



WORLD HEALTH ORGANIZATION

MEETING OF INTERESTED PARTIES

GENEVA, 18 TO 29 JUNE 2001

Communicable diseases

Highlights of activities in 2000

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1. COMMUNICABLE DISEASE SURVEILLANCE

Integrated surveillance and response

1. Global epidemic intelligence received 40% more reports in 2000 from global monitoring networks compared to 1999, and the average time between the receipt of a report and contact with the field was reduced to 24 hours. The first meeting of over 70 partners in the Global Outbreak Alert and Response Network took place in April 2000.¹ The Network demonstrated its unique value for the coordination of the international response during the largest outbreak of Ebola haemorrhagic fever ever recorded, which threatened Uganda and the whole region in autumn 2000 and which was successfully controlled. Epidemic preparedness and response plans were formulated by all WHO regions, and many country plans were developed.

2. The revision process of the International Health Regulations continued in 2000, and a new direction was proposed to the governing bodies for endorsement.² The WHO report on Global surveillance of epidemic-prone diseases³ was issued, and the first step in the development of the

¹ Document WHO/CDS/CSR/2000.3.

² Document A54/9.

³ Document WHO/CDS/CSR/ISR/2000.1.

web-based Global Atlas of Infectious Diseases was made through a successful proof-of-concept application.

3. In close collaboration with regional offices which have endorsed a multidisease approach to national capacity strengthening, national assessments were carried out in selected countries and specific plans of action elaborated. The integrated approach to disease surveillance, which builds on existing and successful disease-specific surveillance programmes (e.g. collaboration with polio eradication programmes), has been implemented in countries in the WHO African Region and initiated in the South-East Asia, Europe and Eastern Mediterranean regions. A specific protocol has been developed for the assessment of national surveillance and response capacity and a special application (HealthMapper) developed for health mapping, with a particular focus on Africa and South-East Asia (e.g. mapping information on malaria risk and health care coverage developed for Roll Back Malaria). Disease-specific applications of the HealthMapper were implemented (for onchocerciasis, guinea-worm, schistosomiasis, lymphatic filariasis and trachoma), and new partnerships were initiated (e.g. with UNAIDS and UNFPA).

4. The special programme for communicable disease control in complex emergencies held its first meeting in December 2000 with its partners (including other organizations of the United Nations system such as UNICEF and UNHCR, and major nongovernmental organizations), in order to consider capacity building for effective alert and response systems as well as disease-specific control activities in populations and territories suffering acute or chronic emergencies. A database of experts and areas of work were defined and a plan of action set up. Support to training programmes in field epidemiology was implemented through continuous support to the Training in Epidemiology for Public Health Intervention Network (TEPHINET) initiated by WHO in partnership with the Centers for Disease Control and Prevention (CDC) (United States). In the framework of the Global Health Leadership Officers Programme based in WHO, epidemiology and public health training were provided to young professionals by special classes, supervision and on-the-job training.

Epidemic disease control

5. To improve diagnostic laboratory capacity in Africa, national assessments, laboratory training and provision of laboratory reagents and supplies were undertaken in collaboration with the Regional Office for Africa. International quality-control assurance programmes were implemented through WHO collaborating centres. Preparatory activities carried out in 2000 for the opening of the WHO Office in Lyon (on 8 February 2001) included the definition of the curriculum for the training programme for laboratory supervisors.

6. Non-commercially-available diagnostics, reagents and standards for Japanese encephalitis, dengue, West Nile, Kunjin and Ross River viruses, yellow fever, other arboviruses and plague were produced by specialized laboratories and distributed to institutions in affected countries.

7. The epidemiology of influenza and influenza viruses continued to be monitored globally. The composition of the influenza vaccine for the northern and southern hemispheres was published in the *Weekly epidemiological record*, as well as recommendations on influenza control. Laboratory capacity for influenza surveillance was strengthened in China in collaboration with the WHO Regional Office for the Western Pacific.

8. To strengthen epidemic preparedness for viral haemorrhagic fevers, protective clothing and equipment were provided to the African Region and laboratory capacity strengthened in India, Kenya

and Viet Nam. Expert technical support was provided for the coordinated response to Ebola in Uganda (see paragraph 1). The Tai Forest project, studying the natural reservoirs of filoviruses (Ebola and Marburg), was completed.

