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# HIV/AIDS in the South-East Asia Region

*Report of the 15<sup>th</sup> Meeting of the  
National AIDS Programme Managers,  
Kathmandu, Nepal, 16–19 October 2000*

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## 1. INTRODUCTION

Since the first case of AIDS in the South-East Asia Region (SEAR) of World Health Organization (WHO) was reported from Thailand in 1984, the AIDS epidemic has spread rapidly in the Region with serious adverse consequences on the health and socioeconomic status of the countries. This Region has now the second largest number of HIV-infected persons in the world, the largest number being in Sub-Saharan Africa. HIV infection has started to spread in the Region from the population subgroups with high risk behaviours to the general population.

WHO has been providing technical and financial support to the Member Countries in their fight against HIV/AIDS and has been organizing annual meetings of the National AIDS Programme (NAP) Managers for sharing experiences and opinions and updating on the recent developments on HIV, AIDS and sexually transmitted infection (STI) prevention and control. In this context, the fifteenth meeting of NAP Managers in SEAR was held in Kathmandu, Nepal from 16 to 19 October, 2000. On 19 October 2000, the meeting was held jointly with National TB Programme Managers in view of the frequent HIV/TB co-infection and of the need for collaborative interventions to fight the two common infections.

The objectives of the 15<sup>th</sup> Meeting of NAP Managers were:

- (1) To review and exchange country experiences on STI/HIV prevention and control in SEAR, including follow-up of the recommendations made in the 14<sup>th</sup> meeting of NAP Managers;
- (2) To discuss the recent advances in the areas of HIV prevention, diagnosis and treatment, including prevention of Mother to Child Transmission (MTCT) of HIV, and their application in and relevance to the Region;
- (3) To identify mechanisms for further strengthening of programme initiatives, including coordination of national responses and intercountry cooperation;

- (4) To recommend further steps needed for enhanced country responses to the AIDS epidemic as well as areas for WHO support, and
- (5) To review progress in implementing research recommendations.

The meeting was organized by WHO's South-East Asia Regional Office (SEARO) in collaboration with and support from His Majesty's Government of Nepal. The meeting was attended by participants from all Member Countries, staff from WHO headquarters, SEARO and country offices as well as from UNAIDS. Dr Vijay Kumar, Director, Communicable Disease Control, WHO/SEARO welcomed the participants and highlighted the importance of the meeting. Dr T.N. Jha of Nepal, Dr I. Abeyewickreme of Sri Lanka and Dr Hla Htut Lwin of Myanmar were nominated as Chairperson, Co-chairperson and Rapporteur respectively. The list of participants and the programme of the meeting are given in Annex 1 and 2 respectively.

## **2. GLOBAL AND REGIONAL OVERVIEW OF HIV/AIDS**

By the end of 1999, globally 18.8 million persons had already died of AIDS and 34.3 million persons were living with HIV/AIDS, making a cumulative total of 53.1 million persons infected with HIV since the beginning of the AIDS pandemic. During the year 1999, 5.4 million persons were newly infected with HIV, at the rate of about 15 000 per day, while 2.8 million persons died of AIDS. More than 95% of the new infections in 1999 were in the developing countries, more than 85% among persons aged 15 to 49 years, about 50% among young persons aged 15 to 24 years and almost 50% among women.

During 1999, about 620 000 children under 15 years of age were newly infected with HIV and about 480 000 children died of AIDS. The cumulative number of deaths due to AIDS among children under 15 years reached 3.8 million by the end of 1999. At the end of 1999, 1.3 million children under 15 years were living with HIV/AIDS, thus making a cumulative total of 5.1 million infections among children since the beginning of the pandemic.

As of 1 August 2000, more than 150 000 cases of AIDS have been reported from nine Member Countries out of 10 in the SEAR, the only country that has not reported any case being DPR Korea. In Bangladesh, Bhutan, Indonesia, Maldives and Sri Lanka, HIV prevalence is low, in Nepal the prevalence is low in pregnant women but high in injecting drug users (IDUs) and the prevalence is high in India, Myanmar and Thailand.

More than 95% of the cases in SEAR were reported from three countries, namely India, Myanmar and Thailand. The reported number of cases is considered to be grossly underestimated due to under-diagnosis, under-reporting and delays in reporting and the actual number of cases is considered to be several times higher. According to a conservative estimate, the number of persons living with HIV infection in the Region is more than 5 million, of whom 3.5 million are in India, 1 million in Thailand and nearly half a million in Myanmar. A large majority of HIV infections, 80 to 90%, were due to heterosexual transmission, followed by unsafe injections among injecting drug users. The number of infections among children due to MTCT is also increasing.

