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TB and HIV/AIDS in the South-East Asia Region

*Report of the
Second Joint Meeting of National AIDS
and TB Programme Managers
Colombo, Sri Lanka, 19-22 November 2002*

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ACRONYMS

AIDS	A cquired I mmuno D eficiency S yndrome
ART	A nti R etroviral T reatment
ARV	A nti R etro V iral
CBO	C ommunity B ased O rganizations
CDC GAP	C entre for D isease C ontrol and P revention, G lobal A IDS P rogramme
COMBI	C ommunication for B ehavioural I mpact
CSW	C ommercial S ex W orker
DOTS	The brand name of the internationally recommended tuberculosis control strategy (D irectly O bserved T reatment, S hort-course)
ECAT	E nhancing C are and T reatment
GAP	G lobal A IDS P rogramme
GDF	G lobal D rug F acility
GFATM	G lobal F und to fight A IDS, T uberculosis and M alaria
GHSS	G lobal H ealth S ector S trategy
HIV	H uman I mmunodeficiency V irus
IDU	I njecting D rug U se
IEC	I nformation, E ducation and C ommunication
IPT	I soniazid P reventive T reatment
LT	L aboratory T echnician
MAP	M ulti-Country A IDS P rogramme – W orld B ank
MDR-TB	M ulti D rug R esistant T B
MTCT	M other T o C hild T ransmission
NACO	N ational A IDS C ontrol O rganization, I ndia

NAP	N ational A IDS P rogram
NGO	N on G overnmental O rganization
NsRTI	N ucleoside r everse t ranscriptase i nhibitors
NNRTI	N on- n ucleoside r everse t ranscriptase i nhibitors
NTP	N ational T uberculosis P rogramme
MTP	M ycobacterium T uberculosis
PI	P roteinase I nhibitor
PMTCT	P revention of M other T o C hild T ransmission
PPP	P ublic- P rivate P artnership
PTB	P ulmonary T uberculosis
PHA	P eople W ith H IV/ A IDS
QA	Q uality A ssurance
RAR	R apid A ssessment and R esponse
SEA	S outh- E ast A sia
SEAR	S outh- E ast A sia R egion
SEARO	S outh- E ast A sia R egional O ffice
SS+	S putum S mea r p ositive
STI	S exually T ransmitted I nfection
STLS	S enior T B L aboratory S upervisor
TB	T uberculosis
TB/HIV	The intersecting epidemics of T B and H IV
UNAIDS	The joint U nited N ations programme on HIV/ A IDS
UNGASS	The U nited N ations G eneral A ssembly S pecial S ession on HIV/ A IDS
VCT	V oluntary C ounselling and T esting (for HIV)
WHO	W orld H ealth O rganization

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1. INTRODUCTION

Tuberculosis and HIV/AIDS are both major public health problems in the South-East Asia Region of WHO. Of the 20 million people suffering from active TB globally, 8 million are in this Region. Each year, three million new cases of TB are added and nearly three-quarters of a million die of the disease. At the same time, the Region is home to nearly 6 million people living with HIV/AIDS or nearly 18% of PHA, the largest proportion following sub-Saharan Africa, making it the second highest Region affected by HIV in the world. TB is the commonest life-threatening opportunistic infection among the HIV-infected in this Region and many Member Countries in the Region are beginning to witness increasing numbers of TB-HIV co-infected individuals. The "dual strategy for a dual epidemic" approach needs to be replaced by a comprehensive and coherent response through a health strategy that addresses both TB and HIV. That the incidence of both diseases is the highest in the economically productive age groups, poses significant threats not only to health; but also to social and economic development in the Region.

The SEA Region has been the first to initiate joint annual meetings for the national TB and HIV programme managers of Member Countries. This has led to laying the foundation for collaboration between the two programmes. The second joint meeting of National HIV/AIDS and TB Programme Managers from Member Countries in the SEA Region was held between the 19-22 November 2002 at Colombo, Sri Lanka.

The specific objectives of the meeting were:

- (1) To review progress made in the areas of TB control, HIV prevention and care, and joint TB/HIV collaborative activities as well as with new initiatives such as the Global Fund to Fight AIDS, TB and Malaria, and cross-border control of priority communicable diseases;
- (2) To critically review and finalize the draft Regional Strategy for TB/HIV, and
- (3) To discuss country-specific plans on TB control, HIV prevention and care and TB/HIV collaborative activities and make recommendations for further strengthening country activities.

2. INAUGURAL SESSION

The meeting was inaugurated by His Excellency Mr P Dayaratna, Minister of Health, Nutrition and Welfare, Sri Lanka, Dr A Kahandaliyanage, Director General Health Services, Ministry of Health, Sri Lanka and Dr. Kan Tun, WHO Representative to Sri Lanka and attended by national TB (NTP) and AIDS programme (NAP) managers from all Member Countries of the SEA Region (with the exception of India and NAP Maldives) and WHO country, regional and HQ staff working on TB and HIV.

It was noted that Member Countries are making unstinting efforts to control both TB and HIV in the face of a heavy burden of disease with regard to both.

The progress made within the Region with DOTS expansion since it was first introduced in the Region in 1993 has been appreciable. Nearly two-thirds of the population in the Region now have access to DOTS services. While the strategy has yielded treatment success rates of 80% or above consistently under programme conditions all over this Region, the case detection under DOTS, which is the indicator of access and utilisation of these services by those affected with TB is at overall 25%. If the targets of universal coverage, 85% treatment success and at least 70% case detection, are to be met by the target date of 2005, much more needs to be done.

Similarly, experience in the countries of this Region has shown that a number of interventions have contributed successfully to the prevention of spread of HIV. Examples include ensuring blood safety, targeted condom programmes among commercial sex workers and their clients, combined with the syndromic management of sexually transmitted infections implemented in some countries at national scale. Harm reduction programmes for injecting drug users are efficient and cheap interventions to prevent HIV transmission in this population; however, there are many barriers to expand programmes beyond limited scale projects. The majority of HIV infections in children occur through transmission from mother to child, where effective interventions exist to prevent this mode of HIV transmission. Urgent action to improve access to voluntary counselling and HIV testing, as well as HIV/AIDS care including anti-retroviral treatment, must be undertaken.

Financial limitations that hampered the scaling up of DOTS and programmes for HIV prevention and care including antiretroviral treatment are no longer valid in the new international environment of increased funding

for health, particularly for HIV and TB. National TB and HIV programmes in Member Countries in the Region must make the most of the opportunities presented by recently established international initiatives such as the Global Fund to fight AIDS, TB and Malaria to enhance the health of the Region's people.

3. TB AND HIV IN SOUTH-EAST ASIA

The South-East Asia Region bears 40% of the global TB burden and ranks second after sub-Saharan Africa in the estimated number of people living with HIV/AIDS. Each year, nearly three million cases of TB and 750 000 TB deaths are estimated to occur in the SEA Region. Five high burden countries including Bangladesh, India, Indonesia, Myanmar and Thailand contribute to approximately 95% of all notified TB cases in the Region. In December 2002, of the 42 million persons estimated to be living with HIV globally, nearly 6 million were in the SEA Region. Thailand, Myanmar and six states in India are reporting generalized HIV epidemics, whereas Indonesia and Nepal are still at the stage of concentrated epidemics with high HIV prevalence among injecting drug users IDUs (Indonesia and Nepal) and among female commercial sex workers CSWs (Indonesia). Of the estimated 6 million adults living with HIV in the Region, about half are likely to be infected with TB. The extent to which HIV will contribute to the TB epidemic in the Region depends on the degree of overlap between the population groups infected with TB and those with HIV.

3.1 Country Experiences

Several countries in the SEA Region have initiated responses to this dual epidemic. For example, in India, a national policy of coordination of common activities for HIV/AIDS and TB is being formulated by the National AIDS Control Organization (NACO) and the Central TB Division. TB and HIV/AIDS are reciprocally included in the national policies of the two programmes. Activities including sensitization and training of key staff from both programmes are underway. Ad hoc HIV prevalence surveys among TB patients were carried out in selected sites. The following tools were developed: 1) Treatment guidelines for TB in HIV-infected individuals, 2) TB/HIV guide for health workers and 3) TB/HIV training manual for medical officers. Voluntary counselling and testing (VCT) services at the sub district

level (AIDS programme) will incorporate screening for TB symptoms and referral to diagnosis and treatment of TB and AIDS care. The recently appointed national HIV/TB consultants are expected to facilitate the local coordination of service delivery, referral, NGO involvement, cross-training and infection control in the six high HIV prevalence states.¹

In Myanmar, both TB and HIV/AIDS are high priorities in the national health plan, 1996-2001. The most common mode of transmission of HIV in Myanmar is through intravenous drug use, thence through commercial sex workers and their clients, and thereafter through the general population. HIV sentinel surveillance, including among TB patients, between 1995 and 1997 has shown a fluctuating but overall reduction since 1993. The age groups most affected are between 20 to 39 years and the HIV sero prevalence among TB patients was 4.7% in September 1997. Males are affected more than females in the ratio of 4:1. With progress of expansion of DOTS in the country, survival of HIV-positive TB patients who complete treatment has increased from 13 to 32 months. Pilot projects of TB-HIV were undertaken in five townships at the Myanmar-Thai border with the objective of early detection of HIV and provision of treatment for TB.

Following a coordination meeting between the NTP and NAP, at the central level, local authorities, NGOs and health staff in the townships were sensitized and training, appropriate health education and VCT services were set up. The interventions that were undertaken were condom promotion and provision, partner tracing, rigorous implementation of DOTS, and joint supervision, reporting and monitoring. The key lessons learnt from this initiative were (1) that TB clinics could serve as an entry point for VCT thereby avoiding the stigma of attending an STD clinic; (2) improved cure rates for TB among TB-HIV co-infected patients; and (3) early recognition and management of other opportunistic infections. The main problems faced were language barriers, frequent migration and the lack of resources to sustain activities including supervision. Future plans include enhanced collaboration with local and international NGOs, cross-border cooperation, scaling up of IEC on TB and HIV at the community level, cross-training of staff of both programmes, provision of TB and STD drugs for opportunistic infections

¹ First Joint SEARO NAP/NTP meeting 2001

through both programmes, promotion of home care and scaling up to an additional 16 border townships in a phased manner through the cross-border disease control initiative with Thailand.