9. Seven meetings were held during 2000 to set up intercountry technical networks on HIV/AIDS/STI surveillance. National, regional and global data on HIV/AIDS continued to be collected, compiled, analysed and disseminated, in collaboration with WHO regional offices, collaborating centres and other institutions. In order to interpret trends and epidemic growth patterns, and to forecast the impact of AIDS on the basis of new methodologies and updated surveillance data, a further series of meetings was held and the development of new software was initiated. Operational guidelines were prepared (on HIV surveillance, STI surveillance and HIV testing) and the final second-generation HIV surveillance package was translated into 15 languages.

10. The global cholera task force held two meetings, one at WHO headquarters and another involving regional offices. A training video for cholera management was prepared and distributed, and work on the preparation of guidelines continued. The annual meeting of the International Coordinating Group on Vaccine Provision for Epidemic Meningitis Control (ICG) was held in Cairo (Egypt) in September 2000, as well as several meetings of subgroups of the ICG. International support during epidemics of meningococcal disease was coordinated by the partners, and vaccine and other materials made available at preferential prices to countries with emergency needs. The WHO-recommended thresholds for detection of epidemics were published, and the ICG newsletter was issued. National capacity for preparedness and response to epidemic meningococcal disease was strengthened through training of laboratory personnel in selected countries of the African, South-East Asia and Eastern Mediterranean regions.

11. Epidemiological data on *Leishmania*/HIV co-infections, obtained through the WHO worldwide surveillance network, were regularly collected, mapped and disseminated through technical publications. Guidelines on the diagnosis and treatment of *Leishmania*/HIV co-infection were developed, promoted and distributed. Rapid assessment missions were carried out when epidemics occurred and, in cases of visceral leishmaniasis, basic supplies provided in order to reduce the mortality rate. Audiovisual materials were produced for training and advocacy purposes to illustrate epidemiology and control approaches in different epidemiological situations around the world.

12. Workshops and national coordination meetings were held for the surveillance and control of African trypanosomiasis, with the participation of national control programmes, nongovernmental organizations and donors. The surveillance office in Yaoundé (Cameroon) was reinforced, and the mapping of endemic areas and data collection proceeded. Work was carried out to foster the development of new drugs against trypanosomiasis, and standardized treatment regimens with existing drugs were established.

Animal and food-related public health

13. The World Survey of Rabies 2000 was published and a procedure was initiated for prequalification of human rabies vaccine. In order to develop a new vaccine bait and delivery system for dog and human rabies elimination in selected countries, contacts were established with potential recipient countries and meetings held in India and Thailand. Guidelines for improved surveillance of leptospirosis reached the final stage of preparation and a study on the cost-effectiveness of brucellosis control in Mongolia was presented.

14. The global *Salmonella* database (SalmSurv) of antimicrobial resistance surveillance data was extended, and an external quality assurance programme for *Salmonella* reference laboratories established. Global principles for the containment of antimicrobial resistance in animals intended for food were produced,⁴ as well as guidelines for national surveillance of non-human use of antimicrobials. The latter formed the basis of training courses held in Argentina, Greece, Mexico, Thailand and eastern Europe.

Anti-infective drug resistance surveillance and containment

15. The WHO/International Union Against Tuberculosis and Lung Diseases (IUATLD) global project on resistance surveillance in tuberculosis was extended. Support was provided for national and regional workshops on monitoring antimalarial drug resistance and for the initiation of networks of sentinel sites. A tool for the assessment of antimicrobial resistance surveillance systems was tested in four countries of the WHO South-East Asia Region, and updated software for the surveillance of resistance was released. Partnerships with professional societies were developed to assist national training activities to achieve sustainability.

16. The WHO Antimicrobial Resistance InfoBank prototype was evaluated. A global database on antimalarial drug resistance was developed. Elaboration of the global strategy for containment of antimicrobial resistance was continued, with a workshop on implementation of the strategy held in September 2000, and the draft document placed on the web and circulated widely for comment.

