

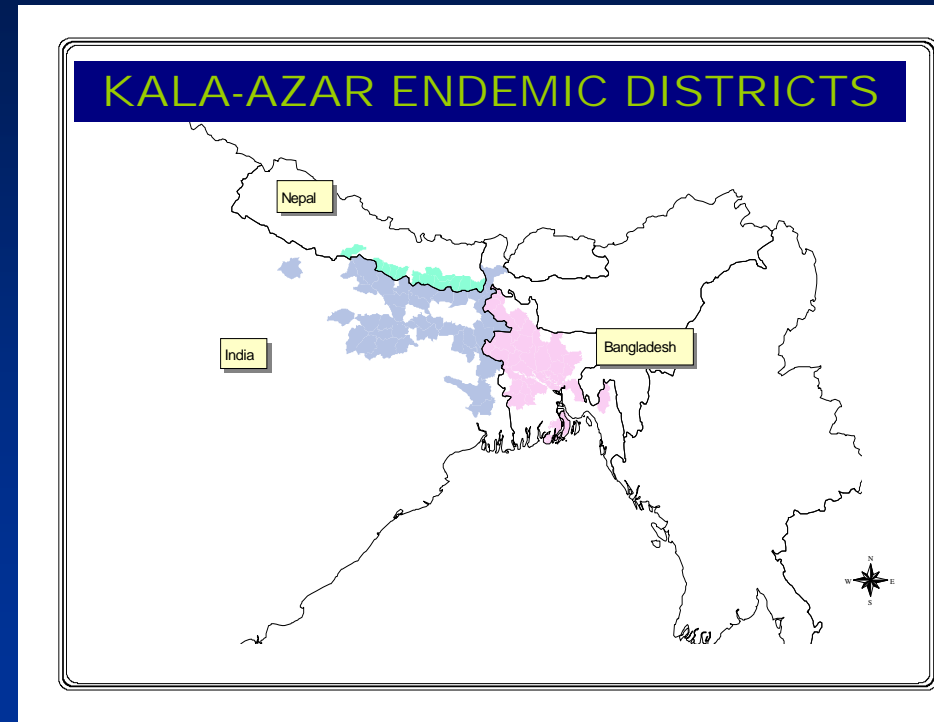
# Current Status and Future Challenges

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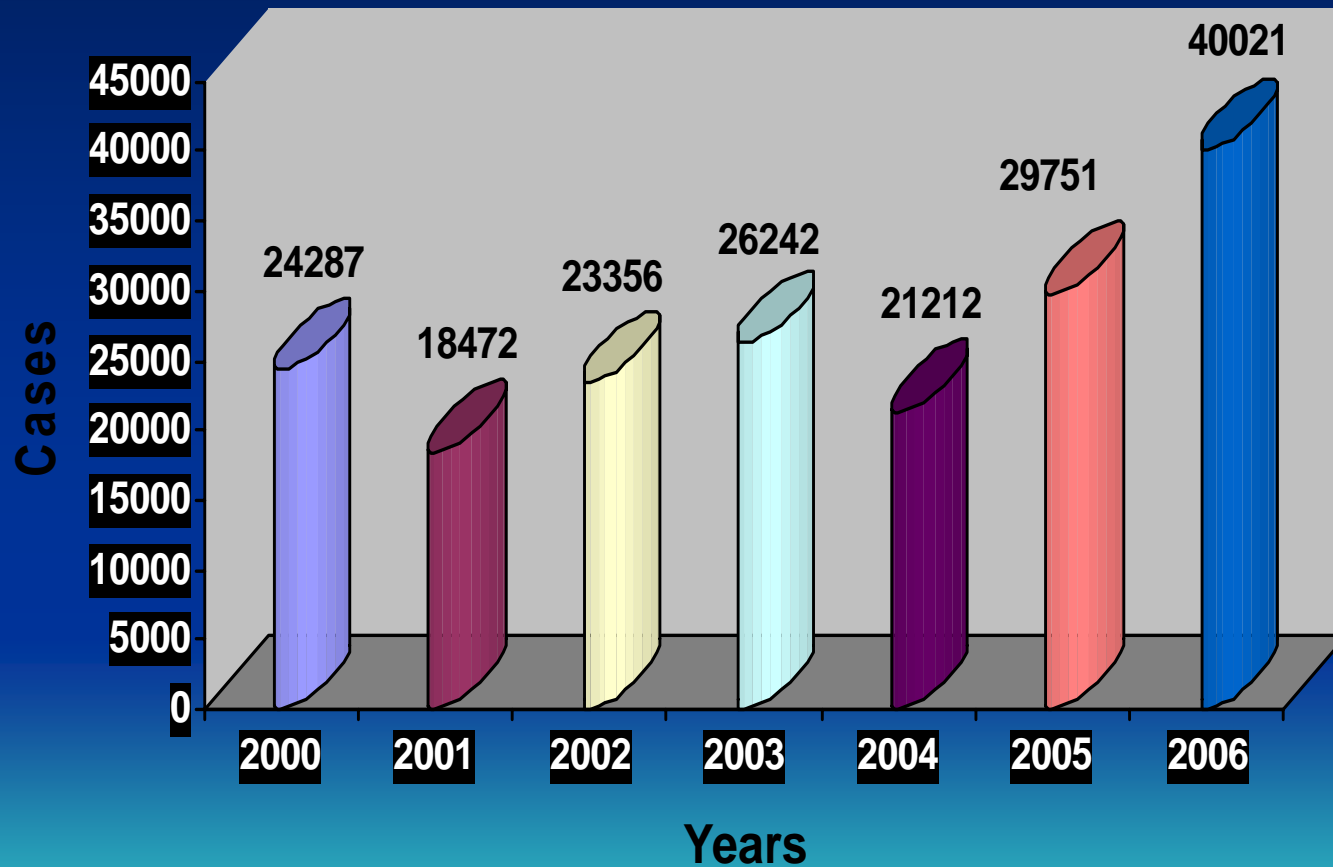


