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Cross-border Initiatives On Priority Communicable Diseases

*Report of an Intercountry Meeting
New Delhi, India, 24–27 July 2001*

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1. INTRODUCTION

HIV/AIDS, TB, malaria and kala-azar are major concerns between the neighbouring countries of Bangladesh, Bhutan, India and Nepal. Cross-border migration of people between these countries have been going on since centuries, but has increased manifold in recent times due to economic boom, employment potential, population explosion, infrastructural development, education, pilgrimage etc. Trafficking in women and young girls pose a serious threat so far as spread of HIV/AIDS is concerned.

Diseases like malaria, TB and HIV/AIDS are widely prevalent between all the four countries. Kala-azar as an endemic disease is confined to selected districts of India, Nepal and Bangladesh, but absent from Bhutan. Drug-resistant *P.Falciparum* is encountered on both sides of the border. Attempts were made earlier by WHO to control malaria and kala-azar between 1995-98 and several border meetings were organized, but no effective solutions could be found.

As these diseases are spreading rapidly between these countries through the national borders causing human sufferings and tragedies, Health Ministers of these countries expressed their serious concern and urged upon WHO to initiate measures for cross-border control of such diseases. Accordingly, an informal consultation between these countries was held at Kathmandu in March, 2001 to discuss technical policies and operational issues related to cross-border disease control. Eleven districts from four countries were selected for action process and further discussions were held with the country programme officers from 24-27 July 2001 with the following objectives:

- (1) To agree on coherent technical policies relating to cross-border interventions;
- (2) To finalize joint plans of action related to the prevention and control of priority communicable diseases like HIV/AIDS, TB, malaria and kala-azar, and
- (3) To review and finalize the technical and operational guidelines on planning and implementing integrated control of priority communicable diseases in selected cross-border districts.

2. OPENING SESSION

The consultation was inaugurated by Ms Poonam Khetrapal Singh, Deputy Regional Director, WHO, South-East Asia Region. Welcoming the participants, she drew their attention towards the devastating impact of these diseases on the health and economy of the people and traced their linkage with mass migration of people. Absence of a functioning health system, remoteness of the border districts, and lack of a coordinated approach to disease control, complicate the situation further. The need to develop a synchronized, coherent diseases control strategy for implementation is important and this requires consensus on the technical policies for diseases prevention and control to finalize joint plans of action among the four countries with common borders.

Dr Vijay Kumar, Director, Department of Communicable Diseases Surveillance, WHO Regional Office for South-East Asia chaired the meeting and called for uniform approaches for diseases control and collaboration at national, state/region and district levels and mentioned the constraints namely, physical, technical constraints in the form of diagnosis, drug schedule, regimen, resistance and lack on consensus and local action.

Dr Jai P Narain, Regional Adviser, HIV/STI and STB programme, gave an overview of the objectives of cross-border collaboration and detailed the progress made in this regard since the last meeting in Kathmandu. The main objective of cross-border collaboration with initial focus on HIV/AIDS, TB, malaria and kala-azar is to ensure health care access to the people of border districts. It is essential to share all information and data in regard to these diseases between the districts, adopt harmonious control measures, share technical resources, and ensure treatment of patients regardless of their nationality or legal status. While initiating discussion on the joint plan in Kathmandu meeting, three specific recommendations were made:

Government and international bodies may accord:

- (1) High priority for control of communicable diseases and initiate implementation of joint plan of action
- (2) Work out operational plan and technical policies in regard to identified diseases
- (3) Finalize joint plans of action in consultation with country/district health authorities.

There is large-scale movement of people in the border areas who are mostly young, single, moving out in search of employment and face cultural and other barriers. There is limited access to health services as well as information about their availability in the border districts. There is a strong need for advocacy for political and administrative support, evolving an uniform technical policy, establishment of a channel of communication across the border, coordination of activities with local partnerships, and organization of regional coordination to bring these countries together at all levels. The guiding principles for all such activities as agreed in Kathmandu are joint planning, local implementation, sustained financing, integrated service delivery, and bottoms up approach.

The meeting was attended by the programme officers from the four participating countries, WHO /SEARO staff members and others. (See list of participants at Annex 1).

Districts selected and identified for implementation of cross-border diseases control activities are:

- Bangladesh (Sylhet) and India (Jaintia hill)
- Bhutan (Chukha, Samste) and India (Jalpaiguri, Darjeeling)
- India (Lakhimpur Kheri, East Champaran) and Nepal (Kailali, Bara, Rauthat).

3. SITUATION OF PRIORITY COMMUNICABLE DISEASES IN THE SOUTH-EAST ASIAN REGION

3.1 HIV/AIDS

The first case of AIDS in the Region was reported from Thailand in 1984 and since then 173 000 cases have been reported with Thailand, India and Myanmar accounting for more than 95% of cases. The AIDS epidemic began in the 1980s and by 2000, more than 5 million persons are living with HIV. HIV prevalence is low in Bangladesh, Bhutan, India and Nepal except in certain parts of India and among injecting drug users in Nepal. However risk behaviours are present in all the countries and there is potential for rapid spread. Substantial proportions of adults appear to have multiple sex partners,

condom use is low, drug users share and reuse syringes and needles and professional donors donate more than 80% of blood collected. Large number of migrant workers, truck drivers, trafficked women cross the porous borders, thus increase the vulnerability of HIV infection in border areas.