2. COMMUNICABLE DISEASE PREVENTION, ERADICATION AND CONTROL

17. In order to achieve programme objectives, coalitions need to be generated between the private and public sectors, bilateral aid agencies, the media and other organizations. These strategic alliances for controlling communicable diseases are crucial, for only by joining forces can global targets be achieved. WHO creates a platform for key players to jointly develop strategies and to mobilize the resources needed to implement these strategies. Currently, the main partnerships in this area of work are: the Global Alliance for the Elimination of Leprosy (consisting of endemic countries, DANIDA, the International Federation of Anti-Leprosy Associations, Novartis, the Nippon Foundation and the World Bank); the Global Alliance to Eliminate Lymphatic Filariasis (ministries of health, WHO, GlaxoSmithKline, Merck & Co. Inc., the Governments of Japan and the United Kingdom, CDC (United States), the World Bank, academic institutions, nongovernmental organizations, etc.); the Global Buruli Ulcer Initiative (with partners such as the Nippon Foundation and various nongovernmental organizations and academic institutions); Partners for Parasite Control; and the Global Collaboration for Development of Pesticides for Public Health (consisting of industry, national and government-supported agencies, regional and international organizations, universities and research institutions).

18. Among the key elements of the global alliances for lymphatic filariasis and leprosy are the drug donation programmes associated with these partnerships, in view of the fact that such elimination programmes are time-limited.

⁴ Document WHO/CDS/CSR/APH/2000.4.

Elimination and eradication of targeted diseases

19. During 2000, strategic plans for the eradication and elimination of targeted communicable diseases, involving all relevant partners, were developed. At the global level, the Technical Advisory Group for leprosy reviewed progress towards elimination. The global programme review group for lymphatic filariasis reviewed and approved country plans of action for eight countries; the lymphatic filariasis elimination programme was officially launched in 2000; and terms of reference for the Global Alliance to Eliminate Lymphatic Filariasis were agreed upon by all partners who, later in the year, met for the first time as part of the Global Alliance. Plans for the final eradication phase of dracunculiasis were developed, and the WHO Advisory Group on Buruli ulcer and the Global Buruli Ulcer Initiative coordinated the work of nongovernmental organizations and other partners in a joint effort to raise awareness about the disease, mobilizing support to assist affected countries, and promoting research.

Intensified country support

20. WHO works with countries to implement their intensified strategies through planning, training, social mobilization, procurement of essential drugs, technical and financial assistance, monitoring, evaluation and certification.

21. At the operational level, partnerships were strengthened and coordination between countries, international organizations and organizations of the United Nations system improved. Detailed plans for eradication and elimination of targeted diseases were developed and supported, for example: regional leprosy elimination plans in five regions (Africa, Americas, South-East Asia, Eastern Mediterranean, Western Pacific); regional lymphatic filariasis elimination plans in the Americas, South-East Asia and Eastern Mediterranean; and subregional meetings in Africa and the Western Pacific. National programme managers of dracunculiasis-endemic countries worked together to develop a common strategy and to improve subregional and cross-border technical coordination for dracunculiasis. The filariasis and onchocerciasis programmes worked intensively throughout the year to develop an integration strategy, with the joint committee for lymphatic filariasis working together with the Mectizan® Expert Committee to coordinate the donations of drugs for lymphatic filariasis and onchocerciasis programmes in Africa.

22. Supervisors and village volunteer health workers were trained on surveillance and case-management for guinea-worm in Yemen; lymphatic filariasis programme managers and health workers were trained on geographical information systems and lymphatic filariasis mapping for African countries; and the first two international training courses in lymphatic filariasis disability management were conducted in Brazil and India.

23. A global technical network of social mobilization experts was established, and school-based health education tools were developed and field-tested for malaria and Buruli ulcer. Social mobilization activities in this area of work were supported (for example activities for social mobilization against leprosy are under way in two countries). The planning and implementation of the Winterthur Health Advocacy Forum held in October 2000 was undertaken, and advocacy work in the area of communicable diseases was supported through the production of brochures and other information material, including the Infectious Diseases Report 2000.

24. Procurement of essential drugs is organized against diseases targeted for elimination. Treatment of leprosy is provided free of charge to countries which request it: 8 million multidrug

therapy (MDT) blister packs were supplied to 60 countries. To treat populations at risk of lymphatic filariasis, WHO procured diethylcarbamazine (DEC) tablets on behalf of countries. Technical and logistic assistance to field activities included direct technical assistance to lymphatic filariasis programmes in Comoros, Egypt, Togo and the Pacific island countries; the implementation of the intensified leprosy elimination strategy in the 10 major endemic countries; and direct technical assistance for guinea-worm programmes in Chad, Kenya, Sudan and Yemen.

