Disease									
	Cholera	Meningo-coccal meningitis	Malaria	TB*	Measles	MNT	Total-tetanus	Diphtheria	AIDS	Leprosy
Afghanistan	NA	NA	30 5947	25 473	1 296	39	NA	179	NA	31
Bahrain	0	0	71 ^a	273	4	0	0	0	129	0
Djibouti	NA	NA	1 616	3 646	298	NA	NA	NA	2 395	0
Egypt	0	189	23 ^a	11 453	77	58	NA	0	500	1 134
Iran, Islamic Republic of	1 133	85	18 966 ^b	11 153	7	1	8	15	800	79
Iraq	0	44	47	10 963	908	18	21	6	124	0
Jordan	0	6	86 ^a	349	28	1	2	0	129	0
Kuwait	NA	NA	302 ^a	517	10	0	0	0	87	6
Lebanon	1	188	57 ^a	442	618	0	3	0	311	0
Libyan Arab Jamahiriya	NA	NA	12 ^a	2 143	292	0	2	0	611	NA
Morocco	NA	1 578	100 ^a	25 909 ^c	NA	NA	NA	NA	1 344	43
Oman	0	1	544 ^a	321	25	0	1	0	601	5
Pakistan	NA	NA	NA	163 927	2 981	518	697	23	316	551
Palestine	NA	NA	0	41	1	0	1	0	86	0
Qatar	2	2	168 ^a	639	74	0	0	0	117	NA
Saudi Arabia	NA	NA	1 059 ^b	4 248	373	22	32	7	718	30
Somalia	NA	429 ^d	28 529	15 464	NA	NA	NA	NA	86	62
Sudan	NA	3 673 ^d	NA	30 491	1 374	94	NA	13	6 325	782
Syrian Arab Republic	NA	NA	28 ^a	4 799	375	5	5	0	135	7
Tunisia	NA	NA	38 ^a	2 486	15	0	2	0	749	1
United Arab Emirates	0	11	1 544 ^a	103	29	0	1	0	22	7
Yemen	0	1 050	186 353	6 545	6 285	46	46	8	386	395
Total	1 136	7 256	545 490	321 385	16 959	802	821	251	15 978	3 133

* All forms of TB cases

NA no data available

^a imported cases

^b local cases out of the total shown (Islamic Republic of Iran 14 396, Saudi Arabia 204)

^c 2004 data

^d total meningitis

Universal access to HIV prevention, treatment, care and support

In late 2003, the 3 by 5 Initiative was launched to ensure access to antiretroviral treatment for 3 million people living with HIV/AIDS in low- and middle-income countries by the end of 2005 (the "3 by 5" target). Since then, coverage of antiretroviral therapy in these countries has more than doubled - increasing from 400 000 to approximately 1.3 million people worldwide receiving treatment by December 2005¹. Although the "3 by 5" target was not achieved, it has had an important catalysing effect, and has been acknowledged as an important step in a longer-term global effort to realize the objectives set out in the Millennium Development Goals.

Through the Initiative, invaluable experience was gained in countries and it was shown that large-scale HIV treatment access is achievable, effective and increasingly affordable, even in the poorest and most challenging settings. Perhaps most importantly, the 3 by 5 Initiative showed that expanded international financial support, improved international coordination and communication, clear milestones, robust monitoring and evaluation, enhanced partnership structures, improved implementation of lessons learnt and an intensified focus on strengthening health systems are all essential elements to achieving universal access in 2010.

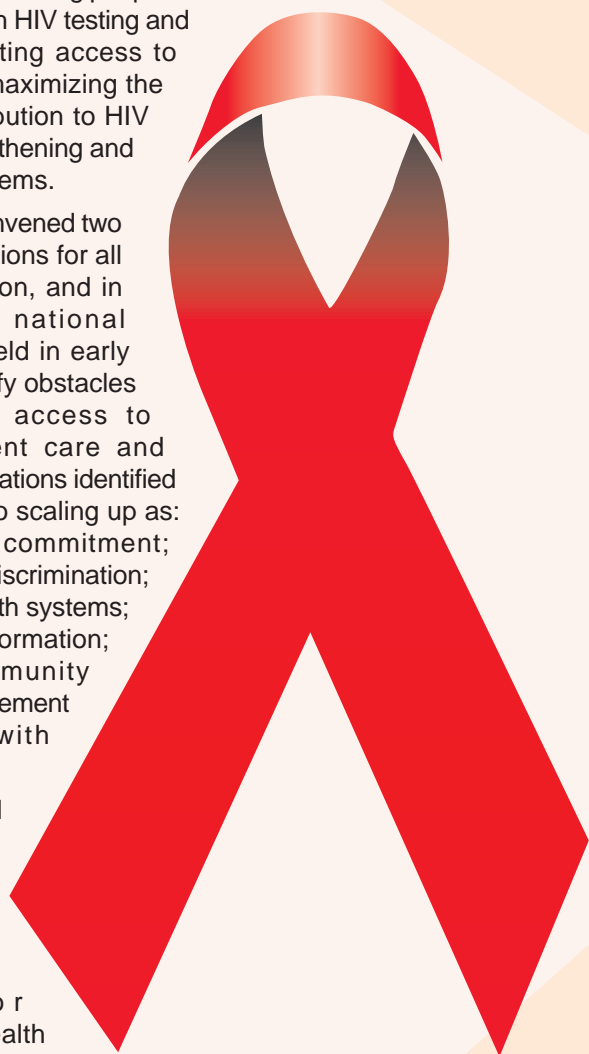
To maintain momentum and build upon the progress made so far, in July 2005 leaders of the G8 group of industrialized countries announced their intention to "work with WHO, UNAIDS and other international bodies to develop and implement a package for HIV prevention, treatment and care, with the aim of coming as close as possible to universal access to treatment for all those who need it by 2010". This goal was subsequently endorsed by all UN Member States at the High Level Plenary Meeting of the 60th Session of the UN General Assembly in September 2005.