# The Problem

- 109 districts in Bangladesh, India and Nepal
- 200 million people at risk
- Kala azar : a disease of the poor
- Economic burden of kala azar is large



# Kala-azar in endemic region in South East Asia



# FACTORS FAVOURING KALA-AZAR ELIMINATION

- **Effective interventions available to interrupt transmission**
  - **Effective oral treatment**
  - **Indoor Residual Spray for vector control**
- **Diagnostic tools available for field use 'rk 39'**
- **No animal reservoir**
- **In the past, use of DDT almost eliminated Kala azar**
- **Disease geographically focalized**
- **Political commitment expressed by the Health Ministers of 3 effected countries**

# Elimination of Kala-azar from endemic countries in the South-East Asia Region

## Health Ministers sign Memorandum of Understanding



## *Goal of elimination*

To contribute to improving the health status of the vulnerable groups and 'at risk' population living in kala azar endemic areas of Bangladesh, India and Nepal by the elimination of kala azar so that it is no longer a public health problem

## *Target of elimination*

To **reduce the annual incidence of kala azar to less than one per 10,000 population** at the district or sub district level (upazila in Bangladesh, sub district in India and district in Nepal) **by 2015**



# STRATEGIES (5 ELEMENTS)

- Early diagnosis and complete treatment
- Effective disease and vector surveillance
- Integrated vector management with a focus on IRS, ITN and improve of household and community sanitation
- Social mobilization and building partnerships
- Clinical Operational research



# Implementation

- **Preparatory phase (duration 2 years)**
- **Attack phase (duration 5 years)**
- **Consolidation phase (duration 3 years)**
- **Maintenance phase**





# Progress made

- Passing a resolution on kala-azar elimination 60th World Health Assembly, held in May in Geneva, 2007.
- The World Bank committed financial support for elimination programme in India.
- Guidelines and Standard Operating Procedures for Kala-azar elimination have been developed.
- Conduction of operational research. Multi-centric studies carried out since 2006 and projects have been extended to 2008 with TDR support.

# Future directions

- To reinforce efforts to set up national control programmes that would draw up guidelines and establish systems for surveillance, data collection and analysis
- To strengthen prevention, active detection and treatment of cases of both PKDL and visceral leishmaniasis.
- To strengthen capacity of peripheral health centres so that they provide appropriate diagnosis and treatment and act as sentinel surveillance sites.



# Cont..

- To strengthen collaboration between countries that share common foci; increase the number of WHO collaborating centres for leishmaniasis; interagency collaboration at national and international levels in all aspects; national control programmes; and
- To promote sustainability of surveillance; improve knowledge in prevention; support studies on surveillance and control and share experiences in the development of studies and technology for prevention.