25. The following main monitoring and certification activities were carried out during 2000: leprosy elimination monitoring in eight countries; strengthening of guinea-worm surveillance in countries reporting zero cases (for future certification and to prevent reintroduction of infection); review of progress in the elimination of lymphatic filariasis in the Western Pacific Region; verification and preparation of country reports for guinea-worm in five African countries; and definition of criteria for the certification of onchocerciasis elimination. The International Commission for the Certification of Dracunculiasis Eradication held its fourth meeting at WHO, during which applications for certification were reviewed, with 42 countries/territories certified free of dracunculiasis transmission during the meeting. With the certification of India, the entire South-East Asia Region of WHO is now free of dracunculiasis transmission.

Controlling parasitic diseases

26. With the help of a broad group of partners, WHO has developed a package for the control of morbidity due to schistosomiasis and soil-transmitted helminths in high-transmission areas using existing health care and educational channels. The strategy was proposed to the governing bodies for endorsement.⁵ Member States are being urged to reach the following minimum targets aimed at reducing morbidity by 80%: regular administration of chemotherapy to at least 75% of all school-age children at risk of morbidity by 2010; and access to essential anthelmintic drugs in health services in endemic areas, even at peripheral level, for the treatment of symptomatic cases and of children, women and other groups at risk of morbidity.

27. Evidence for policy has been built in collaboration with the ministries of health of endemic countries, with the support of WHO collaborating centres and research institutions (e.g. Johns Hopkins, McGill, Cornell and Glasgow universities and the London School of Hygiene and Tropical Medicine). The Thrasher Foundation, the Wellcome Trust, CIDA, the Micronutrient Initiative, USAID, and the Governments of Belgium, Italy, Japan and the Netherlands have supported the development and documentation of pilot country experiences.

28. In 2000, WHO established some major collaborative activities with other organizations: WFP incorporated the package into its school feeding programme in Ecuador and Nepal with increasing success, and it is planning to scale this up to all 59 country programmes. UNICEF is implementing deworming in Cambodia, Mauritania, Nepal and Viet Nam. UNHCR is addressing the problem in Bhutanese refugee camps. The World Bank, with the technical support of WHO, is implementing worm control in the school health programme of Guinea. The Hashimoto Initiative and the Asian Centre of International Parasite Control are promoting and supporting training and control activities against parasitic infections in Asia. WHO provided technical assistance to a range of countries, reviewing schistosomiasis activities in countries such as Botswana, the Islamic Republic of Iran and Morocco, initiating an operational research programme in Uganda, and supporting opisthorchiasis and schistosomiasis control activities in Lao People's Democratic Republic in collaboration with the

⁵ Document A54/10.

German Pharma Health Fund. Plans of action were developed for several countries, a training course for francophone countries was conducted, and data on morbidity from soil-transmitted nematode infections and schistosomiasis were collected and analysed.

29. Within the context of the Roll Back Malaria (RBM) project (see paragraphs 57-62), and in collaboration with key partners and representatives from endemic countries, a strategic plan for capacity building for RBM was developed. Training modules for comprehensive vector control were finalized during a regional course held in India, and a variety of other training materials, including manuals, bench-aids and videos were developed. Three international courses on planning malaria control were held in collaboration with the Regional Office for Africa for anglophone, francophone and lusophone African countries, and a regional course on comprehensive vector control was conducted.

Vector control

30. Technical guidance and support were given to national dengue programmes, and follow-up of the African network for insecticide resistance monitoring continued. A preliminary assessment of the potential environmental impacts of insecticide-treated nets was made, and specifications for netting material were developed.

31. Work carried out by the WHO Pesticide Evaluation Scheme (WHOPES) included the completion of laboratory and field evaluations, the review of the final reports by the fourth meeting of the WHOPES working group, and the publication and dissemination of WHOPES recommendations. WHO specifications for pesticides were updated, and documents were issued on the following subjects: insecticides for indoor residual spraying for malaria control; manual for indoor residual spraying; space-spraying application of insecticides for vector and public health pest control; and decision-making criteria and procedures for judicious use of insecticides. A database for monitoring pesticides was set up for the use of Member States, and the second meeting of the Global Collaboration for Development of Pesticides for Public Health was convened, its report published and disseminated and its recommendations implemented.