The universal access goal advocates an essential package of HIV prevention,

treatment, care and support to be made available to all those who need it. In the health sector, scaling up is aligned with strategic directions that involve enabling people to know their HIV status through HIV testing and counseling, accelerating access to treatment and care, maximizing the health sector's contribution to HIV prevention, and strengthening and expanding health systems.

WHO and UNAIDS convened two sub-regional consultations for all countries of the Region, and in several countries national consultations were held in early 2006 in order to identify obstacles against expanding access to prevention, treatment care and support. These consultations identified the main challenges to scaling up as: increasing political commitment; reducing stigma and discrimination; strengthening the health systems; gathering strategic information; and ensuring community participation and involvement of people living with HIV/AIDS.

In 2005, WHO and national AIDS programme managers, together with other partners, developed a Regional Strategy for Strengthening the Health Sector Response to HIV/AIDS. This strategy defines an essential service package for HIV prevention, treatment and care. It acknowledges the challenges and identifies the strategic actions to reach as close as possible to the goal of universal access by 2010. The strategy will be the guiding framework for the health sector's contribution to scaling up towards universal access within the Region.



¹Progress on Global Access to HIV antiretroviral therapy: A report on "3 by 5" and beyond. Geneva, WHO and UNAIDS, March 2006

Upcoming DCD meetings

Meeting	Venue and Dates	Objectives
16th Intercountry Meeting of National AIDS Programme Managers	Amman, Jordan 27–29 June 2006	<ul style="list-style-type: none"> • Brief participants on Universal Access Initiative • Develop indicators to monitor implementation of the Regional Strategic Plan 2006–2010 • Work out national action plans for implementation of the Regional Strategic Plan
Regional Meeting of National Coordinators and Partners on Integrated Leprosy Control	Alexandria, Egypt 25–27 June 2006	<ul style="list-style-type: none"> • Review progress in sustaining leprosy control activities • Discuss approaches for integrated leprosy control within existing health systems • Discuss collaborative activities with partners
6th Intercountry Meeting of National Malaria Programme Managers	EMRO 3–6 July 2006	<ul style="list-style-type: none"> • Review the progress in the implementation of malaria control strategies • Discuss and develop the costing of malaria prevention and control • Finalize the regional RBM strategic plan 2006–2010 with the financial element • Finalize the country-specific RBM strategic plans 2006–2010
11th Intercountry Meeting of National Tuberculosis Programme Managers in the EMR	Cairo, Egypt 3–5 September 2006	<ul style="list-style-type: none"> • Monitor progress in Tuberculosis control in the countries of the Region, towards 2015 targets • Discuss the strategic direction towards MDGs • Discuss mechanisms to activate STB partnership at regional and country level • Finalize the regional strategy for public private mix and develop regional plans
Inter-country Meeting on Measles/ Rubella Control Elimination	Amman, Jordan 13–15 November 2006	<ul style="list-style-type: none"> • Discuss new advances and strategies related to measles elimination and Rubella Control • Follow up country progress in implementing measles elimination and rubella control activities • Review, update and revise national plans for measles elimination and rubella control • Discuss and recommend activities to strengthen national measles elimination and rubella control programmes
6th Meeting of Regional Programme Review Group on Lymphatic Filariasis Elimination	EMRO 20 December 2006	<ul style="list-style-type: none"> • Review and evaluate progress in implementation of lymphatic filariasis elimination programmes • Coordinate elimination activities at national and regional levels • Discuss and approve annual reports and re-application forms for provision of drugs for mass drug administration
Preparedness for Human Pandemic Influenza: Intersectoral Collaboration	Cairo, Egypt During the 3rd quarter of 2006	<ul style="list-style-type: none"> • Support national alert systems to detect severe respiratory diseases • Build capacity to cope with a pandemic, strengthen the early warning system and intensify rapid containment operations to absorb the impact of a pandemic • Support national pandemic preparedness including multisectoral development and publication of national plans, implementation and testing • Promote legislation that allows authorities to introduce and enforce extraordinary measures and facilitate intersectoral health-related activities during pandemic



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