In Nepal, a planned collaboration between the national AIDS and TB programmes includes the following components: joint policy and strategy on TB/HIV; joint planning, evaluation and logistics management; information sharing and dissemination; training of health workers; advocacy and operational research. The national TB programmes (NTP) has carried out HIV prevalence surveys in TB patients in selected TB centres since 1993/94. The National TB Programme is establishing a TB/HIV Centre (SAARC).

The HIV epidemic in Thailand has moved through the stages of being limited first to high-risk behaviour groups to being transmitted through bridge populations to the general population. Among the countries in the Region, Thailand is the most advanced in containing the HIV epidemic and in the response to TB/HIV. Behavioural surveillance has shown that there is evidence of continuing behavioural change among 21 year-old males in northern Thailand in terms of decreasing number of visits to commercial sex workers to under 10% and increasing condom use to well over 95% between 1991 and 1999. Antiretroviral therapy (ART) has been introduced under the HIV/AIDS care package in Thailand including prevention of mother to child transmission (PMTCT). A total of eleven thousand adults and two thousand children received ART in 2002. The trends in notification for new smear positive TB patients is gradually increasing and case detection in Thailand currently stands at 50%. The contribution of HIV to the TB epidemic is significant. Of 160 350 reported HIV/AIDS cases between 1988 and 2000, 44 177 had active TB. The sero prevalence of HIV among new TB cases shows a distinct difference in northern Thailand where prevalence of HIV is high as compared to the rest of the country. Overall trends, however, show a gradual decline since 1996.

A national TB/HIV working group has been established as an interface between national AIDS programme (NAP) and NTP providing guidance to collaborative TB/HIV activities. The working group developed a national policy for integrated TB/HIV strategies for the prevention and control of TB. A technical advisory group on INH preventive therapy has also been established. In northern Thailand where HIV prevalence in active TB is the highest compared to the country average, the Ministry conducted an

assessment of INH preventive therapy services and drafted technical and operational guidelines on INH preventive therapy for PWHA. Currently INH preventive therapy is piloted in 22 sites in Northern Thailand since 2001 using the aforementioned guidelines and is being expanded to more sites countrywide². Ultimately, in October 2002, the restructuring of the Ministry of Public Health led to the formation of a Department of Disease Control with structural integration of TB, AIDS and STD Division under one umbrella.

3.2 Regional Strategy on TB/HIV

The regional strategic framework to decrease the burden of TB/HIV, describes the expanded scope of interventions to control TB/HIV, comprising (i) interventions against TB (full implementation of the DOTS strategy, intensified case-finding, and TB preventive treatment); (ii) interventions against HIV, and therefore indirectly against TB, e.g. condoms, STI treatment, safe injecting drug use (IDU); (iii) the use of anti-retroviral treatment (ART), and (iv) surveillance, necessary to monitor both the burden of TB/HIV and the impact of the control measures instituted.

The programme managers jointly reviewed the draft TB/HIV strategy document and made recommendations on the technical aspects for incorporation into the final document. These included: (i) expanding the section describing the epidemiology of TB/HIV in the SEA Region including available data and recent estimates with some explanations as to the limitations posed by the lack of sufficient and or accurate data in several countries, particularly since this will form the basis for policies adopted nationally; (ii) adapting the strategic approach to countries grouped according to their particular epidemiological situation, and (iii) to emphasize functional TB and HIV programme integration aimed at delivering mutually agreed joint activities, rather than structural integration.

A suggested grouping of Member Countries based on HIV prevalence: low overall HIV prevalence (Bangladesh, Bhutan, Maldives, DPR Korea, Sri Lanka); low HIV prevalence, but with concentrated epidemics in certain high-risk populations (Indonesia, Nepal); higher HIV prevalence (India, Myanmar, Thailand) was proposed (**Table 1**).

² Ministry of Public Health, Thailand, WHO, JICA. Assessment: Isoniazid Preventive Therapy (IPT) For People Living with HIV in Upper North of Thailand. December 2000

Table 1: Prioritization of TB/HIV Interventions by HIV Prevalence

Low HIV Prevalence Countries	Low HIV prevalence countries with concentrated epidemics	Higher HIV prevalence
Bangladesh, Bhutan, Maldives, DPR Korea, Sri Lanka	Indonesia, Nepal	India, Myanmar, Thailand
Proposed interventions: DOTS strategy HIV prevention Surveillance	Proposed interventions: DOTS strategy HIV prevention Surveillance and preparations for <ul style="list-style-type: none"> • intensified TB case-finding • cross-referral • INH preventive therapy for TB • Anti-retroviral therapy 	Proposed interventions: DOTS strategy HIV prevention Surveillance and <ul style="list-style-type: none"> • intensified TB case-finding • cross-referral • INH preventive therapy for TB • Anti-retroviral therapy

http://www.stoptb.org/Working_Groups/TBHIV/WHO_Thailand/Assessment_IsoniazidPreventive.htm

It was agreed that the essential interventions to control TB/HIV in all three groups comprised full implementation of the DOTS strategy, strengthening of all interventions aimed at HIV prevention, and the establishment of a systematic, comprehensive surveillance system. The additional measures considered necessary in the group of countries with a higher HIV prevalence were intensified TB case-finding, establishment of effective cross-referral for TB and HIV between the clinical services of both programmes and the provision of TB preventive treatment and anti-retroviral therapy. In the group of countries with low HIV prevalence, but with concentrated epidemics in certain high-risk populations, it was considered that preparations to implement these additional interventions should be made if necessary, depending on the rate of TB/HIV co-infection as determined by rigorous surveillance measures. In addition, recommendations to undertake interventions in a phased manner, with provision for strict monitoring and evaluation at each stage of implementation, and the inclusion of relevant operational research were proposed. The year 2003 was proposed as a target date for establishing effective collaboration between the two programmes,

developing national policies, strategic plans and guidelines, and establishing surveillance for TB-HIV in all countries.

3.3 Piloting TB/HIV Activities at the District Level: Methodological and Operational Issues

The district (or equivalent) is the usual administrative unit in any country, particularly in the context of health sector reform and decentralization underway in several Member Countries. The lessons on implementation and collaboration at this operational level would serve well in subsequent replication and expansion at the national level, since all key service providers involved in implementation, including the public sector care facilities, NGOs, community-based organizations (CBOs), private practitioners, and practitioners of alternative medicine involved in both DOTS and HIV/AIDS care and prevention services including VCT, prevention and treatment of opportunistic infections, palliative care, STI management, condom promotion and blood safety are all present at this level. At the national level, leadership, advocacy, consensus on policy and strategy and technical assistance need to be provided for the development of district level operational guidelines. These guidelines need to be simple, practical, evidence-based and replicable in order to enable rational planning, setting of priorities and implementation. A work-plan with clear objectives including the resources required, would need to be formulated. A step-wise approach, beginning with a situation analysis at district level to collect baseline data on both the burden of co-infection and existing services, meetings to facilitate coordination among all stakeholders, and the preparation of plans for implementation, monitoring and evaluation must be undertaken. A coordinating body/person must be chosen and a TB/HIV committee appointed if necessary, with clearly defined terms of reference and a reporting structure. The roles and responsibilities of each partner at each level must be enunciated.

The unique core activities of each of the two programmes and those to be undertaken in collaboration must be defined. For example, for the DOTS programmes, these would be ensuring efficient microscopy services, regular supplies of anti-TB drugs, and training of health staff in the protocols for TB case management, reporting and supervision. Activities that would be undertaken in collaboration with the HIV/AIDS programme would be educating TB patients about HIV/AIDS, condom promotion offering VCT to TB patients, and targeted TB case finding among VCT clients. Similarly, the

core functions of the HIV prevention and care programme would be the provision of STI services, condom promotion, nursing care, psychological support and referral. Collaborative activities would include TB case detection, identification and referral of suspects, sputum collection and TB treatment supported by volunteers. The importance of establishing a system of reporting at district level cannot be over-emphasized. Regular, possibly monthly stakeholder meetings must be held and an annual review and preparation of the next annual work-plan undertaken jointly, with feedback being provided to the national level and vice versa.

3.4 Conclusions

Concluding the joint session on TB-HIV, it was agreed that the WHO Regional Office would finalize the strategy document based on the above discussions and in addition, provide assistance as required to Member Countries in developing national strategic plans for implementation of TB/HIV activities, support pilot projects to implement TB/HIV interventions at district/ township level and document and disseminate experiences from ongoing and planned TB/HIV activities.

1. AN OVERVIEW OF THE REGIONAL SITUATION OF TUBERCULOSIS

4.1 Burden of Tuberculosis

Several factors have contributed to fuelling the epidemic in the South-East Asia Region. Changing population demographics, conflicts and poverty have led to increasing migration, homelessness, and a compulsion to live and work in high-risk environments, causing increasing numbers of people to develop active tuberculosis. Inadequate attention to TB control in the past, poorly resourced public health delivery systems, a lack of community participation and sub-optimal health-seeking behaviour have made implementation of TB control difficult, as has the minimal or non- involvement of other sectors such as health providers in the private sector, industrial set-ups, teaching medical institutes and those offered by NGOs and traditional healers who are close to and cater to the health needs of a large number of people in national TB control programmes in Member Countries in the Region.