The lessons learnt from the programmes to prevent and control HIV/AIDS/STI in SEAR are as follows:

- (1) Prevention does work, however, national commitment is a key to an effective programme;
- (2) While there are many success stories in the Region, these projects or approaches must be upscaled urgently in order for these to make a significant impact on the epidemic. To do so, communities must be involved both in prevention and care activities;
- (3) National capacity-building and strengthening of public health infrastructure is crucial to the success of the programme;
- (4) Surveillance is critical for generating political commitment and action;
- (5) Care and prevention must go hand in hand, and
- (6) Stigmatization and discrimination are counterproductive.

To implement an effective programme, it is essential to ensure unequivocal and ongoing political commitment, involve all sectors, integrate

prevention and care strategies, strengthen national capacity and carry out operational research. Proper utilization of resources, multi-disease control programme, sound database and appropriate indicators to measure progress facilitate the implementation of the programme.

### **3. UPDATES IN HIV/AIDS PREVENTION AND CONTROL**

#### **3.1 STI Prevention and Control**

STIs are very common and cause considerable morbidity with a high rate of complications. STIs pose a bigger problem for women than men and facilitate HIV transmission. Factors that facilitate dissemination of STI are efficiency of transmission, rate of sex partner change and duration of infectiousness. The social and demographic determinants of dissemination of STI are socioeconomic status, male to female ratio, age structure and population density. STIs can be controlled by barriers and vaccines, health education, and case and partner management.

The main objectives of STI prevention and control are to interrupt transmission of STI, to prevent complications and sequelae, and to reduce the risk of HIV infection. That epidemiological synergy exists between HIV and STI is supported by biological evidence, seroconversion studies and intervention trials.

Improving the quality of STI care remains a priority. Both symptomatic and asymptomatic STIs must be considered in prevention and control to reach a large proportion of STI patients. Approaches to STI case management can be based on clinical diagnosis, etiological diagnosis and syndromic management. Because of the limitations of the first two approaches, priority is given to syndromic approach. WHO is revising some of the flow charts used for syndromic management. WHO's core functions in STI control include policy formulation, advocacy, knowledge management, technical assistance to countries, development of partnership, setting norms and standards, and development of new technologies and tools. Strategic areas of action should aim to improve access to quality STI care, promote early and effective health

care seeking behaviour, and establish simple and affordable surveillance systems to monitor trends and interrelations of HIV and STI epidemics.

During discussions, the need to focus on primary prevention of STI was emphasized. There is also a need to carry out operational research to estimate disease burden and validate syndromic approach. Participation of the private sector is crucial to the success of STI prevention and control programme as most of the STI patients seek care from the private sector.

### **3.2 Preventing Mother-to-Child Transmission**

Mother-to-child transmission (MTCT) of HIV can occur during pregnancy, during delivery or through breastfeeding. The risk of MTCT is between 15 and 30% in non-breastfeeding children and between 25 and 45% in breastfeeding children. The risk factors for MTCT of HIV include high maternal viral load, low CD4 count, impaired cell mediated immunity, prolonged rupture of membrane, prematurity, low birth weight, bacterial chorioamnionitis, occurrence of STI, first twin, use of obstetric procedures such as forceps and electrodes, and subclinical mastitis.

Primary prevention of HIV infection in women is the best option of prevention of MTCT. Next is the avoidance of pregnancy by infected women. Termination of pregnancy, if desired, can be considered where it is legally allowed. In case of pregnancy continuing into delivery, various interventions may be considered. These include voluntary counselling and testing (VCT) to identify infected pregnant women; good care during pregnancy, labour and delivery; use of antiretroviral (ARV) drugs, Caesarean delivery and avoidance of breastfeeding. The barriers to these interventions especially in the developing countries include late care-seeking by pregnant women; lack of good antenatal care services; lack of VCT; lack of resources for equipment, kits, ARV drugs, breast milk substitute and manpower; adverse effects of improper artificial feeding; judgemental attitude of health care providers and negative attitude of the community.

A number of issues need to be clarified in relation to MTCT. Prominent among them are type, duration and efficacy of ARV treatment; development of resistance to antiretroviral drugs, short and long term effects of prophylaxis,

role of non-ARV interventions, risk factors for breast milk transmission; and provision of VCT services.