Bangladesh is estimated to have 13 000 HIV-infected persons till the end of the year 2000, Bhutan reported one case of AIDS and is estimated to have 100 infected persons, India has estimated 3.86 million infected persons, while Nepal reported 383 cases with estimated 33 000 infected persons.

3.2 Tuberculosis

With 3 million new cases and 750 000 deaths per year, the South-East Asia Region accounts for 36% of the global burden of tuberculosis, with 75% of the morbidity and mortality occurring in the age group of 15-45 years. TB is widely prevalent in these countries because of poor socioeconomic status, lack of access to health care and infrastructure. DOTS programme has been introduced in all these countries of which Bangladesh and Bhutan have carried out extensive work, Nepal has made considerable expansion of the programme, while India is still in the process of DOTS expansion to all the districts.

3.3 Malaria

About 95 million people live in the bordering areas of the four countries and malaria is endemic in border districts with occasional spread in epidemic proportions. Emergence of multiple drug resistance *P.falciparum* spreading across the border is a severe threat to these countries.

In countries of the Region, political commitment is not reflected for adequate allocation of resources and this leads to institutional deficiencies and weak programme management due to lack of capacity building and poor research support. Malaria is exacerbated due to highly efficient vectors, multiple vector transmission, prolonged transmission season due to climatic conditions, land use pattern, and unplanned exploitation of natural resources, usually resulting in epidemics.

Countries of South-East Asia adopted the revised global malaria control strategy in 1995 with the objective to prevent deaths, reduce morbidity, and bring about a decrease in social and economic loss.

3.4 Kala-Azar

Visceral leishmaniasis or kala-azar is a major health problem in some parts of Bangladesh, India and Nepal while Bhutan is free from it. About 20 000 cases were reported from the Region in 1999. During the malaria eradication era, when blanket house spraying was applied for vector control, the number of kala-azar cases was suppressed at low levels, but when the strategy of spraying was changed, kala-azar re-emerged in the sixties, established itself in endemic form in Bihar, spreading to neighbouring West Bengal and then to Nepal.

4. CROSS-BORDER INTERVENTIONS FOR COMMUNICABLE DISEASES CONTROL: COUNTRY EXPERIENCES.

4.1 Bangladesh

Out of 54 districts, 30 districts share a border with four states of India. Prevalence of HIV is low in the country and appropriate measures have been taken to prevent the epidemic. A comprehensive national policy and a plan of action have been formulated emphasizing targeted interventions and strengthening of STI management. However the interventions need to be augmented in border areas.

DOTS is extended to 460 rural thanas and covers 95% of the population. Case detection rate is still low, treatment success rate is over 80%. Multi-drug resistance level is low, as is the incidence of HIV among patients with tuberculosis.

17 border districts with 13.4 million population have malaria problem, 13 districts are responsible for 90% of total malaria cases and 99% of total *P.Falciparum* cases. Emergence of drug resistance is posing a serious problem. Malathion EC for indoor residual spraying and Deltamethrin e EC for impregnation of bed nets have been used with good results. The support of NGOs sustains the programme and community participation in malaria control is solicited.

Seven districts of Bangladesh bordering West Bengal in the western side have reported kala-azar cases and there is gradual increase in kala-azar cases. Low socioeconomic conditions, mud houses, cattle sheds, frequent flooding and population movements have contributed to the existence and spread of kala-azar in the Region. Case diagnosis is made on the basis of history, clinical examination and Aldehyde test and patients are treated with Sodium Antimony Gluconate. Vector control is done through spray of DDT in selected areas.

4.2 Bhutan

Bhutan shares its border with four Indian states extending over a linear length of 600 kms with 40% population living in border districts. The role of cross border spread of HIV has been well recognized. A multisectoral approach for prevention and control of HIV/AIDS is adopted, and a task force and working committees have been formed.

DOTS has been extended in the country; with more than 80% population having access to DOTS, case detection rate is around 67%, and treatment success rate is 89%. By the year 2002, the country is expected to be covered fully with DOTS.

Border districts are forested, malarious and contribute > 90 % of total malaria cases, about 30% cases are estimated to be imported from India. Problem of multidrug resistance is on the increase. Malaria control activities in Bhutan include early case detection and prompt treatment. A revised drug policy is in force. No IRS is in vogue currently and malaria transmission is being reported every year.

Kala-azar is not a problem along Indo-Bhutan border.

4.3 India

India shares borders with all the three countries of Bangladesh, Bhutan and Nepal.