The incidence of TB in the Region is highest in the 20-54 year age group, thus seriously affecting the social fabric and economic development;

the financial losses sustained in the Region are estimated at USD 4 billion per year. The spread of HIV in the Region and the emergence in recent years of multi-drug resistant strains of tuberculosis pose additional threats.

4.2 Progress with DOTS in the Region

DOTS services are now available to over 60% of the Region's population; under the DOTS strategy, over 2 million patients have so far been treated with a success rate of around 84% under programmatic conditions in all areas where the strategy has been applied. The quality of diagnosis has been good; however, the number of cases detected under DOTS is still low at around 25% of all estimated cases.

The recognition of the importance of effective collaboration with other sectors providing care for patients has led to several partnership initiatives in the Region. The active involvement of the private health sector has resulted in several Public-Private Partnership (PPP) projects in the Region and to the development of policy and planning for expansion of successful models of PPPs in Member Countries. Partnerships with medical facilities in Member Countries have similarly been initiated to include teaching of DOTS in medical schools in the Region and to actively involve these teaching facilities in national TB control programmes. Plans are underway to introduce DOTS at the workplace, targeting the health facilities of large employment sectors.

Joint plans of action for initiation of disease control including TB, in the border districts of Bangladesh, Bhutan, India, and Nepal have been drawn up and will be carried forward in 2002. The Thai-Myanmar border programme for disease control is already in place.

In the area of drug supply and logistics, several countries will receive assistance through the Global Drug Facility (GDF) to ensure regular supplies of quality drugs; Myanmar was among the first countries to have benefited.

A network of laboratories for quality-assured smear microscopy services is being established and expanded in all Member Countries. Mechanisms to ensure external quality assurance systems and drug resistance surveillance coordinated by the designated supra-national reference laboratories such as the Tuberculosis Research Centre at Chennai, India, the designated reference laboratory in this Region, are also being established.

Increasing commitment for resources for TB control have been an encouraging development for TB control programmes in the Region- several countries have benefited from bilateral and multilateral donors. The Global Fund holds promise of additional resources.

There is clear commitment from governments within this Region for achieving global targets and nationwide DOTS coverage in each country. Given the current rate of progress, it is expected that the Region is expected to achieve the set targets of universal coverage, at least 85% treatment success and 70% case detection by 2006.

4.3 Country-specific Progress with DOTS

Progress as described in the Region as a whole, is a reflection of the considerable progress made with DOTS since this strategy for TB control was introduced in all Member Countries in the Region between 1993-1994. Of the five high-burden countries in the Region, Bangladesh has covered virtually the entire country with DOTS; case detection is being intensified. India has expanded rapidly to cover 450 million people by December 2002 and has plans to cover 80% of the population by 2004. Indonesia has demonstrated strong political commitment and has extended DOTS services to 98% of the population; technical strengthening is under way. Myanmar has implemented DOTS in 85% of the country and with the support recently made available, will expand to cover the entire country by 2003. Thailand has achieved 85% coverage; and implementation in the urban areas, TB-HIV collaborative activities and strengthening of supervision and reporting is being undertaken in order to improve treatment outcomes. DOTS has been integrated into a comprehensive programme for providing primary health care for all. Among the low burden countries, Bhutan has achieved complete population coverage; improving the delivery of ambulatory DOTS in the difficult terrain is under way. DPR Korea is rapidly expanding DOTS; current population coverage currently stands at 66%. The Maldives achieved and has maintained global targets since 1995. Nepal has implemented DOTS successfully and achieved these targets in mid-2002. Sri Lanka has achieved 95% population coverage with DOTS; fully ambulatory DOTS has been introduced in 13 districts and with improved cure rates, is expected to achieve global targets between 2003-2004.

4.4 Key Challenges to TB Control

Though progress with DOTS expansion in all Member Countries has been good, case detection remains low at an overall 27% in the Region. This is a cause for grave concern, as it means that a large majority of those most in need of DOTS services are not benefiting from these. It is, therefore, necessary not only to further expand DOTS but also to improve the reach and quality of implementation in order to increase case detection, so that increasing numbers of those suffering from TB are successfully treated and cured.

Continuing constraints for national TB programmes in the Region are (i) lack of sustained commitment to TB control, particularly in countries where health care has been decentralized to the level of local governments; (ii) a continuing lack of adequate technical and managerial expertise within programmes to sustain and improve the core functions of DOTS; (iii) transitional difficulties in the implementation of DOTS programmes during the process of health sector reform; (iv) insufficient involvement of other health sectors in DOTS implementation; (v) low community awareness leading to poor utilization of available services, and (vi) the need to meet emerging challenges such as HIV associated TB and MDR-TB. While efforts have been being made to forge partnerships with other sectors, these now have to be rapidly scaled up. Stricter supervision mechanisms to monitor programme performance and surveillance have to be established to monitor impact. Operational research to identify locally appropriate mechanisms, particularly to reach the most vulnerable, needs to be undertaken to increase the reach and utilization of DOTS. Only then will it be possible for the South-East Asia Region to achieve the global targets set for TB control by 2005.

The key concerns for TB control in the Region which emerged from the country presentations made by the national TB programme managers are detailed below.

Resources and Commitment

Human resources

A major challenge to TB control now lies in ensuring that sufficient technical skills are made available and retained within the programme to ensure successful implementation of the plans of action developed by all national TB

Control programmes in the Region. Sustaining adequate staff with the requisite skills to effectively carry out the key activities under DOTS, particularly smear microscopy, quality assurance of laboratory services and supervision and monitoring, especially in the larger high-burden Countries remains a concern.

Financial resources

Member Countries in the Region continue to be heavily dependent on external resources for TB control. However, contrary to the situation until end 2001, funding for TB control is no longer an immediate concern. The applications from six national TB programmes in Member Countries in the Region for additional funding for TB control have been approved by the Global Fund against AIDS, TB and Malaria (GFATM) over an initial period of five years. Several countries continue to benefit from funding from other bilateral and multilateral donors.

Commitment

Programme managers from several Member Countries expressed their concern at the varying level of commitment accorded to TB control. As country priorities in the national health agenda change in the face of perceived or actual threats from other diseases, or other non-health related emergencies, resources often tend to be channelled away from TB control. National policy-makers and governments in the Region must be urged to continue to accord TB control a high priority to ensure optimal levels of funding from national budgets and commitment for adequate staffing of national TB control programmes in order to meet the 2005 targets set for TB control. In the context of decentralization, local governments also need to be sensitized to the need to allocate greater resources for TB control.

Inadequate Involvement of Other Sectors

A considerable proportion of TB patients in the Region continue to attend and undergo care in other health sectors. These cases are not uniformly notified to the National Programmes and the quality of case management, both in terms of diagnosis and treatment remains variable. In rural areas, traditional and unqualified health providers cater to those seeking care. It is therefore equally important to sensitize patients about DOTS services, as it is to involve all health providers in extending DOTS to their clients or in referring those

suspected of TB to existing DOTS facilities. In this regard, increasingly involving the private sector which has been recognized as providing care for over a significant proportion of TB cases (upto 60% in some countries), medical teaching institutions and business & industry is paramount.

Low Community Awareness

Low community awareness of the symptoms of TB, lack of motivation, fear of disclosure of a traditionally stigmatized disease and other social and economic concerns need to be addressed. Effective communication campaigns to improve community awareness of the symptoms of TB, the need to seek care and of the facilities available for free diagnosis and treatment and social mobilization and marketing approaches to improve motivation to seek help need to be established. Patient-centred services which assure patient convenience are essential prerequisites while the use of patient enablers and incentives may need to be considered. Operational research to identify locally appropriate means for enhancing health seeking behaviour and utilization of health care services in the Region must be more actively pursued.

Health Sector Reform

The transition period from vertically administered programmes to integrated multi-disease control programmes and the process of decentralization of health services that is ongoing in several Member Countries in the Region has proved difficult. Integration and decentralization have resulted in diversion of resources to other health programmes as well as in some loss of control over budgeting, planning and implementation, especially with respect to ensuring an adequate number of skilled health workers, ensuring regular drug procurement and in-country logistics, supervision and monitoring. Countries could benefit from sharing information on the health sector reform process globally and in the Region.

Laboratory Services

In the area of diagnosis, peripheral laboratories are often inadequately equipped. There is a lack of sufficient numbers of trained laboratory personnel. A network of accessible and quality assured microscopy centres need to be established in all areas providing DOTS services.

Drugs and Logistics

Some Member Countries continue to face difficulties with anti-TB drug procurement. Assistance is now being made available through the Global TB Drug Facility (GDF) for the supply of first-line anti-TB medications and for technical assistance for direct procurement. This will, to a great extent, help mitigate this major constraint. Among the countries in the Region who have benefited so far from GDF assistance are Bangladesh, DPR Korea, India, Indonesia and Myanmar.

TB-HIV Co-infection

The Region is home to nearly 3 million TB-HIV co-infected individuals. The advent of HIV has altered the course of the TB epidemic in those parts of the Region where HIV prevalence is high such as in northern Thailand, and in parts of India and Myanmar. This necessarily calls for adjustments in the focus of TB control programmes. Greater collaboration between TB and HIV control programmes is being actively pursued as described in the section on TB-HIV. Good DOTS implementation is a vital tool to extend and improve the quality of life among people living with HIV/AIDS. The development of a regional strategy on TB-HIV and the initiation of joint TB-HIV collaborative activities in several Member Countries are encouraging developments. National policies strategies and guidelines to operationalize activities first in pilot districts and then to plan for scaling up these interventions in those countries with a high prevalence of HIV or in those with concentrated epidemics must be formulated. Countries with low prevalence need to implement baseline activities which include effectively implementing DOTS throughout the country, strategies for HIV prevention and surveillance measures (See Table 1)

MDR-TB

Only three countries in the Region have participated in the two previous global drug resistance surveys—India (sub-national), Nepal and Thailand. Data from these and from other limited studies in the Region are however, encouraging, with the overall reported multi-drug resistance rate being at around 2%. The emergence of drug resistance in the Region requires that more intensive drug resistance surveillance be planned. An additional six countries are expected to participate in ensuing rounds of the global survey. India and Nepal are exploring the possibility of initiating DOTS Plus projects in selected health settings.