Tuberculosis⁶

32. Following the Amsterdam Declaration in March 2000 and the request by Member States at the World Health Assembly in May 2000 for WHO support in the implementation and expansion of proper tuberculosis control, WHO has focused on developing a global strategy aimed at accelerated DOTS expansion.

33. At the first meeting on DOTS expansion held in Cairo in November 2000, a Global DOTS Expansion Plan, composed of medium-term plans of action for each country, was presented and endorsed by the 22 high-burden countries, the technical and financial partners of WHO and the entire WHO/tuberculosis control network at headquarters, regional office and country levels. The Plan prioritizes the development of country-specific partnerships for DOTS expansion as a platform for coordination and collaboration among governments of endemic countries, technical agencies involved in international tuberculosis control, local nongovernmental organizations and donor agencies. The aim is a clear medium-term plan of action for each country supported by the international community and backed by political commitment.

⁶ Tuberculosis control was included in this area of work in 2000.

34. In the months that followed, priority was therefore given to helping develop sound plans of action, beginning with the 22 high-burden countries: 12 out of 22 have already prepared medium-term plans to expand DOTS, and the remaining countries have committed to doing so during 2001. All WHO regions organized a meeting of tuberculosis programme managers in 2000, and each region is working on a five-year strategic plan (already completed in the Western Pacific Region) that addresses the needs of all countries.

35. WHO will soon be issuing a financial assessment of tuberculosis control resources for the 22 high-burden countries, following the information presented in Cairo and subsequent work by planners and health economists. As part of this assessment, a profile was developed for each of the 22 high-burden countries, including identification of key partners working in countries and estimation of the financial gap which needs to be filled in order to expand DOTS more widely. A Stop TB Working Group on DOTS Expansion was established to continue this work.

36. In order to support countries, several documents and guidelines were prepared, for example on prevention of tuberculosis in health care facilities and tuberculosis control in prisons. Together with the IUATLD and the Royal Netherlands Tuberculosis Association (KNCV), definitions for tuberculosis programmes were standardized and published.

37. In the area of tuberculosis monitoring and surveillance, the Global Tuberculosis Control 2000 - WHO Report was published in March 2000. This report is a key document for monitoring the performance of tuberculosis programmes worldwide towards achieving global targets. Studies using new modelling methods were completed, on the impact of DOTS on tuberculosis epidemiology and burden relief in China and Peru, and health economics assessments were conducted. New global estimates of tuberculosis incidence were completed to provide a basis for the estimation of case-detection rates. New global estimates of HIV-associated tuberculosis and multidrug-resistant (MDR)-tuberculosis were also completed.

38. In the area of new strategy and policy development, several activities were undertaken and completed. Within the framework of the Adult Lung Health Initiative, evidence-based primary and secondary care guidelines targeting low- and middle-income countries were prepared, accompanying training tools developed, and adapted training materials tested. The process of adapting generic guidelines to countries was initiated in Morocco, Nepal and Peru.

39. In the area of tuberculosis/HIV, the community tuberculosis (and HIV) care project was completed at a "lessons learned" workshop held in Harare (Zimbabwe) in September 2000. This project provided sound evidence that community tuberculosis care is cost-effective when compared to the routine practice of hospitalization and health-service based tuberculosis case management. Pro-Test projects, aiming at improving collaboration and achieving functional integration of tuberculosis and HIV/AIDS programmes, were supported. Key work began to formulate a comprehensive strategic framework of HIV/tuberculosis management that optimizes collaboration between tuberculosis and HIV/AIDS programmes, building upon strengthened health systems and services.

40. Regarding the role of private for-profit practitioners in tuberculosis control, a global assessment was completed and a policy document endorsed by a group of experts that met in Geneva in August 2000. This document is the basis for implementation of private-public mix (PPM-DOTS) projects in seven locations of five high-burden countries to test how private practitioners may effectively be engaged in sound tuberculosis control work.

41. In the area of MDR-tuberculosis, norms and guidelines were developed with international partners to guide and inform the setting-up of operational research studies of DOTS-Plus, a novel strategy built on DOTS that targets management of MDR-tuberculosis in resource-poor settings. As the difficulty of access to second-line antituberculosis drugs necessary to treat MDR-tuberculosis is a major constraint owing to prohibitive costs, work was carried out to find a solution that combines increased access while augmenting control on the use of these drugs. Together with KNCV, Harvard/Partners-in-Health, CDC (United States), *Médecins sans frontières* (MSF) and the national tuberculosis control programme in Peru, a Green Light Committee (GLC) has been established to review proposals for DOTS-Plus projects and allow access to pooled procurement of second-line drugs. Through negotiations with the pharmaceutical industry and together with MSF, the costs of second-line drugs have substantially decreased during 2000, in some cases up to 95% concessionary prices are now made available to DOTS-Plus projects that have obtained approval by GLC.