Various issues were raised during discussions. They include advantages and disadvantages of breastfeeding and artificial feeding, high cost of testing and of drugs, and insufficient use of counselling. Supply of Nevirapine free of cost by the manufacturers for prevention of MTCT in developing countries is a welcome decision.

### **3.3 Accessibility to Antiretroviral Drugs**

There is a need to scale up and strengthen responses to the staggering dimensions of the epidemic. The goals of HIV/AIDS care are to reduce HIV-related mortality and morbidity, improve the quality of life of people living with HIV/AIDS (PLHA) and improve survival of PLHA. Key interventions for care include VCT, psychosocial support, home and community based care, medical management, and behavioural issues in HIV care and support.

Accessibility and availability to care are essential for providing care to PLHAs. However, there is a big gap in access to drugs in developing countries. A large number of activities are necessary for providing care to PLHAs. They can be divided into three groups – essential activities, activities of intermediate complexity and cost, and activities of high complexities and cost. Essential activities include VCT, psychosocial support, palliative care, treatment of opportunistic infections, nutritional care, STI care and family planning, and recognition and facilitation of community activities.

Access to HIV-related drugs can be improved by

- (1) Rational selection and use by applying local treatment guidelines, using evidence on drug efficacy, safety, quality and cost, and appropriate use by health professionals and PLHA;
- (2) Affordable prices through price information, competition and negotiation, reduction of duties and taxes, and local production;
- (3) Sustainable financing through advocacy for public and external resources, additional allocation of funds, and

- (4) Reliable health and supply system through integration with other drugs, bulk purchase, efficient distribution system, and quality assurance.

During discussions, the need to improve access to ARV drugs was stressed. Factors that help in providing access are health insurance of population at risk, health promotion of infected persons, prophylaxis for and prevention of opportunistic infections, cost sharing, and opportunities for recovery. However, as the cost of ARV drugs is very high, prevention should be given top priority.

## **4. COUNTRY EXPERIENCES**

### **4.1 Rapid Assessment of Drug Use, Indonesia**

A rapid assessment in Indonesia indicated that about 80% of IDUs were male and youths aged 15 to 24 years constituted 60% of IDUs. The IDUs started with non-injectable drugs and switched on to the injectable form in an average of two years. HIV prevalence among IDUs is increasing and has reached 17.5% in Bogor and over 20% in Jakarta. There was low condom use during their sexual contacts and they were not concerned about their own health. The community tended to blame the drug users, drug dealers and security personnel for the drug problem. Detoxification is considered to be applicable in emergency cases only, there is limited rehabilitation of drug users, the existing laws are very restrictive and not much attention is paid to harm reduction.

Although high risk behaviours are widely prevalent, HIV prevalence is still low in the country, probably due to the Muslim religion of the vast majority of the population and small number of clients of the commercial sex workers. Documentation of the rapid assessment process will be useful for future as well as for other countries. However, it provides only a bird's eye view and comprehensive surveillance of HIV including behavioural surveillance is necessary in the long run. The rapidity of the assessment and its cost need also to be considered.

## **4.2 Condom Promotion and Use, Myanmar**

Condom promotion is one of the important strategies in prevention and control of HIV in Myanmar. Routine condom promotion activities are being conducted in all parts of the country and condom messages have been disseminated through health care providers, nongovernmental organization (NGO) volunteers and peer educators. The number of condoms distributed through various channels was over 7 million. As 100% condom use programme was found to be cost-effective and efficient in the prevention of HIV and STI, NAP has decided to start a pilot programme in four townships, two of which are in the border area. The main strategy of this programme is to gain the cooperation of government authorities and the owners of the entertainment establishments in order to emphasize the need to use condoms in all sexual encounters. The main strategy will be strengthened by education campaigns, STI services, NGO activities and condom social marketing in the project areas. The approach and method of implementation is designed in the national cultural and social context. The estimated condom requirement in each township is 100 000 per year. The project will be implemented in four phases, namely preparation, implementation, monitoring and evaluation and will be followed by extension to other parts of the country.

During discussions it was pointed out that although small scale pilot projects may succeed, a large scale or national programme may not. Sustainability is an important issue regarding condom supply and it is necessary to ensure accessibility, availability and affordability of condom. Policy commitment, establishment of regular contact between health care providers and commercial sex workers and the organized nature of the sex industry are key factors responsible for the success of 100% condom usage in Thailand.