Supervision, Monitoring and Surveillance

Sufficient numbers of trained staff to effectively carry out TB control activities are lacking in many countries. Supervision of programme activities as well as training and motivation to maintain high standards need to be strengthened. The recommendation for DOTS programmes to adhere to quarterly reporting with provision for evaluation of implementation and feedback for early corrective interventions is one of the strengths of DOTS programmes. All countries need to ensure that regular sub-national and national level programme reviews and annual internal, mid-term and end of term external reviews are held to ensure the quality of implementation.

TB Services among Vulnerable Populations

National programmes in the Region in addition, require to make additional efforts to deliver DOTS to populations marginalized on the grounds of ethnic differences, poverty or gender, including migrants whether internal or external, who are among the most vulnerable. The porous borders in the Region encourage both legal and illegal migration; absence of information on the quantum of migration, and lack of clear guidelines for the application of DOTS among these displaced and often homeless people are some of the difficulties. Clear policy guidelines and plans of action for TB control in border areas are therefore, essential for TB control in countries in the SEA Region which share common borders.

Operational research in priority areas such as ensuring gender equity in access to health, DOTS services in urban areas and in hard to access terrains and for the underprivileged have begun to yield results and the lessons learnt from these need to be used to define policy and guidelines for wider application.

4.5 Priorities for TB Control in the Region

Reaching Case Detection and Treatment Success Targets under DOTS

Since the declaration of TB as a global emergency and the adoption of the DOTS strategy as the basis for TB control in 1993, good progress is being made in expanding the strategy globally. The DOTS strategy is in use in 148 countries today and globally, population coverage is gradually increasing.

While treatment success rates are high, DOTS programmes are far from reaching the case detection targets; the case detection under DOTS stands at an overall 30% globally. It appears that rapid expansion alone will be insufficient to achieve the set target of 70% case detection.

DOTS programmes, therefore, have to address the lacunae that this necessarily implies and examine the steps that require to be taken in order to meet this target. The first and foremost requirement is that DOTS needs to be implemented more intensively and widely, especially in high burden countries. Second, all efforts must be made to ensure that the key components of DOTS, namely diagnosis, provision of regular drugs under direct observation, recording and reporting and issues relating to programme management such as training, logistics, supervision, monitoring and regular evaluation are carried out effectively. Planning and costing of plans for TB control is a must to mobilize commitment and resources both from domestic budgets for health and from international donor countries and agencies. Third, it is essential to address the issues relating to the barriers at each step that prevent the available services from being utilized by larger numbers of TB suspects and cases. It is equally crucial to increase the reach of DOTS through partnerships with all health providers so that all those seeking care for TB are diagnosed and treated under DOTS.

Human Resource Development

Several issues relating to this key programmatic concern were raised. First, a paradigm shift from the simplistic approach of organizing training courses to one of managing human resources for effective TB control needs to be adopted and all national TB programmes should establish an overall long-term goal for human resource development for the programme as a whole depending on a needs-based assessment of the skills and the numbers of personnel with those specified skills required for the programme, over a sufficiently long period. A plan for all activities to reach and maintain technical capacity in all DOTS districts should then be drawn up with clearly defined short and medium-term targets for human resource development based on staff turnover and performance of already trained staff. A prerequisite for this would be the appointment of a focal point for training at the national level. Training should include all levels of personnel expected to deliver DOTS services and in order to do this, it is equally important for the principles and

practices of DOTS to be included in both in-service and per-service training of medical, nursing and paramedical personnel. All training undertaken should be relevant to the skills required by various levels of staff; the training content should match the job descriptions of the various categories of health providers involved in DOTS. A mechanism for ongoing follow-up on the implementation of the plan for human resource development including quality control of training and attention to ensuring availability of adequate numbers of skilled staff at all times, in view of the constant turnover of staff within most programmes, must also be put in place.

Building Partnerships to Stop TB

It is becoming increasingly clear that public health systems cannot effectively undertake TB control alone. A much broader coalition is necessary to ensure that efforts to provide quality DOTS services to all TB cases are effectively undertaken and sustained. Mechanisms for effective intersectoral collaboration through linkages with all health providers within and outside the health sector have to be established in order to build a wider resource base for implementation of national TB programmes and to ensure uniform and optimal standards in case management. Recognizing the need for increased collaboration with health providers in the private sector, teaching institutes and industry, Member Countries in the Region initiated several projects that helped towards formulating policies and guidelines for public-private partnerships and the inclusion of teaching institutes in DOTS activities, particularly relating to training, implementation and research. DOTS is being introduced into the workplaces in large employment sectors. Partnerships with communities have long been a strength of national TB programmes in the Region – examples are the involvement of 'swastha sevikas' in Bangladesh, the Maternal and Child Welfare Association in Myanmar, and the setting up of district and village "DOTS committees" in Nepal. Collaborative activities were also initiated with the HIV/AIDS control programmes in many Member Countries (See Section 3). These partnerships in addition, help to develop mechanisms to set common priorities and plans, maximize the value of available resources through consensus, and aid national TB programmes in more effectively advocating and in raising additional human, technical and financial resources for TB in a coordinated manner.

Advocacy, Communication and Community Mobilization

The aims of an effective advocacy and communications campaign for TB control are to develop effective links with a variety of partners and stakeholders in several activities that collectively contribute to improved TB control. It is therefore centred around raising awareness, advocating for increased commitment at all levels, and achieving a specific change in health-seeking behaviour, in order to contribute towards achieving increased case detection and improved cure rates. The campaign links key global messages with national or local issues and builds a relationship between grass-roots activities and the global objectives. The key objectives that are required to be met by national TB control programmes through such campaigns are to promote a better understanding of TB and the need to seek a cure, of DOTS as a means of availing oneself of free diagnosis and cure for TB. Only then will DOTS services be utilized optimally and the stigma attached to the disease reduced. These communication campaigns need to be “massive repetitive, intensive and persistent” and sustained over long periods to achieve the desired effect. In this context, the Communications for Behavioural Impact or “COMBI” strategy prepared by WHO/HQ, incorporates lessons learnt over 50 years of health education and experience from consumer communication in the private sector. It comprises public relations, advocacy and administrative mobilization, community mobilization, sustained appropriate advertising and personal ‘selling’ through interpersonal communication/counselling. Piloting of this strategy has been proposed in Bangladesh and in the state of Kerala in India, with a view to introducing and scaling up communication for improving community awareness and utilization of DOTS services in the Region.

4.6 Country-specific Priorities and Plans for Increasing Case Detection under DOTS and Improving the Quality of DOTS Services

The tables below show the key interventions proposed by national programme managers to increase case detection under DOTS and improve the quality of DOTS services in their respective countries (Tables 2 and 3):

Table 2: Plans for Increasing Case Detection and Improving Quality of Implementation in High TB Burden Countries

Priority Areas	Planned Activities				
	Bangladesh	India ³	Indonesia	Myanmar	Thailand
Increased Political Commitment			Undertaking advocacy at provincial level for increased commitment to TB control.		Undertaking advocacy at central and provincial levels for increased commitment to TB control.
Training	Training all levels of health staff as per training plan		Improving training modules and preparing simple manuals for general staff. Continuing with training of staff at all levels as per training plan of the NTP.	Developing a training plan and implementing training of all levels of newly recruited staff and refresher training of previously trained staff.	
Staffing	Filling all existing vacancies in staff positions	Filling vacancies of LTs and STLS.		Filling all sanctioned vacant posts.	
Collaboration With Private Sector	Involving private practitioners and village doctors	Sensitizing medical practitioners through professional associations like Indian Medical Association.	Initiating pilot projects on public-private partnerships for DOTS	Sensitizing general practitioners to the need for early referral to NTP. Implementing pilot projects on public-private partnerships for DOTS in selected townships as planned.	Establishing collaboration with private practitioners, especially in metropolitan cities.
Increased Service Delivery In Public Health System	Involving other public health services such as large hospitals	Involving other public health services.	Involving all public health facilities and training of all staff in these.	Involving large general and speciality hospitals in the NTP.	
Service Delivery In Other Areas		Involving other Government sectors and medical		Involving other health and non-health related ministries.	Expanding urban DOTS project.

³ Information on India was provided by WHO Temporary Advisors and WHO staff due to the absence of the national programme managers.