3. RESEARCH AND PRODUCT DEVELOPMENT FOR COMMUNICABLE DISEASES

42. Highlights of the major progress and achievements of the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) are outlined below. Full details of progress in the 1999-2000 biennium can be found in the programme report which will be presented to the Joint Coordinating Board at its twenty-fourth session, to be held in Geneva on 25-26 June 2001. Copies of the report will be available to participants in the meeting of interested parties.

43. The work on onchocerciasis skin disease has contributed to the plans of the African Programme for Onchocerciasis Control (APOC) to eliminate onchocerciasis based on distribution of ivermectin. Increased knowledge and awareness of onchocercal skin disease has made it easier for health workers to engage affected communities in the single-dose, annual treatment programmes, and to get their commitment to carry out and pay for the treatment themselves.

44. In understanding the molecular basis of mosquito resistance to the malaria parasite, major gene loci have been identified where genes responsible for disrupting parasite development in the mosquito are located (these genes are later transferred to susceptible mosquitos). The factor responsible in susceptible mosquitos for activating the gametes, an early stage of the parasite's life cycle, was found to be xanthurenic acid. A number of possible receptors (such as enzymes) on the surface of mosquito cells that the parasite recognizes before it invades the cell have been identified, as well as over 20 immune-response genes (proteases, protease inhibitors and transcription factors) from *Anopheles gambiae* mosquitos. An international effort in *Anopheles* genomics research has been initiated as a new tool for improved understanding and control of malaria parasite development in the mosquito.

45. The development of genetic and molecular tools for engineering a mosquito that is resistant to malaria was described in 2000 for *Anopheles stephensi*, one of the major carriers of malaria in urban areas of the Indian subcontinent. Use of this system, and its application to the main vector of human malaria in Africa, *Anopheles gambiae*, will speed up understanding of the physiology of the mosquito carriers of the disease and their interaction with the malaria parasite and could lead, ultimately, to the replacement of wild mosquito populations with "safe" strains of mosquito that cannot transmit malaria.

46. New field data on the population structure of *Anopheles gambiae* from studies looking at the amount of genetic variation between populations, indicate the existence of a historical or present-day

barrier to gene flow of this species, the major vector in Africa. Through cross-breeding of man-biting species with animal-biting species of mosquitos, proteins and genes thought to be involved in recognizing human odours have been identified, and cloning and initial characterization of several classes of these olfactory genes in *Anopheles gambiae* have been performed.

47. Parasitic genome discovery has been hugely successful and has resulted in a logarithmic increase in the catalogue of known parasite sequences. All the parasite genome databases in the genome projects are available in public domains. Postgenomic investigations may therefore exploit the databases for functional analysis, providing ideal opportunities for researchers from disease-endemic countries to be at the cutting-edge in this field of research.

48. Evaluation is currently being performed on the fumigant canister, which fights the mosquito *Aedes aegypti* that transmits the dengue virus. APOC is now using rapid assessment procedures from studies sponsored by the programme to identify villages at high risk for onchocerciasis and filariasis. Once these villages are identified, an annual single dose of chemotherapy with ivermectin may be administered.

49. The programme has helped prove the principle of efficacy of treated nets. The demonstration of bednet efficacy has encouraged the private sector to undertake product development and has recently brought new innovations to market such as “dip-it-yourself” kits, more durable nets and bednets that do not need redipping.

50. The use of artemether as an intramuscular injection for treatment of severe malaria has been expanded to more than 30 endemic countries and has been included (restricted use) in the WHO Model List of Essential Drugs.

51. Mass treatment of lymphatic filariasis consists of a single dose of a two-drug treatment. This is the basis of the strategy for elimination of lymphatic filariasis by 2020 and the programme has played a seminal role in demonstrating its safety and efficacy. Since the lymphatic filariasis treatment programme was initiated in 2000, GlaxoSmithKline has provided 34 million tablets of albendazole through WHO, WHO has facilitated the procurement of 115 million tablets of DEC, and Merck and Co. Inc. have provided ivermectin for the lymphatic filariasis programmes in Ghana, Nigeria and the United Republic of Tanzania.