## **4.3 Ensuring Blood Safety, Bangladesh**

There are 74 government blood banks and a number of private blood banks in Bangladesh. About 200 000 to 250 000 units of blood are collected every year, about 75% from professional donors and 15% from replacement donors. Blood units are not screened for transfusion-transmitted infections. About one quarter of the professional donors are positive for hepatitis B and syphilis. In view of the poorly developed blood transfusion services (BTS), the National

AIDS Committee has decided to delink the safe blood transfusion sector from the NAP in order to expedite upgrading and building capacity of the BTS.

The Government of Bangladesh has formulated policies and strategies to ensure safe blood transfusion. The main objectives are to ensure safe BTS in central and district hospitals, to establish an effective and functioning monitoring and evaluation system and to promote voluntary blood donation. Various interventions and activities that have been designed to achieve these objectives include capacity-building of the concerned institutions, training of staff, procurement of supplies and equipment and campaigns for promotion of voluntary blood donations.

During discussions, progress on achieving the target of safe blood in the Region by the year 2000 was discussed. It was agreed that scaled up efforts must be made to achieve the target as soon as possible by promoting voluntary blood donations, universal screening of donated blood for HIV and other transfusion transmitted infections, and rational use of blood. These interventions should be supported by quality control and legislation to cover both the public and the private sector.

#### **4.4 Initiatives on MTCT, Myanmar**

According to surveillance carried out in Myanmar in September 1999, the prevalence of HIV among pregnant women ranged from 0 to 6.5% with an average of 1.9%. Prevention of MTCT has been accorded a high priority. A comprehensive pilot project was established during the first quarter of 2000 in two high prevalence townships, namely Tachileik and Kawthaing. The project included establishment of voluntary counselling and testing, provision of antiretroviral drug Nevirapine, improvement of obstetric care, strengthening of family planning services, counselling on infant feeding and programme administration. So far, the curriculum in various training programmes has been reviewed, HIV testing policy formulated Nevirapine has been approved as the ARV drug for prevention of MTCT.

Among the strengths for prevention of MTCT in Myanmar are the existence of a good family planning and maternal child health service, trained counsellors, STI care services, good hospital facilities and a number of NGOs.

The constraints facing the project include absence of VCT, lack of ARV drugs, inadequate obstetric and postnatal care and lack of funds.

#### **4.5 HIV Prevention Among Injecting Drug Users, Nepal**

The number of drug users in Nepal is estimated to be between 40 000 and 50 000. According to a rapid assessment survey, about three quarters of them started taking drugs as teenagers. Most of them are literate, only 7% being illiterate. A vast majority of them (88%) took drugs as a result of peer pressure. The other reasons for taking drugs were curiosity, unemployment, failure in examination, lack of support or sympathy from parents and entertainment. Although they usually started with non-injecting drugs, they quickly switched to injecting drugs because of quicker effects, easy availability and lower cost. Use of multiple drugs in injectable forms is a disturbing trend.

The prevalence of HIV among injecting drug users (IDUs) was fairly low from 1991 to 1995 but since then went on increasing to reach 42% in 1999. The main risk factors are use/exchange of unsterile syringes and needles, frequency of drug administration and sexual behaviour. According to the above survey, 70% took drugs once or twice daily, while 25% took three or four times a day. 74% of drug users used injecting drugs and 65% shared the syringes and needles. 75% of the drug users took the drugs in a group of three to six persons. A number of IDUs cleaned their syringes and needles but not effectively e.g. most of them who cleaned used ordinary water. A large number of IDUs were sexually active and two-thirds had premarital sex. They had multiple sex partners and did not use condoms.

The Strategic Plan for HIV/AIDS in Nepal outlines the strategies to prevent HIV among IDUs which include increasing access to treatment and rehabilitation, providing sterile syringes and needles, and reducing the demand of alcohol and drugs. A Harm Reduction Programme has been started with funds for advocacy, peer education and other interventions. Two sites for needle exchange are being operated by the NGOs, one in Kathmandu and the other in Pokhara. However, the coverage is very low. The main constraints facing the programme are the legal restrictions and the very small number of NGOs willing to participate in the programme.

During discussions, it was noted that the problem of drug use in general and of injecting drug use in particular is increasing throughout the region. Experience in the countries of the Region was shared at the meeting. It was agreed that apart from avoiding unsafe injection, the issue of sexual transmission of HIV in IDUs should also be addressed. It was pointed out that rapid assessment should be followed by scaling up interventions in an integrated way.