Planned Activities					
Priority Areas	Bangladesh	India ³	Indonesia	Myanmar	Thailand
		colleges in both private and public sectors			
IEC (Information, Education & Communication)	Launching IEC campaigns to improve community awareness. Piloting of COMBI in Kerala State.	Hiring a media agency for IEC. Pilot COMBI in Kerala State.	Developing strategy for IEC and advocacy and appropriate materials for both. Conducting a workshop on COMBI.	Developing and implementing a comprehensive IEC strategy.	Developing mass media campaigns and interpersonal communication by health workers in the community for TB and HIV AIDS.
Laboratory Services	Ensuring quality assurance (Training Laboratory personnel and developing and establishing a system for QA)	Implementing blinded protocol for QA	Establishing external quality assurance system.	Increasing number of laboratories and sputum collection centres to improve access to microscopy services.	Undertaking drug resistance surveillance and effective QA.
Drugs & Logistics	Considering introduction of patient-wise drug boxes		Establishing protocols for effective procurement and logistics.		
Supervision, Monitoring And Evaluation	Arranging quarterly meetings with district administration Reviewing meetings at central and Thana levels.		Improving supervisory protocols and ensure implementation of regular supervision. Recruiting supervisory level staff.	Establishing TB supervisory committees at national, state, district and council levels. Undertaking regular supervisory visits and reviewing meetings.	
Incentives For Patients				Instituting patient incentives to decrease defaulters	

Table 3: Plans for Increasing Case Detection and Improving Quality of Implementation in Low and Intermediate Burden Countries

Priority Areas	Planned Activities				
	DPR Korea	Nepal	Maldives	Sri Lanka	Bhutan
Increased Political Commitment				Advocating to provincial health directorates for increased commitment to TB	Enhancing political commitment for TB
Training	Training staff in computer-ised data management at district and provincial levels		Training central staff in supervision and case management		Training trainers for doctors, programme officers and TB in – charges
Staffing					Recruiting additional staff and health workers to function as TB in – charges at peripheral level.
Collaboration With Private Sector		Involving polyclinics and nursing homes.			
Increased Service Delivery In Public Health System		Utilizing central hospitals and peripheral health posts as DOTS centres.		Setting up branch clinics in curative institutions.	
Service Delivery In Other Areas		Introduce DOTS into slum areas and prisons and factories.			
IEC (Information, Education & Communication)	Targeting community and general doctors	Targeting school children women's groups and World TB Day (Week-long case finding campaign)	Launching a mass media campaign through Radio/TV.	Developing and implementing a comprehensive IEC campaign.	Enhancing IEC activities Running DOTS exhibitions during festivals.
Laboratory Services	Introducing system for QA	Recruiting and training additional lab	Establishing microscopy services in each	Expanding microscopy services to curative	Training all laboratory technicians.

Priority Areas	Planned Activities				
	DPR Korea	Nepal	Maldives	Sri Lanka	Bhutan
	Setting up reference laboratory for MDR TB	assistants. Improving laboratory network.	health centre. Training central lab staff in culture and sensitivity.	institutions.	
Drugs & Logistics	Introducing patient-wise drug boxes.	Piloting introduction of patient-wise drug boxes in cross-border districts.			
Supervision, Monitoring & Evaluation	Improving transportation - procuring cars and motorcycles. Arranging review meetings at central and provincial levels.	Building capacity at regional level. Increasing budget for transport. Providing feedback to health workers at quarterly meetings.	Strengthening supervision (funding for travel)	Providing transport for visits to district clinics. Arranging regular review meetings at chest clinics	Purchasing vehicles Implementing use of supervisory check lists. Arranging annual national planning meetings, and regular quarterly review meetings at regional level.

Annex (1) shows the external assistance required by national TB programmes country-wise, in order to undertake the proposed interventions.

4.7 Conclusions

The key conclusions that were drawn from the deliberations of the national TB programme managers on the state of TB control in the SEA Region and on the way forward were as follows:

- (1) While good progress has been made with DOTS expansion, currently at 62% population coverage in the Region, and treatment success rates continue to be high at 84%, efforts have to be made to rapidly expand DOTS to the remaining areas in all countries in the Region, especially to the border districts, hard-to access, remote and large metropolitan cities;

- (2) The low case detection rate is a major concern. All Member Countries are committed to make the necessary efforts as outlined above to focus on increasing the detection of TB cases under DOTS, i.e., building partnerships with all health providers such as private practitioners, NGOs, medical teaching institutes, health facilities in workplaces and with related programmes such as the HIV/AIDS programme to widen the network of DOTS services; enhancing community awareness and utilization of DOTS through effective communication and social mobilization approaches, through analyzing and addressing the obstacles to the utilization of available services from the patient perspective, and actively pursue innovative approaches to improve both the delivery and utilization of DOTS services, and
- (3) All efforts will be made to simultaneously maintain and improve the current quality of implementation; effective supervision and monitoring will be ensured.

2. AN OVERVIEW OF GLOBAL AND REGIONAL PROGRESS MADE IN HIV/AIDS PREVENTION AND CARE

5.1 Global Health Sector Strategy (GHSS)

Conscious of the need to define and strengthen the role of the health sector within a broad multisectoral response to HIV/AIDS, the World Health Assembly adopted a resolution in May 2000 (WHA 53.14) requesting the Director-General of WHO to develop a strategy for addressing HIV/AIDS as part of the United Nations system-wide effort to combat the HIV/AIDS epidemic. The global health sector strategy (GHSS) lays out that health systems and ministries of health should be empowered to play a leadership role in HIV/AIDS prevention and control. The three goals of the health sector strategies to combat HIV/AIDS are:

- (1) To prevent transmission of HIV;
- (2) To reduce morbidity and mortality related to HIV/AIDS, and
- (3) To minimize the personal and societal impact of HIV/AIDS.

The GHSS proposes an essential package of interventions for HIV prevention and care, with actions taken by countries and WHO. WHO's roles in this context are to provide technical support in identifying and implementing priority interventions, evaluating outcomes of programmes and services, capacity building and promoting the use of clinical management and antiretroviral treatment guidelines. WHO's priority is to provide strategic advice to countries in responding to international efforts on expanding access to antiretroviral treatment in meeting the global target to provide **antiretroviral treatment for 3 million people in developing countries by 2005 (Three by Five Goal)**.

5.2 Health Sector Strategy to Combat HIV/AIDS: Regional Perspective

Challenges for implementing a health sector strategy in the SEA Region are scaling-up of effective interventions, overcoming stigma and discrimination, improving community acceptance of HIV, improving access to VCT, including ART in HIV/AIDS care policy, strengthening capacity in HIV/AIDS surveillance and research, as well as limited resources for strengthening the health infrastructure. Ten priorities for the prevention and care of HIV of WHO in the Region were identified as follows:

- (1) Promoting community-based interventions, particularly condom promotion and provision;
- (2) STI management;
- (3) Targeted interventions;
- (4) Improved quality of blood;
- (5) Prevention of Mother-to-Child Transmission (PMTCT) including HIV prevention among women of child-bearing age;
- (6) Voluntary Counselling and Testing (VCT);
- (7) Antiretroviral Treatment (ART) in HIV/AIDS care continuum;
- (8) TB/HIV;
- (9) Surveillance, and
- (10) Research**

The guiding principles of the WHO Regional Health Sector Strategy are to reinforce the government stewardship role, strengthening capacity of

national health services, resource mobilization and financing strategies, improving surveillance and health Information systems and developing public-private partnerships.

It was concluded that WHO SEARO pursue the development of an Asia-Pacific Health Sector Strategy in collaboration with WHO WPRO, taking into consideration the specific epidemiological and response situation in Asia and the Pacific. The strategy would be presented to the health ministers in Asia.

5.3 HIV/AIDS, TB/HIV and STI Surveillance

WHO, UNAIDS and other international agencies such as Family Health International (FHI) recommend second generation HIV/AIDS surveillance to better monitor trends and project estimations for programme planning and monitoring. First generation surveillance was restricted to HIV sentinel surveillance and AIDS case reporting. Second generation HIV surveillance also includes STI, behavioural, and HIV/TB surveillance.

The status of HIV/AIDS surveillance in the Region was reviewed (**See Annex II**). Most countries have established HIV sentinel surveillance and have started to plan for or have conducted behavioural surveillance. The weakness of STI surveillance was noted. ARV resistance monitoring is still to be established.

Questions were raised on the possibility of using the existing surveillance systems to monitor UNGASS indicators such as the prevalence rate of HIV infection among 15 to 25 years old persons. Although in most countries this could be done by sampling pregnant women in this age group, it was noted that country specific situations should be considered. For example, in Sri Lanka, the majority of women marry nowadays after 25 and it is therefore very difficult to obtain a large sample size in the aforementioned age group.

It was recommended that in countries with low level of HIV infections, it was important to maintain HIV surveillance in high -risk groups in order to detect the initial spread of infection. This is the situation in six countries in the SEA Region and parts of India⁴.

⁴ Information on India was provided by WHO Temporary Advisors and staff due to the absence of the national programme managers.

It was noted that the monitoring of mortality trends in young adults was not included in the WHO/UNAIDS second generation surveillance guidelines - although it was proposed as a good tool to monitor the HIV/AIDS epidemic. Most countries have now established some sort of a yearly review and analysis of data collected for programme planning. Most countries expressed their interest to receive technical and financial support for improvement of their surveillance system.

5.4 HIV and Injecting Drug Use

HIV/AIDS epidemics in Asia have been characterized by explosive concentrated epidemics among injecting drug users (IDUs) in several countries. While priority must be given to the rapid scaling-up of already proven effective targeted interventions to reduce HIV transmission in this population, major limiting factors have been the lack of high level political commitment, appropriate guidelines and qualified resources. Therefore, WHO has reinforced its support for strengthening country capacity to adopt and implement a comprehensive HIV prevention and care package for injecting drug users including harm reduction interventions.

High level political support has been secured in China, Indonesia and Vietnam. Guidelines have been finalized, adapted and translated on: (1) Training for HIV prevention outreach to IDUs; (2) Advocacy for effective HIV prevention among IDUs; and (3) Policy and programme development for HIV prevention and care among IDUs. Tools are now being disseminated, with the initiation of training of national staff and implementation of clean injecting and substitution programmes. WHO supports countries to develop national strategic plans for HIV prevention and care for IDUs. It was noted that WHO considered that scaling up of sensitive prevention efforts for IDUs was feasible.

In 2003, the first Bi-regional Harm Reduction Meeting was held in Hanoi, Vietnam and first steps to establish a bi-regional contact group on harm reduction made. WHO/WPRO and SEARO would serve as a secretariat for that bi-regional contact group.