52. A Wellcome Trust study on international funding for malaria research concluded that, of six major funding bodies and relative to the financial investment of each, the programme had the highest number of acknowledgements per unit of investment, the most funding acknowledgements in total, and that the programme’s performance was in line with other top funding bodies.

53. In another Wellcome Trust study on malaria research capacity in Africa, the programme came out top of the list for all indicators used (source of funding for African malaria research laboratories, and master’s degree and PhD). A Harvard University analysis revealed the programme to be the leading funding source for research on African trypanosomiasis, leishmaniasis, leprosy, malaria and onchocerciasis, second for Chagas disease, filariasis and schistosomiasis. Over 80% of the programme’s funded papers were cited at least once.

54. Former grantees provide opportunities to train young scientists to develop research teams, and to promote partnerships. Former trainees and supported institutions now play pivotal roles in research as well as in control and health policy-making, nationally, regionally, and internationally. Technology

transfer is successfully occurring through an exchange of local and foreign investigators, and by the training of investigators in specialized fields in both developing and developed countries (for example in Thailand).

55. The web site and listserv have become important media through which the programme disseminates and exchanges information. Key information is simultaneously posted on both the web site and listserv. The programme's scientists list has over 1500 participants, 35% of whom are scientists from developing countries. New content is posted to the web site and the listserv on almost a daily basis.

56. The programme has developed guidelines (standard operating procedures) for clinical investigators, a good laboratory practice (GLP) training manual, and is developing a GLP handbook to be used as a reference quality document in disease-endemic countries. In addition, a document to be used in areas of research that are not currently regulated is being developed.

4. MALARIA

57. Semi-annual reviews of WHO's contribution to the Roll Back Malaria Partnership were completed and published, country action was reviewed and a system of reporting against the composite workplan was initiated in all WHO offices. Coverage was regularly secured in the global and regional media, 14 press releases were issued and responses were given to over 140 media enquiries. A newsletter was established, and international and regional publicity were secured through the mobilization of African Olympic sports stars. Additional resources were mobilized from 10 major donors.

58. The third global partners meeting adopted a loose partnership with annual consultative meetings. A concept paper on private-sector partnership was presented to the meeting, and work with several corporate partners continued. A forum on partnerships with nongovernmental organizations during complex emergencies was held. Consensus meetings for countries affected by malaria were held in all WHO regions. New or reconfigured partnership structures were designed in over 70% of these countries, and situation analyses and strategy development were completed for over 50% of them. An intelligence database of information on action to roll back malaria was established and the first update was carried out.

59. An informal consultation for updating antimalarial treatment guidelines was convened, resources were mobilized for the implementation of country-based plans, with a special focus on community-based control, and programme managers from endemic countries were trained in planning and implementing action at country and community level. Technical support and guidance were provided to countries, regions and partners on various aspects of malaria control, including during complex emergencies and epidemics.

60. A document outlining strategic approaches to address research and development needs was drafted, and operational research support was provided to several countries. Work was carried out on a mechanism to develop human resource and institutional capacity for evidence-based actions to roll back malaria. Seed funds to launch high-priority research and development were provided.

61. Key factors enabling or hindering the activation of partnerships at country level to roll back malaria were reviewed. Distribution channels for consumer goods are being mapped, and a gender-

specific communications strategy developed for deployment through FAO's sustainable development mechanisms. Issues of gender and equity were addressed within other products. A document on the economics of malaria was drafted, and an institutional analysis was conducted in the WHO African Region.

62. Preliminary draft technical guidelines were prepared on monitoring methodology, including specification of indicators. Three support missions were carried out in 2000 in African countries to develop plans and procedures for data collection and analysis. A network of geographical surveillance systems (18 sites in 13 countries) was supported to assess age- and cause-specific mortality in different areas of malaria transmission pressure. A workshop on standardization of transmission procedure estimates was held in Ouagadougou (Burkina Faso).

5. TUBERCULOSIS⁷

Framework for action to Stop TB – the Global Partnership to Stop TB

63. The Ministerial Conference on Tuberculosis and Sustainable Development, held in Amsterdam in March 2000, was a major milestone in the evolution of the Global Partnership to Stop TB. Ministers of health, finance and development-planning from 20 countries that account for almost 80% of the global tuberculosis burden participated, together with high-level representatives of organizations of the United Nations system, donor countries and technical agencies.