The need for coordination among various sectors within the country and among various international agencies was highlighted. A meeting of WHO, UNAIDS and UNDCP held recently in this context agreed to a synergistic and effective approach to demand and harm reduction through needle exchange, drug substitution and education for harm and demand reduction.

#### **4.6 HIV Surveillance Including Behavioural Surveillance, India**

After the first case of AIDS was reported in India in 1986, surveillance was started in 1987 in 62 surveillance centres and nine reference centres to estimate the burden of HIV infection, monitor the trend and use the findings in planning interventions. Sentinel surveillance was started in 1994 at 55 sentinel sites. Data from sentinel surveillance from 1994 to 1997 showed a high prevalence of HIV in high risk population groups and percolation of HIV from the high risk groups to the general population. From 1998, the number of sentinel sites was increased to 180, 79 for STD patients, 89 for antenatal women, eight for IDUs and four for others. The findings led to clear demarcation of the level of HIV epidemic in the states and union territories and identification of operational problems. The epidemic is concentrated in a few states and is at a low level in other states. These data helped estimate the number of HIV infections in the country. The estimate is reviewed and revised periodically and the current estimate is 3.5 million.

A recent survey carried out in Tamilnadu State of India showed a very high awareness of 98%. There is increasing condom use by commercial sex workers and male and female factory workers. The survey also showed increased bargaining capacity of commercial sex workers, a reduction in the number of sex partners and an increased perception of risk among high risk groups such as truckers.

Experiences in HIV surveillance in other countries were also shared at the meeting. During discussions, the need to implement the response based on the findings, to evaluate sentinel surveillance and to conduct STI surveillance was emphasized.

#### **4.7 Enhancing Access to ARV Drugs, Thailand**

The Thai Working Group on HIV/AIDS has estimated that 984,000 persons have already been infected with HIV in Thailand since the beginning of the epidemic, of whom 289,000 have already died, 29,000 new infections will occur during 2000 and 55,000 will develop serious AIDS related illnesses during this year. It has also been estimated that 300 000 to 400 000 are currently suffering from AIDS symptoms and need medical care, including prophylaxis of opportunistic infections (Ois) and community-based care.

There is a big gap between the requirement and availability of ARV drugs in Thailand. ARV treatment was started in 1992 with monotherapy using AZT. An evaluation in 1994 showed a coverage of under 5% with low adherence to treatment. In 1997, the HIV/AIDS Clinical Research Network (CRN) approved dual therapy. In 2000, a policy on triple therapy was approved. To improve the accessibility to ARV drugs, several measures were taken including compulsory licensing, parallel importing, use of generic production, and negotiations for bulk purchase. Strategies have been modified to improve equitable access to drugs and adherence to ARV treatment. Three pilot projects are expected to be implemented in 2000-1- (a) ARV programme for mothers who were recently recruited in the prevention of MTCT; (b) ARV programme for Northern part of Thailand where the infrastructure including the training of health staff in ARV has already strengthened; and (c) Development of appropriate ARV regimens for PLHA. These projects will be evaluated later, particularly for health care service package including treatment of Ois, prophylaxis of Ois, community participation, NGO and PLHA support, and adherence to ARV treatment.

## **5. COLLABORATION BETWEEN TB AND HIV PROGRAMMES**

### **5.1 Overview of TB/HIV Situation in the SEA Region**

An overview of the situation of TB and HIV in the Region shows that the Region accounts for a considerable burden of both with 8 million active cases of tuberculosis and 5 million cases of HIV/AIDS. Both primarily affect individuals in the age group between 15 and 49 years, thus severely affecting social and economic progress in the Region. While higher rates of infection are reported among intravenous drug users and commercial sex workers, HIV is beginning to spread to the general population in many parts of the Region. High risk behaviour coupled with the vulnerability resulting from migration and population movements for economic and other reasons spur the spread of HIV and secondarily of TB. 50-70% of AIDS patients in the Region have tuberculosis. HIV is the most important risk factor for progression from infection to active tuberculosis; concurrently, tuberculosis is the leading opportunistic infection among the HIV-infected persons and the leading cause of death among people living with AIDS.