Table 4 : Situation on IDU and HIV in Selected Countries

Country	Situation
Indonesia	<ul style="list-style-type: none"> • Problem mainly among young people. • A survey using WHO rapid assessment and response tools (RAR) was conducted in eight provinces / districts during 2001. • It is estimated that among drug users coming for drug treatment, 80% are injecting drug users, out of which 50% are found to be HIV seropositive. • Harm reduction is an integral part of the MoH National Strategic Plans for AIDS. • Harm reduction has been included in the first round GFATM proposal in Indonesia. The activities will be implemented in Jakarta and Bali through NGOs. • Advocacy and pilot projects such as the distribution of clean injecting equipment and methadone maintenance through support from WHO and other partners continue.
Bangladesh	<ul style="list-style-type: none"> • 2000 – 2001 HIV prevalence among IDUs was 1.7% • Risk behaviour for HIV transmission among IDUs such as needle sharing does exist. • Drug rehabilitation and treatment centres for drug users are established. • NGOs are working in the field of IDU and HIV prevention through World Bank funding.
Myanmar	<ul style="list-style-type: none"> • Supply and demand reduction are the main thrusts of policy for Myanmar. The Central Committee for Drug Abuse Control (CCDAC) is responsible for that programme. • IDUs are registers and channelled to a rehabilitation programme in drug treatment centres for detoxification. • Since March 2002, the government has included harm reduction activities into the national AIDS programme. The programme is planning to introduce a number of pilot sites where needle exchange, buprenorphine and methadone substitution will be provided.
Thailand	<ul style="list-style-type: none"> • Supply and demand reduction are the main thrusts of policy for Thailand. • There is a clear shift from injecting heroin to use of methamphetamines. The proportion of injecting clients coming to substitution treatment centres had decreased to 50% among drug users. • The Bangkok Metropolitan Administration has established methadone maintenance clinics. • In northern Thailand, NGOs are operating a number of small scale projects with needle and syringe exchange as well as methadone maintenance programmes. However, these projects have not been expanded or scaled up as national strategies.

5.5 Voluntary Counselling and Testing: Implementation Issues

Barriers to implementation and lessons learnt for voluntary counselling and testing (VCT) were presented.

VCT is a public health strategy that aims at reducing HIV transmission on a voluntary basis and increases people's access to knowledge and understanding of HIV status, thereby facilitating the early and appropriate uptake of care and support services. VCT includes pre-test counselling, voluntary and confidential HIV testing and post-test counselling. Counselling and psychosocial support assist in test-taking decision-making and coping as demonstrated in Thailand and other countries around the world. Counselling also assists in HIV status disclosure to family members. VCT reduces risk behaviour, especially in HIV positive as recently documented in Kenya, Tanzania, and Trinidad. VCT is cost-effective in high HIV prevalence countries as in Tanzania with USD 17.78 per DALY saved and in Kenya with USD 12.7.

Barriers for implementation identified are of structural / operational, technical, attitudinal, societal and communal nature as well as related to monitoring of quality. Elements of quality HIV counselling include accountability and responsibility in service provision. Governments play the key role to setting quality and standards.

Participants shared their concerns as to barriers in health care setting such as hospital staff not sensitized to VCT; lack of client centred approach; low HIV awareness in many settings; acceptance of VCT in community setting and lack of monitoring of VCT quality.

Telephone counselling exists in many countries and is useful in emergencies, and for clarifying some conditions and urgent needs of clients, but is not recommended for pre – and post test counselling. It could serve as an entry point for bringing people to VCT. Health information delivery over the phone exists, for example in India and Thailand.

Mandatory testing and home-testing are not recommended by WHO and UNAIDS.

VCT Situation in Selected Countries (Table 5)

In India, VCT was primarily to provide psychosocial support during the WHO Global Programme on AIDS (GPA) times on a one to one basis and has now become a tool for HIV prevention. The existing problem in India is that VCT is still unlinked to other services. VCT is often positioned in medical colleges

with access to a health laboratory. However, referral linkages to other care and support services within the hospital and the community are missing. A huge proportion of people do not return for their test results (40 – 50 %). Therefore, the Government of India has introduced the use of rapid tests in order to increase the uptake of post-test counselling.

Thailand has a nationwide policy on VCT since the early nineties and VCT is implemented in every district. Over 90% of clients return for their test result. Existing health staff such as nurses and midwives were trained in counselling. The availability and quality of health laboratories play an important role in VCT. Laboratory technicians are trained in HIV testing and VCT. Universal precautions as part of infection control measures and post-exposure prophylaxis are implemented more or less throughout the country.

Table 5: VCT Status in Selected SEAR Countries, November 2002

	Number of sites	Target	Time lines
Bangladesh	1	6 VCTs	by end 2003
Bhutan	0	20 VCTs	by 2007
India ⁵	445	600, one in each district, expand to sub district level	by end 2003 by 2008
Indonesia	0	30 VCT, one in each province	by 2007
Nepal	2	9 VCTs 34 counselling centres without testing	by 2006
Myanmar	40	60 VCTs, one in each district	by end 2003
Sri Lanka	23	43 (8 teaching and 12 provincial hospitals)	2004
Thailand	Nationwide programme	All districts	

In Bangladesh, there are 97 public and private laboratories where HIV testing is offered. Patients are then referred for confirmatory HIV testing if

⁵ Information on India was provided by WHO Temporary Advisors and staff due to the absence of the national programme managers.

tested seropositive and most clients do not return for their HIV test result. Bangladesh strongly expressed the need for support from WHO to establish VCT services and appropriate linkages and referral to care and support systems.

In Nepal, clients are referred to laboratory for HIV- testing and to the National Centre in Kathmandu for counselling.

Sri Lanka raised the issue of medical doctors not being trained in the concept of VCT. There is still resistance, especially among medical doctors to accept VCT. The misconception is that patients coming to the hospital have already agreed to HIV testing as one of the diagnostic tools used.

In Indonesia, the major challenge is to link counselling services with HIV testing facilities. The authority of laboratory services does not fall under the Directorate of Communicable Diseases. Also NGOs and facilities in the private sector are providing VCT. There is a strong need for coordination and collaboration among these partners to assure proper counselling standards.

5.6 WHO Strategies to Prevent HIV Infection in Pregnant Women, Mother and their Infants

It is estimated that around 2.7 million children are living with HIV and that approximately 2 000 are infected with HIV each day, globally. Increasing HIV prevalence in women of child-bearing age and subsequently mother-to-child transmission of HIV-1 (MTCT) are the major causes of HIV infection in children.

In June 2001, during the United Nations General Assembly Special Session (**UNGASS**) on HIV/AIDS, 189 Member States declared their commitment to action to: " By 2005, reduce the proportion of infants infected with HIV by 20 per cent , and by 50 per cent by 2010...."

WHO has therefore developed a framework for action, which includes:

- (1) Primary prevention of HIV infection in women
- (2) Prevention of unintended pregnancies among HIV-infected women
- (3) Prevention of HIV transmission from HIV-infected women to their infants
- (4) Provision of care and support to HIV-infected women, their infants and family

Provision of Care and Support to HIV-infected Women, their Infants and Family

About a quarter of HIV seropositive pregnant women have CD4 count < 200 and require prophylaxis of opportunistic infections and ARV treatment. Half of the infected infants need ARV before one year of age. PMTCT is a powerful entry point for HIV prevention and care interventions. Thailand has started a national programme supported by CDC GAP, UNICEF and WHO on enhancing care and treatment for mothers, their children and spouses (**ECAT**). The programme includes a package of services for ongoing care, including antiretroviral treatment. India is planning to pilot a similar package of interventions.

Situation in Selected SEAR Countries

In Thailand, the prevalence of HIV infection among the 900 000 women who become pregnant each year is 1-2%, and approximately 13 000 children are born at risk for MTCT annually. Without intervention, 4 000 children would become infected each year, about one seventh of all new HIV infections. MTCT already has infected 30 000 children, caused 7 500 AIDS cases in children, and increased overall mortality rates among children 0-4 years of age in some areas. The national PMTCT programme comprises VCT for all pregnant women attending ANC, antenatal ZDV from 34 weeks gestation, ZDV to the infant (for one week if the mother received ZDV for > 4 weeks and for six weeks if the mother received ZDV for < 4 weeks) and infant formula until 12 months of age. In current practice, generic ZDV tablets are procured from a Thai manufacturer and ZDV syrup from a foreign pharmaceutical company. Based on reports received from 822 hospitals in 75 provinces for the period October 2000 through September 2001, 97% of 573 655 women who gave birth had attended ANC and 93% had been tested for HIV.

In India, by the end of 2001, the prevalence of HIV infection among the 27 million women who become pregnant each year was 0.4%. Approximately 108 000 children are born at risk for MTCT annually. Without intervention, around 30 000 HIV-infected children would become infected each year. In 2000, the Government of India launched a feasibility study in 11 centres of excellence in six high HIV prevalence states. The study included VCT, ZDV from 36 weeks gestation, and counselling on infant feeding options. Of 192 474 women attending ANC in 11 centers, 89% have received VCT, and 54% women counselled were HIV-tested. Of the tested women, 1.7% were HIV

positive and 42% women received ZDV. In 2001, a second feasibility study was initiated using HIV rapid tests and administering nevirapine (NVP). Of women attending ANC in 11 centres, 85% received VCT and 77% were HIV tested. Of the tested women, 1.6% were HIV positive, 66% (305) of the mother-baby pairs took NVP. Based on these results, in 2002, the Government of India determined a national policy to prevent MTCT. Further 62 centres have been trained for PMTCT.

Indonesia started a pilot project in Jakarta and Merauke districts. Constraints encountered are the limited laboratory capacity for HIV testing and lack of trained counsellors. HIV test reagents are expensive and confirmation of tests takes a long time due to difficult communication with reference laboratories.

Nepal and Bangladesh have plans for starting PMTCT. The maternity hospital in Kathmandu, Nepal and some NGOs are already offering some PMTCT interventions. Bhutan has provided one mother-infant pair with short course ZDV. Sri Lanka is currently recommending the Thai short course ZDV regimen and is interested to start a pilot project. Two major maternity hospitals are covering approximately 50% of all deliveries. In Sri Lanka, pregnant women are screened for VDRL and reported anonymously.