# Issues for consideration

- Encourage joint collaborative efforts between three endemic countries, viz., Bangladesh, India and Nepal and also effective follow-up action to ensure sustainability of the elimination programme;
- Review implementation status on an annual basis and share progress made with the highest level on an annual basis;
- Mobilization of resources for the elimination programme; strengthening capacity; enhance programme management to eliminate kala-azar from 3 countries



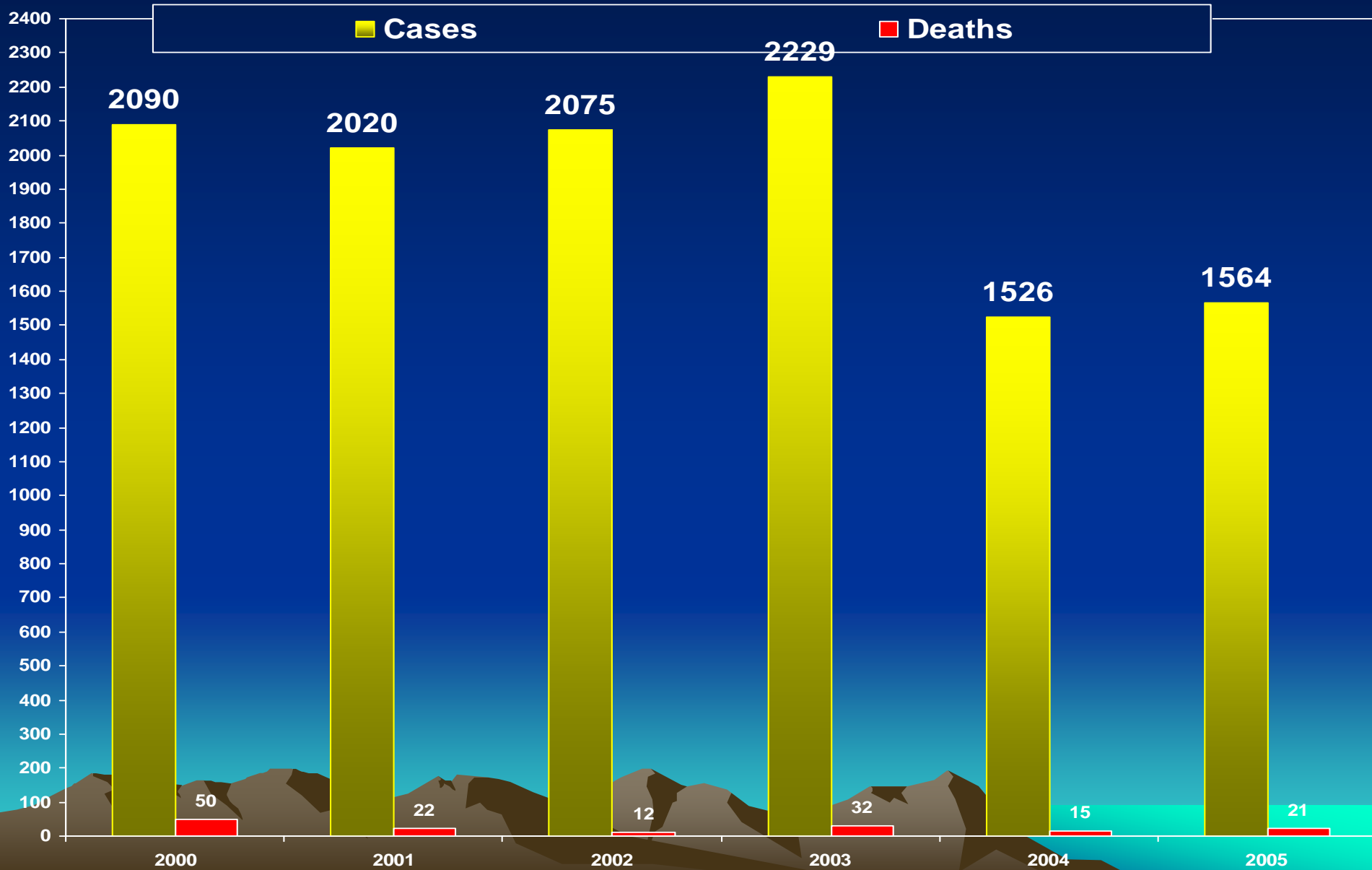
# Kala-azar Endemic Districts, Nepal, 2006



Kala-azar Endemic Districts= Jhapa, Morang, Sunsari, Saptari, Siraha, Dhanusha, Mahottari, Udayapur Sarlahi, Rauthat, Bara, Parsa