The implications of this for the national control programme are increased morbidity and mortality, increasing demands on already over-stretched health services, lower cure rates and the emergence and transmission of multi-drug resistant TB. This underscores the need for rational and effective approaches. The DOTS strategy has proved effective for the treatment of tuberculosis among those affected by HIV, both extending the life span and the quality of life of those patients. IEC campaigns have a major role in bringing about behaviour change and in improving the utilization of health care services. Tuberculosis had shown rising trend in areas of high HIV prevalence in the Region such as in northern Thailand; intensive efforts directed towards public education, prevention and control have now resulted in a fall in incidence of tuberculosis.

### **5.2 Collaboration Between TB and HIV Control Programmes**

Possible areas of collaboration between national TB and HIV control programmes are advocacy, policy formulation, training, programme planning and evaluation, surveillance and research, and the introduction of effective community-based care.

Providing DOTS to HIV-positive patients prolongs their lives and reduces the risk of transmission of TB. Voluntary counselling and testing reduces the risk behaviour among TB patients and therefore of HIV infections among them. Areas with high HIV prevalence should therefore be rapidly included under DOTS. Constraints such as the lack of sufficient centres for counselling, and for the diagnosis and treatment of tuberculosis, the absence of coordination between the two programmes at country level in terms of the services available should be addressed. TB preventive therapy should be a part of the care package for people living with HIV; however, it must be ensured that there are adequate counselling facilities and sufficient capacity within national control programmes to meet the additional demands that this would generate. Clear guidelines for voluntary counselling and testing for co-infection need to be established and the implications carefully considered, especially in view of the current low tuberculosis case detection rates, the added costs involved and the possibility of a dual stigma further reducing health-seeking behaviour, in addition to the technical difficulties in advocating preventive therapy in this group of patients. Operational research to assess the effectiveness of the diagnostic and treatment algorithms currently being used for TB/HIV and to assess the efficiency of currently recommended preventive treatment for TB among the HIV positive needs to be established. The Regional office has initiated several collaborative activities- efforts have been made to involve medical colleges, the private medical sector and regional associations such as SAARC to develop joint plans of action and to support cross-border activities.

### **5.3 Country Team Presentations and Discussions on Collaborative Activities**

Several examples of collaboration between the TB and HIV control programmes exist within the Region. In Myanmar, 20 TB/HIV sentinel surveillance sites were established for offering counselling and preventive care while measuring the prevalence of co-infection in the community. HIV prevalence among TB patients has risen from 1.7% in 1995 to 4.7% in 1997 with a preponderance among males. With the institution of DOTS for the HIV co-infected, cure rates and survival rates have tripled. Following this study, collaborative programmes were established in 15 townships and intensive IEC on home care and condom promotion and on DOTS for TB patients together

with integrated teaching on TB and HIV/AIDS in teaching institutes was begun. The sharing of technical expertise, IEC activities, logistics, advocacy for resource mobilization and resources is expected to benefit both programmes.

In Thailand, DOTS has been extended to HIV-affected people along with the prevention and care package already available to them. Counselling and screening for tuberculosis among people with HIV have led to earlier detection and higher treatment success rates. Priority is now being given to further improve and expand DOTS services, infrastructure and coverage. More intensive public education is required to address misconceptions about tuberculosis in communities and especially among patients.

An integrated training curriculum for all communicable diseases has been developed in Bangladesh. It is felt that it is equally important to include the private sector and that this would ensure long-term sustainability. In Nepal, HIV testing is being offered at five DOTS centres accompanied by counselling.

In Indonesia, surveillance to assess the prevalence of TB among HIV-positive people and vice-versa and integrated modular training for health workers and health promotion to increase case-finding have been initiated.

In India, combined activities in the areas of advocacy and training and the provision of additional staff to provide services jointly for HIV and TB have been initiated.

#### **5.4 Massive Effort Against Diseases of Poverty**

The understanding that good health must be at the centre of economic development has resulted in increasing political commitment for sustained funding to the health sector, especially against the disease of poverty. The goals of this initiative are to mitigate high mortality diseases linked to poverty through more effective use of vaccines, drugs and commodities currently available through diversified health services, i.e. a mix of Government, NGOs, private providers, employers and others, so as to reach the world's poorest. The initiative will also stimulate research and development for better use of existing tools and of new technologies. The implications of this for the South-East Asia Region are significant, in view of the fact that most challenges and

opportunities to improve health care among the poorest and most vulnerable lie in this Region.