5.7 Access to Antiretroviral Drugs (ARVs): Issues and Challenges

Less than a decade ago, people living with HIV/AIDS had little hope. They faced the gradual destruction of the immune system, followed by treatment of opportunistic infections, wasting, periods when they felt fine followed by bouts of debilitating illness. The result of HIV infection was a steady inexorable decline towards the complete destruction of the immune system and finally, death.

Since 1996, the advent of new classes of antiretroviral drugs and their use in combination have changed the way people in the developed countries think about HIV/AIDS. Although there is no cure for HIV/AIDS, antiretroviral drugs have dramatically reduced morbidity and mortality, and prolonged and improved the quality of life of many people living with HIV/AIDS. The introduction of these new classes of ARVs in 1996 was a turning point for hundreds of thousands of people in the developed world.

Since the Durban AIDS Conference in 2000, the following major milestones have occurred:

- (1) Prices of ARV combinations have dropped >80% to first-line regimens to less than USD 1 per day;
- (2) Global political commitment to access to care and treatment was declared by the world leaders during UNGASS, G8 Summit and Abuja Summit);
- (3) New financing sources are available (GFATM, Multi-country AIDS Programme -MAP, bilateral donors);
- (4) Field experience has shown that ARV treatment is feasible;
- (5) Member States are planning/implementing ART programmes (Table 6);
- (6) DOHA declaration on WTO and TRIPS is allowing use of generic drugs;
- (7) New WHO ARV guidelines for the use in resource poor countries have been published;
- (8) Antiretroviral drugs are included in the WHO Essential Drug List, and
- (9) WHO and UNICEF have started a prequalification scheme for generic ARV producers and drugs.

The ultimate goal should be universal access to ARVs for all PHA in need in the long term. **The WHO interim goal that 3 million people should be on ARVs was announced at the Barcelona Conference in 2002.** WHO is promoting this target to inspire people needing to take action and start looking into country situations and to explore how to make ARVs available.

There is an urgent need to advocate for HIV/AIDS care and ARVs to HIV programmes. Access to ARV will reduce the burden of HIV on the health system and prolong the quality of life of infected people. Some countries have received funds from GFATM for ARV treatment programmes.

Multiple partners are needed for working together towards a common goal and for the provision of technical assistance to developing countries for scaling-up of ARV therapy. A global partnership called the International Treatment Access Coalition has been formed. WHO is the secretariat of that coalition. An interim steering committee has been set up - the committee will govern until summer 2004 to work out the detailed Plan of Action by end of year 2003.

WHO SEARO has published ARV guidelines in 2002 defining standardized combination ARV regimens for use in resource poor settings and recommending minimum requirements for safe monitoring of ARV therapy.

Major issues

Basic determinants of adherence to drugs were discussed. Issues raised were anticipating the amount of drugs needed for the next years, increasing the number of people knowing their HIV status, strengthening capacity of health services and cost of establishing services to deliver a comprehensive HIV/AIDS care package (VCT, OI prevention and treatment, ART, other care and support services).

Table 6 : Status of ART in Selected Countries of the SEA Region, November 2002

	Myanmar	Thailand	Indonesia	Sri Lanka	India ⁶
Policy on ART	Yes	Yes	Yes (MTP 2001 – 2006)	Draft	Tactical endorsement but no budget
Guidelines	Present	Yes	Ongoing	Updating	Yes
Training	One doctor trained	Done	HCW/MO	Planned	National TOT and regional training ongoing on ART
VCT	Counsellor available	yes	To be strengthened as apriority	For ART	To be expanded. Target VCT in each district (600)
Drug access	Ranbaxy donation	Yes	Not locally manufactured but tax free imports allowed	Not locally manufactured	Generic manufacturer. Two on pre-qualification list, No access in the public sector, freely available in the private sector

⁶ Information on India was provided by WHO Temporary Advisors and staff due to the absence of the national programme managers.

	Myanmar	Thailand	Indonesia	Sri Lanka	India ⁶
Laboratory	To be strengthened	Yes	To be strengthened	Yes	HIV diagnostics free from import duty CD4 available in 25 cities and private sector
Future plans	Pilot in one district at IDH 60 townships / 324 All townships by 2005 NGO/CBO continuum of care	To reach 23 000 by 2003 and 50 000 by 2005	Four high priority provinces GFATM approved, Potential for intercountry collaboration	Target universal access by 2005 GFATM for cost effectiveness study	GFATM for PMTCT Plus Innovative cost recovery studies Intercountry collaboration in drugs
TA needed		Yes	Assess feasibility	Yes	

TOT=training of trainers, HCW=health care worker, MO= medical officer, IDH= Waibagi-Infectious Disease Hospital on HIV, TA= technical advice, MTP=Medium Term Plan

5.8 Conclusions

The key conclusions that were drawn from the discussion among the national AIDS programme managers on the status of HIV prevention and control in the SEA Region and on the way forward were as follows:

While good progress has been made within some countries in scaling up HIV prevention and care interventions including establishing second generation HIV/AIDS surveillance, efforts have to be made to rapidly expand priority interventions to the remaining countries in the Region. The health sector will play a key role in moving the progress forward.

The low coverage of interventions in many countries is of major concern. All Member Countries are committed to make the necessary efforts to scale up effective interventions for HIV prevention and care through advocacy, strengthening capacity, enhancing community awareness and utilization of HIV prevention and care services through effective communication and social mobilization approaches, analyzing and addressing the obstacles to the utilization of available services from the patient and

provider perspective and actively pursue innovative approaches for the delivery and utilization of antiretroviral treatment services.

All efforts will be made to simultaneously maintain and improve on the current quality of implementation; effective supervision and monitoring will be ensured.

3. UPDATE ON GFATM

Of an amount of US\$ 1.4 billion allocated over five years during the first round of proposals, US\$ 282 million was allocated to countries in the SEA Region; a total of nine components from DPR Korea, India, Indonesia, Sri Lanka and Thailand. In the second round, 21 components from SEAR Member Countries were submitted.

Many issues regarding the Global Fund still need to be resolved including the choice of Local Fund Agent (LFA) and the slow process in grant negotiations and disbursement, the procurement and monitoring and evaluation systems. One of the major concerns is that the countries that are in the greatest need of resources may not be able to access the funds if the proposals do not include a comprehensive approach.

Seven tips for a successful proposal were suggested:

- (1) Articulation of situation analysis and intervention gap;
- (2) Clarity of goal, objectives and broad activities;
- (3) Clarity of indicators and targets;
- (4) Consistency with national/ international policies and strategies;
- (5) Demonstration of additionality and complementarity;
- (6) Identification of resource gap, providing detailed budget with allocations to various implementing partners, and
- (7) Ensuring feasibility and sustainability.

Since the beginning of the Global Fund, WHO/SEARO has been providing support to Member Countries in terms of information and communication, and technical support in proposal development and implementation. Many meetings/forums have been supported or organized by

WHO/SEARO for the exchange of information and experiences. Technical support was provided to all countries in the proposal development and in the peer review of the proposals before submission to the Fund.

4. RECOMMENDATIONS

Realizing the importance of strengthening national capacity in prevention and control of SARS and other similar infections, and based upon the deliberations in three groups followed by a plenary session, the participants made the following recommendations:

7.1 For WHO

TB/HIV

- (1) WHO SEARO should finalize the TB/HIV Regional Strategic Framework based on the feedback from participants including those from the consultative group which met on 18 November 2002 by 31 December 2002.
- (2) In order that Member Countries gain/share experience in operationalizing the Regional TB/HIV Strategic Framework, WHO should provide technical and financial support in implementing the strategy in a few pilot districts in Member Countries and to operationalize existing plans on TB-HIV.

TB

- (1) WHO should provide technical assistance to Member Countries in building capacity for quality assured microscopy services, management of drugs and supplies, IEC and for improved programme management.
- (2) Member Countries should be assisted through developing tools to better monitor and evaluate the performance of DOTS implementation under the NTPs, and identifying human and financial resource requirements.

- (3) WHO should assist in resource mobilization through multilateral and bilateral donor partners to meet the identified resource requirements.
- (4) Member Countries should be supported in areas of intersectoral and cross-border collaboration for priority communicable diseases including TB control through provision of technical and training materials, support for implementation and for operational research.
- (5) WHO should assist countries in developing innovative, effective approaches to IEC, advocacy, and behaviour change.
- (6) WHO should help countries in documenting experiences and identifying strategies to adapt to ongoing health sector reforms while preserving essential NTP functions and capacities.

HIV

- (1) WHO SEARO should consider developing a regional health sector strategy on HIV/AIDS in collaboration with WPRO and mobilize resources for strengthening health infrastructure and capacity for example from bilateral, multilateral agencies.
- (2) WHO SEARO should assist countries in expanding second generation HIV/AIDS surveillance including TB-HIV surveillance, to generate evidence for action. This includes evaluation of existing surveillance systems, and creation of an HIV/ AIDS database at regional level for use by Member Countries.
- (3) WHO SEARO should facilitate policy dialogue and implementation in the area of HIV/AIDS prevention and care including (harm reduction strategies among IDUs, especially in areas with high rates of HIV among injecting drug users (IDUs).
- (4) WHO SEARO should continue to support countries in scaling up VCT services, training of counsellors, laboratory technicians and in procurement of HIV test kits for HIV prevention and as an entry point to prevent MTCT, antiretroviral treatment (ART) and TB preventive therapy.

- (5) Enhancing access to ART is an issue of the highest importance since the prices of antiretroviral drugs have come down remarkably over the past 1-2 years, primarily because of generic competition. In view of the need to enhance access to ART in the SEA Region and to ensure appropriate use both in the public and private sector, WHO support in advocacy to promote ART at country level, develop standard tools and training, establish systems for ARV drug resistance surveillance is necessary. Mobilizing resources will be of critical importance in order to achieve the global target of 3 million people having access to ART by 2005.