Population at risk- Approx. 5.5 Million

# Kala-azar cases



# National KA Elimination Program Management

National Planning Commission

HMG Nepal  
Ministry of Health & Population

National Kala-azar  
Coordination Committee

Department of Health Services

LMD  
NHIECC  
NPHL

RHSD

EDCD

3 Reference Centre-  
BPKIHS Dharan;  
Janakpur Zonal Hospital  
Sukraraj. Hospital.Teku, KTM

EDR

CDR

Resource:  
Epidemiology &  
Diseases  
Control Division

Disease  
Control  
Section

KA Elimination Unit

Regional KA  
Elimination  
Unit

Reg Tech.  
Unit

6 Districts

6 Districts

Disease Surveillance Unit

# Nepal

- Diagnosis & treatment:
  - Decentralisation
  - rk39 strip test : PHC level
  - Miltefosine (Pilot district)
    - PHC level, supervised (DOT)
  - Parasitology at 2<sup>nd</sup> level (Zonal hospital & Medical college)





# Community level surveillance and social mobilisation

- Suspect case detection : through FCHV at village level socially active groups
- Involvement of school teachers, drug retailers, traditional healers and other service providers engaged in alternative health service system



# Obstacles

- Funds to accelerate and expansion of activities
- Ongoing political conflict.
- Coordination of cross border synchronization.



# Strategies-the five pillars

## 1. Early Diagnosis and Complete Case Management

- Agreed case definition
- Screening by 'rk 39' or DAT
- Confirmation by examination of bone marrow aspiration in selected hospitals
- Treatment by oral effective drug Miltefosine or injectable paromomycin
- Directly observed treatment , use of treatment cards
- Amphotericin B and liposome as rescue drug



# Strategies-the five pillars

## 2. Integrated vector management and vector surveillance

- Indoor residual spray is the mainstay- DDT in India, pyrethroids in Bangladesh, Nepal. Spraying focused but intensive based on stratification and vector surveillance
- ITNs to complement IRS to reduce human vector contact
- Sanitation in household and peri domestic environment
- BCC strategy should be complementing the vector control efforts



# Strategies-the five pillars

## 3. Effective disease and vector surveillance

- Classify cases as suspect, possible and confirmed
- Surveillance should include cases of PKDL
- Passive case surveillance- include regular reporting by private providers
- Active surveillance at least once per year
- Intensify active surveillance as cases decline
- Kala azar should be made a notifiable disease



# Strategies-the five pillars

## 4. Social Mobilization and partnership building

- BCC for success of early diagnosis and complete case management, cooperation in IRS, adoption and correct use of ITNs and environmental management
- Partnerships at national and international, district and state levels
- Partnerships and networking amongst institutions within the health sector (nutrition, anaemia control, HIV, TB control) and outside the health sector e.g. environmental control and poverty alleviation programmes



# Strategies-the five pillars

## 5. Clinical and Operational Research

- Addition of new drugs and diagnostics
- Validation of diagnostic tests under field conditions
- Rapid assessment and mapping of the disease
- Monitoring of drug and insecticide resistance and of quality of drugs
- Diagnosis and treatment of PKDL
- Implementation and intensive monitoring in pilot districts
- Increasing access in poor and marginalised communities
- Public private mix, networking
- Increasing the capacity in research



# Implementation

Preparatory phase (duration 2 years)

- Development and review of national policy, regulations and strategy
- Operational plans- identify resource gaps and constraints, consolidation into project document
- Advocacy plans
- National coordination committee and working groups
- Regional alliance/partnerships





# Implementation-preparatory phase

- Mobilization of additional resources
- Mapping of areas for IRS
- Validation of disease burden
- Development and adaptation of technical guidelines and reporting formats- standards and SOPs
- BCC strategy
- Identification of research priorities and development of capacity for research
- Establishing a system for procurement, logistics and supplies
- Intensive implementation in pilot districts and intensive monitoring



# Attack phase (duration 5 years)

- IRS in all the affected areas for five years
- IVM including ITNs and environmental management
- Access to early diagnosis and complete case management of kala azar and PKDL
- Passive and active case surveillance and vector surveillance
- Community mobilization through BCC
- Monitoring of complete treatment
- Intercountry task force meeting to review progress and exchange information



# Attack phase (duration 5 years)

- Quarterly monitoring, annual review and annual reporting to WHO
- Household and health facility surveys 2-3 years interval
- External country evaluation
- Enhance the research capacity and networking, research coordination
- Active case search at least once a year



# Consolidation phase (duration 3 years)

- Limited IRS based on location of cases
  - International review commission to verify the achievements
- Intensified case detection
- Early diagnosis and complete case management (focus on co infections)
- Treatment adherence
- Continue activities of attack phase
- Maintenance phase (duration to be decided)
  - Monitoring of case incidence at the district and sub district levels
  - Follow up actions where the targets have not been achieved