## **6. REGIONAL PRIORITIES IN HIV/AIDS RESEARCH**

A series of meetings have been held to set the regional priorities in HIV/AIDS research. The Advisory Committee on Health Research (ACHR) recommended the constitution of a task force or an expert group meeting to review research needs, including community-based interventions on HIV/AIDS. A consultation on HIV/AIDS research in December 1999 set the priorities in HIV/AIDS research in the areas of basic science, epidemiology and prevention, social and behavioural research, and HIV/AIDS care. The meeting also emphasized the importance of operational research and the need for collaboration and networking among various agencies. The meeting recommended a number of follow-up actions to promote research, mobilize resources, establish networking, strengthen capacity and share and exchange information. These recommendations were supported by the meeting of the ACHR held in April 2000.

Activities to be implemented in future are identification of priority research areas, development of generic protocols, identification of country institutions to carry out research, provision of technical and financial support, and dissemination and sharing of research findings.

During discussions, the need for capacity building, implementation of research findings and scaling up of the interventions for a wider coverage was emphasized. Some of the priorities for research in HIV/AIDS in the Region were identified as:

- (1) Assessing burden of STI;
- (2) Promoting health-seeking behaviour for STI/HIV Management;
- (3) Involving private sector for STI control;
- (4) Identifying mechanisms to expand prevention interventions among various populations with high-risk behaviour, and
- (5) Indicator to measure progress in HIV prevention and care.

## **7. UNAIDS REGIONAL PRIORITIES**

UNAIDS has set a number of priorities for prevention and control of HIV/AIDS. At the primary level, they are related to life skills focusing on youth, condom promotion in high risk situations, drug use and HIV vulnerability, care and support especially for prevention of MTCT, and mobile populations and vulnerability. Priorities at the secondary level are political advocacy, facilitation of policy dialogue, information exchange and resource mobilization. Priorities at the tertiary level are better integrated UN system strategies and workplans, mobilization of national resources, special assistance to specific countries and strengthened regional task forces and coordinated mechanisms.

The role of UNAIDS intercountry team is to maximize technical assistance and other resources in the Region, support UN system regional activities, bridge UN system and other players in HIV/AIDS and facilitate multicountry responses. The technical profile includes information development, country strategic planning in mobility, social mobilization and alliance building, advocacy and resource mobilization in behaviour change, interventions in drug problem, MTCT and TB-HIV, condom promotion and community mobilization.

The regional task forces are time-bound, linked to regional coordination mechanism, required by UN resolution to accelerate UN action, integral to UN system reform and inclusive of other non-UN system. Regional task forces have been established for prevention of MTCT, mobile population and vulnerability, drugs and vulnerability, youth, and care and support. The terms of reference of regional task forces include support to countries for action, situation assessment, technical support, coordination and communication, resource mobilization and advocacy.

The intercountry team resources can be accessed through request to national UN cosponsor and Country Programme Adviser, request to UN regional cosponsor, participation in regional task forces, and request to UNAIDS secretariat. The main challenges to the intercountry team are balancing regional initiative and national action, flexibility in responding to the changing needs of the epidemic, and relevance to the evolving UN cosponsor and other organizational needs and abilities.

Some of the critical issues in the countries are securing political support, obtaining required funds, collecting information and data, improving coverage and monitoring and evaluation. These issues are being addressed through advocacy in partnership with WHO and UNICEF, resource mobilization and allocation of funds, building technical capacity, and monitoring and evaluation.

It was suggested during discussions that there should be better geographical representation in the regional task forces. There is a need to clarify the strategies in prevention of MTCT in countries with low level epidemic. Various cosponsors have their own comparative strengths and are in a better position to use these strengths in prevention and control. For example, WHO's strengths lie in STI prevention and care, surveillance, care and support of HIV/AIDS, blood safety and prevention of MTCT.

## **8. RECOMMENDATIONS**

### **8.1 For Member Countries**

- (a) To effectively control HIV/AIDS in the Region, effective interventions for prevention and control of HIV/AIDS/STI in all countries should be scaled up in order to achieve nationwide coverage, by preparing and implementing a five-year strategic plan with focus on one or two priority interventions.
- (b) Efforts should be made to implement 100% condom use programme in situations of risk within an enabling environment, with special attention to vulnerable populations.
- (c) As advocacy can be more effective if it is based on evidence, data on burden of HIV/AIDS/STI and socioeconomic impact should be collected regularly and success stories documented and widely disseminated. As changing behaviour is the main aim of prevention efforts, HIV/STI and behavioural surveillance should be carried out in all countries as a part of second generation surveillance with periodic evaluation.
- (d) As STI prevention and care using syndromic case management is a major intervention for prevention of HIV, high priority should be given to

quality and coverage of STI services, with the active involvement of private sector.