7.2 For Member Countries

TB/HIV

- (1) All efforts should be made by Member Countries to raise the profile and importance of TB/HIV at international and national levels and to mobilize resources to combat TB/HIV in the SEA Region.
- (2) In order to gain experience, joint TB/HIV collaborative activities should be implemented in selected districts on a pilot basis to develop a model including in cross-border areas.

TB

- (1) Countries should ensure that key DOTS components are implemented and maintained according to rigorous quality standards, while simultaneously implementing activities aimed specifically at further increasing case detection.
- (2) Ministries of health should build partnerships with a network of care providers, such as private practitioners, NGOs, medical teaching institutes, health facilities in workplaces and with related programmes such as the HIV/AIDS programme to widen the resource base and reach of DOTS services.
- (3) Community awareness and ownership of DOTS should be enhanced through IEC and social marketing approaches to further improve case detection rates.

- (4) Obstacles to the utilization of existing services should be analysed from the patient perspective, and innovative approaches to improve both the delivery and utilization of DOTS services, including targeted case finding approaches among groups at high risk for active TB actively pursued.

HIV

- (1) Since the health sector has a crucial role to play in responding to HIV/AIDS and to guide other sectors, it is important that all countries adapt and operationalize the health sector strategy on HIV/AIDS. The countries may conduct national consultations to prioritize interventions on HIV/AIDS prevention and care that need to be scaled up as well as develop plans for implementation.
- (2) Most Member Countries are conducting HIV sentinel surveillance; however there is a need to evaluate the coverage and quality of surveillance systems, and to expand surveillance activities to include surveillance for STIs, risk behavior as well as for TB/HIV. Countries should establish technical advisory groups on HIV surveillance and research and ensure that quarterly reports on HIV/AIDS surveillance are sent in on an annual basis.
- (3) Given that the HIV epidemic has the potential to spread rapidly in many countries, there is an urgent need to establish national policy and a legal framework for harm reduction among injecting drug users. The countries should also develop national plans of action for harm reduction among IDUs, and use available tools to scale up interventions among this population.
- (4) Member Countries should urgently scale up VCT services and monitor their quality and performance. Without availability of VCT, it is not possible to implement services such as PMTCT, TB preventive therapy and ART.
- (5) Based on country experiences on pilot projects on PMTCT, efforts are needed to scale up the use of nevirapine and/ or zidovudine to prevent transmission of HIV from infected mothers to their babies.

At the same time, preventing HIV among women of child-bearing age must remain an important priority.

- (6) Given the remarkable reductions in prices of ARV and other related international developments, Member Countries should actively promote the use of ART as a part of HIV/AIDS care, undertake situation analysis, develop national policies, include ARV in the essential drug list (EDL), establish a technical working group on ART for implementation.

Annex 1

**TB- INTERNATIONAL ASSISTANCE REQUIRED FOR
TB CONTROL IN MEMBER COUNTRIES OF SEAR**

	Technical	Financial
Bangladesh	Technical support from WHO-SEARO in all activities	Financial support for involvement of private practitioners & other public health services, IEC/COMBI and laboratory quality assurance
India	Technical support through network of WHO consultants Technical guidance for COMBI activities	Funding for additional consultants for PPM-DOTS Funding for COMBI/IEC coordinators and COMBI activities
Indonesia	Technical assistance in developing training manuals, IEC materials, external quality external quality assurance system and supervision	Nil
Myanmar	Technical support for IEC Experience sharing with other high burden neighbouring countries on involvement of Private sector & IEC	Financial support for IEC and PPM-DOTS, training and mobility for supervision
Thailand	Support for expansion of the urban DOTS model Technical support for research WHO regional high level ministry conference IEC Coordinator/training	Support for expansion of the urban DOTS model

(LOW AND INTERMEDIATE TB BURDEN COUNTRIES)

BHUTAN	External consultants for training of trainers	Financial assistance for training and supervision
SRI LANKA	External consultant for lab issues & research and to revise training modules International training on laboratory methodology, monitoring and evaluation	Financial assistance for improving health centre facilities at peripheral level
NEPAL	Assistance with updating of case estimates, assistance for DOTS plus and drug resistance surveillance, annual reviews, WHO international training for lab technicians	Funds to intensify case finding
DPR KOREA	External consultants for training and short term epidemiological estimation Assistance from the GDF	Funds for provision of individual patient anti-TB drug boxes
MALDIVES	Monitoring External consultant for training	Financial assistance for international training, IEC and laboratory supplies

Annex 2

STATUS OF HIV/AIDS/STI SURVEILLANCE IN SELECTED COUNTRIES OF SEAR, NOVEMBER 2002

Country	HIV Sentinel Surveillance	AIDS Case Reporting	STI Surveillance	Behavioural Survey	Arv Resistance	Technical Support Required	Operations Research	Funding Required
Bangladesh	Y:1998 SI:8 ST:Annual	Y:1998 SI:HOSP ST:Ongoing	Y:1998 SI:CL ST:Ongoing	Y:1998 SI:FHI ST:Ongoing	Y:NO	Most Areas	ART VCT PMTCT	Y
Bhutan	Y:1996 SI:10 ST:Biennial	Y:1997 SI:HOSP ST:Ongoing	Y:1996 SI:CL ST:Ongoing	Y:2002 ST:Planned	Y:NO	Most Areas	ART PMTCT VCT STI	Y
DPR Korea	Y:1996 SI:1 ST:Annual	Y:NA SI: ST:	Y:NO SI: ST:	Y:NO SI: ST:	Y:NO SI: ST:	Training Testing	STI TB-HIV	Y
India ⁷	Y:1992 SI:360 ST:Annual	Y:1988 SI:Hosp ST:Ongoing	Y:1992 SI:CL +Comm ST:Ongoing	Y:2000 SI:National ST:Comp Let	Y:NO ST:Planned	QC	ART F-Condom MDR-TB	Y
Indonesia	Y:1992 SI:15 ST:Annual	Y:1987 SI:Hosp ST:Ongoing	Y:1992 SI:CL ST:Ongoing RPR	Y:1996 SI:10 ST:Regular	Y:NO ST:Planned	Y	TB-HIV MDR-TB ART STI	Y
Myanmar	Y:1992 SI:29 ST:Annual	Y:1991 SI:Hosp ST:Ongoing	Y:1997 SI:CL + Comm ST:Ongoing RPR	Y:1997 SI:40 ST:Pilot	Y:NO ST:Planned	2 ND Gen Surv. Started 2002	TB/HIV MDR-TB ART Adult Mort STI/IDU	Y
Nepal	Y:1998 SI: ST:One Time	Y:1990 SI:Hosp ST:Ongoing	Y:NO SI: ST:	Y:2002 SI:1 ST:Donor	Y:NO	Most areas of Surv.	STI VCT ART Condom	Y
Sri Lanka	Y:1993 SI:10 ST:Annual	Y:1987 SI:Hosp ST:Ongoing	Y:1993 SI:CL ST:Ongoing VDRL	Y:NO	Y:NO	QC BSS Evaluation LAB QC	ART F-Condom VCT STI	Y
Thailand	Y:1989 SI:76 ST:Annual	Y:1984 SI:Hosp. ST:Ongoing	Y: SI:CL ST:Ongoing	Y:1995 SI:20 ST:Regular	Y:YES	Evaluation	ART	Y

Y-years activity started; SI: number of sites; ST: status of activity; CL: Clinics, QC: Quality Control

⁷ Information on India was provided by WHO Temporary Advisors and staff due to the absence of the national programme managers.

Annex 3

PROGRAMME

Monday, 19 November 2002

- 0900-1230 hrs
- Opening Ceremony
 - Welcome to and introduction of programme managers
 - TB/HIV in South-East Asia Region followed by country presentations
 - Myanmar
 - Nepal
 - Thailand
- 1400-1700 hrs
- Regional strategy on TB/HIV – Dr S P Tripathy
 - Implementing the TB/HIV Strategy: Piloting at district level – Dr Jai P Narain

Tuesday, 20 November 2002

Concurrent Sessions

- 0900-1230 hrs
- TUBERCULOSIS**
- PLENARY
- Global and regional overview of TB – Dr Nani Nair
 - Country presentations on DOTS expansion plans: – 10 minutes each followed by discussion
- HIV/AIDS**
- PLENARY
- Global and regional health sector strategy: Dr Gilles Pomerol / Dr Jai P Narain
 - Surveillance (behavioural, STIs and HIV) and research Issues – Dr Jai P. Narain
 - Harm reduction for IDU – Dr G Pomerol
- 1400-1700 hrs
- Issues and challenges
 - Reaching targets: issues to be addressed – Dr Holger Sawert
 - Human resource development – Dr Karin Bergstrom
 - Building partnerships – Dr Jai P Narain

- Advocacy and communications mobilization –
Dr Ninan Varughese
- Group Work
Surveillance and Research
- Group Work
Harm Reduction in IDU
- Presentation of group work

Wednesday, 21 November 2002

0900-1230 hrs **TUBERCULOSIS**

Group Work:

Key issues and possible interventions

- Increasing case detection
- Improving quality of implementation

HIV/AIDS

- VCT implementation issues – Binod Mahanty
- WHO strategies to prevent HIV infection in infants –
Dr Ying-Ru Lo
- Access to ARVs: Issues and challenges –
Dr Gottfried Hirnschall / Dr Subash Hira

1400-1700 hrs

- Group Work
- Presentation of Group Work
- Group Work
 - VCT
 - ARV
- Presentation of Group Work

Thursday, 22 November 2002

Combined Session – AIDS & TB Programme Managers

0900-1230 hrs **PLENARY**

- Global Fund: A brief update – Dr Jai P Narain
- Synthesis of NAP and NTP Managers' Meetings –
Rapporteur presentations
- Conclusions and recommendations
- Closing

Annex 4

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