64. Twenty of the high-burden countries committed themselves to accelerated efforts against the tuberculosis epidemic in order to reach global targets by 2005, and called for additional support from the international community through the Amsterdam Declaration to Stop TB. The World Health Assembly in May 2000 endorsed the Amsterdam Declaration and extended the call for action to all Member States.

65. Following the Ministerial Conference, representatives from high-burden countries met with WHO and key partner organizations in Cairo (Egypt) in November 2000, during the first meeting of the Working Group on DOTS Expansion, to discuss national tuberculosis planning. Many of the tuberculosis programmes presented detailed plans and identified the major operational strategies required to expand access and quality of DOTS.

Strengthening the Stop TB Partnership to implement the Amsterdam Declaration

66. A number of meetings were held after the Ministerial Conference in order to ensure accessibility of all partners to the global partnership to Stop TB and to further develop the various components of the partnership.

67. The Stop TB Initiative discussion meeting held in Washington, DC (United States) in June 2000 was successful in achieving agreement among partners on various issues such as the core working principles of the Stop TB partnership, the minimal operating structures such as the Partners Forum and the working groups and the Global Drug Facility activities to support accelerated tuberculosis control (see paragraphs 69-70).

⁷ See also paragraphs 32-41.

68. The Stop TB Ad Hoc Partners Forum that took place in New York in July 2000 brought together for the first time various organizations traditionally involved in tuberculosis control and new Stop TB partners, to achieve the following objectives: provide an update on the current status of the Stop TB movement; endorse a mechanism to support Stop TB; and set up working groups to monitor progress.

Global Drug Facility

69. The Global Tuberculosis Drug Facility (GDF) is a mechanism to expand access to, and availability of, high-quality antituberculosis drugs to facilitate global DOTS expansion. The GDF will enable governments and nongovernmental organizations to implement effective antituberculosis control programmes based on the DOTS strategy. By securing the timely supply of quality antituberculosis drugs, the GDF will complement other activities designed to improve coverage and quality of global tuberculosis control.

70. There was rapid progress towards the development of the GDF in 2000. Following the Ministerial Conference, as well as the ad hoc partners meeting held New York in July 2000, the Stop TB secretariat addressed immediate issues related to the establishment of the GDF, including development of procurement schemes, legal/financial issues, governance and operations. A draft prospectus on the rationale of the facility and operating principles was developed and presented at the first meeting of the Stop TB Working Group on DOTS Expansion held in Cairo in November 2000. The Stop TB secretariat was given the responsibility to develop and operationalize a “fast-track” GDF.

Communications and advocacy

71. Communications guide Stop TB’s global advocacy and media strategies to mobilize political will, financial and human resources, and to increase the involvement of a broad range of multisectoral partners including organizations of the United Nations system, bilateral agencies, nongovernmental organizations, foundations, industry and research institutions. Activities undertaken during 2000 include: preparation of advocacy materials for World Tuberculosis Day 2000 such as a newsletter and the Stop TB Report 2000; ongoing upgrading and maintaining of the Stop TB web site and the establishment of a Stop TB email listserv, with nearly 2 000 members; media relations including the production of five videos and training guides, press packs and fact sheets; development and production of the second issue of the Stop TB series on guidelines for social mobilization entitled *A human rights approach to tuberculosis*; production of various publications in preparation or as follow-up of the Amsterdam conference; the organization of advocacy and social mobilization workshops in Conakry (Guinea) and Kathmandu (Nepal). These meetings form part of wider efforts to mobilize international and national nongovernmental organizations, voluntary patient organizations, religious groups and professional societies.

Special events

72. In the wake of the successful Ministerial Conference held in March 2000, follow-up meetings were held at national, regional and global levels. Regional meetings were held in 2000 in all WHO regions except the African Region (held in March 2001). Furthermore activities focused on the development of national partnerships to Stop TB in several highest-burden countries such as the Democratic Republic of the Congo, Kenya, Nigeria, Pakistan and South Africa. Support to these countries included policy advice on tuberculosis control in the context of health sector reform,

coordinated management of tuberculosis among health care priorities and building of coalitions between communities, nongovernmental organizations, government ministries and departments, the private sector, donor agencies and organizations of the United Nations system.

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