- (e) Countries should develop partnership between health and non-health (e.g. education) sectors and collaboration with other health programmes such as tuberculosis and reproductive health.
- (f) Countries should implement large scale harm reduction programme for prevention of HIV among IDUs, such as needle exchange, drug substitution and outreach activities.

## **8.2 For WHO and UNAIDS**

- (a) WHO and UNAIDS should continue to provide technical and financial support to Member Countries for prevention and control of HIV/AIDS/STI, particularly in scaling up priority prevention interventions and in implementing STI and behavioural surveillance.
- (b) WHO and UNAIDS should support countries in programme planning and review and should develop a core set of prevention and care indicators for monitoring and evaluation.
- (c) WHO and UNAIDS should develop protocols and guidelines in areas of regional research priorities and assist Member Countries in mobilizing resources and capacity building.
- (d) WHO and UNAIDS should facilitate intercountry collaboration including cross-border HIV prevention and care interventions.
- (e) WHO and UNAIDS should consult with countries for making estimates of HIV/AIDS/STI.

## Annex 1

### PROGRAMME

16 October 2000  
0900 to 1230 hrs.

Registration

Welcome and Introduction

- HIV in SEA Region: Lessons Learnt (Dr Jai P. Narain)
- Rapid assessment of HIV situation: Indonesia experience (Dr Saiful Jazan)

What's new in STI Prevention and Control (Dr A. Gerbase)

1400 to 1700 hrs.

- Condom promotion and use (Dr Hla Htut Lwin)
- Update on Preventing Mother-to-Child Transmission (Drs P.N. Shrestha and Myo Paing)
- Enhancing accessibility to ARV drugs in the developing world (Drs A. Gerbase and Anupong C.)

17 October 2000  
0900 to 1230 hrs.

- Progress in ensuring Blood Transfusion Safety (Dr A.K.M. Shamsuddin)
- Experience in preventing HIV among IDU (Dr T.N. Jha)
- HIV/STI and Behavioural Surveillance initiatives in India (Dr P.L. Joshi)

1400 to 1700 hrs.

- Regional Priorities in HIV/AIDS Research (Dr Jai P. Narain)
- Meeting with individual country delegations
  - Bangladesh
  - Bhutan
  - DPR Korea
  - India
  - Indonesia

18 October 2000  
0900 to 1230 hrs.

- UNAIDS priorities at Regional and Country levels (Dr S. Sarkar and Mr Maurice Apted)
- Consultations with individual country delegations (contd...)
  - Maldives
  - Myanmar
  - Nepal

1400 to 1700 hrs.

- Consultations with individual country delegations (contd...)
  - Sri Lanka
  - Thailand
- Preparation and presentation of Conclusions and Recommendations

19 October 2000  
0900 to 1200 hrs.

- Registration for TB Managers  
Opening Ceremony  
Welcome and Introduction (Dr Vijay Kumar)
- Overview of HIV/TB situation (Drs A. Kochi and Jai P. Narain)
  - Collaboration between TB and HIV programmes
    - Myanmar
    - Thailand
  - Addressing cross-border issues: A priority (Dr Jai P. Narain)

1400 to 1700 hrs.

- Private-Public partnerships for disease control (Drs K.J.R. Murthy and D.S. Bam)
- Massive Effort to combat diseases of poverty (Dr Vijay Kumar)
- Country team discussions on collaborative activities followed by selected country presentations/reports
- Closing

## Annex 2

### LIST OF PARTICIPANTS

#### REPRESENTATIVES OF MEMBER COUNTRIES

##### Bangladesh

Dr A.K.M Shamsuddin  
Deputy Director (PHC) and Programme  
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##### Bhutan

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##### Dpr Korea

Dr Kim Jong Hwan  
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Dr Kim U Yong  
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##### India

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Dr K. Gopal  
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##### Indonesia

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##### Maldives

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Mr Ibrahim Waheed  
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### **Thailand**

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### **UNAIDS**

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### **WHO**

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STP, STB

#### **SEARO**

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Department of Communicable Diseases

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Regional Adviser  
HIV/STI Initiative and STOP Tuberculosis

Dr Puru N. Shrestha  
Short-term Professional  
HSI-STB Unit

### **Countries**

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WHO National Professional Officer  
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WHO National Programme Coordinator (AIDS)  
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Thailand

Ms Laksami Suebsaeng  
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