India is concerned with the spread of HIV/AIDS, and has allocated the largest budget for its control, established sentinel centres, accepted syndromic

management of STI, incorporated AIDS education in schools, and trained health workers with change in risk behaviour as the main focus for attention. Blood safety has been given high priority and feasibility of mother to child transmission is under study. A continuum of care model has been accepted as a strategy for care to persons with HIV/AIDS. However, the border districts are yet to receive due attention for prevention and control.

India accounts for a third of the global burden of tuberculosis. DOTS expansion has been scaled up from 1995, currently available to one third of the population with treatment success rate of 84% and seven-fold reduction in TB deaths from 29% to 4% among TB patients.

Malaria is a serious problem all along the border districts and its control is based on active and passive case detection, early detection, prompt treatment and DDT spraying. Recently, insecticide-treated bed nets have been introduced for malaria control.

Kala-azar is endemic in six districts of West Bengal, seven districts of Bihar and one district of Uttar Pradesh along the Indo-Bangladesh and Indo-Nepal borders. Kala-azar control is based on selective vector control with two rounds of DDT spray, early diagnosis, complete treatment, health education and community involvement. The major constraints identified for kala-azar control are inability to organize periodic active case detection programme, early diagnosis, inadequacy of potent drugs at affordable cost, complacency and cross-border issues.

4.4 Nepal

A multisectoral approach with active involvement of NGOs has been accepted to tackle the AIDS problem in the country. HIV sentinel surveillance has been established at six sites and interventions targeted at specific population subgroups like truck drivers, and CSWs. Blood safety, counselling and care of persons with HIV are other interventions included in the plan.

Challenges to TB control in Nepal are emergence of HIV/TB co-infection, MDR tuberculosis and large population movements across the borders, limited access to hill districts etc. DOTS is available in Nepal since 1996, case detection rate is 24% and treatment success rate is as high as 90%. Major challenge lies with ensuring treatment adherence among patients in distant mountainous terrain.

64 districts of Nepal are malarious, 26 districts have border with four Indian states. Early case detection and prompt radical treatment is followed to reduce morbidity and mortality due to malaria.

Kala-azar is endemic in the border district adjoining the state of Bihar in India. There is no active case detection system and the first line of treatment is with sodium antimony gluconate and next in order are Pentamidine and Amphotercin B. Vector control for malaria and kala -azar is based on indoor residual spraying of insecticide, and synthetic pyrethroid compounds.

5. MAJOR TECHNICAL ISSUES AND AGREEMENTS REACHED

5.1 HIV/AIDS

People move across borders for various reasons, the most prominent being economic reason. Border areas receive low priority, low attention and complicated with problems like illicit drug trade, trafficking of girls and women with marginalization and criminalization and all these add to vulnerability to HIV/AIDS. Involvement of all concerned sectors, integration of prevention and care into primary health care services are some of the challenges that need to be addressed. All these call for situational analysis, identifying suitable policies and strategies, designing and implementing appropriate interventions and activities.

Organization of community education for infection prevention through mass media, and interpersonal communication is essential especially for the high risk groups. Supply of and access to good quality condoms, management of sexually transmitted infections through syndromic approach needs to be further promoted. Sustained education must be provided to avoid use or sharing of needles and syringes. Care and support should be provided to HIV infected persons.

5.2 Tuberculosis

Problems specific to tuberculosis control in border areas are (i) constant and large scale migration of population, making both case finding and completion

of treatment, a difficult task, (ii) lack of clear policy guidelines/resources to extend health services to migrants and refugees leading to denial/lack of access to DOTS in host countries; (iii) variation in policies and practices along the border; absence of mechanism for cross-referral and coordinated activities compounding the difficulty in transferring patients across the borders and in ensuring adherence to treatment; (iv) border districts are often last to have DOTS established; (v) poverty, lack of basic facilities such as knowledge, access, terrain, and transport and often, compulsion to adopt high-risk behaviour put migrants at increased risk for disease.

DOTS needs to be extended to remote, peripheral and border districts, sputum microscopy to be promoted for case detection, ensure early case detection, adopt uniform policies and treatment regimens and ensure completeness of treatment of infected persons. All patients put on the treatment, must receive a health card and basic information on diagnosis, treatment provided and duration followed, may be clearly mentioned. A TB patient, on migration to the bordering country, may be provided treatment by the host country as per schedule prescribed in his own country. A collaborative mechanism in the border districts needs to be developed between TB and HIV/AIDS programme.

5.3 Malaria

During malaria resurgence, cross-border problems increased due to large scale population movement which facilitated spread of the infection and emergence of drug resistant *P. Falciparum*. On the Indo-Nepal border, there is large scale movement of Nepalese agricultural labourers to distant places of India. On the Indo-Bhutan border, large numbers of Indian labourers are working in hydroelectric plants. Besides, at Phuntshilling, thousands of day labourers visit Bhutan daily for suitable employment. All these people do not receive adequate medical care from any source and perpetuate the transmission of drug resistant malaria. A large number of tea gardens on the Indian side of the border are not brought under strict malaria control programme and thereby facilitate the endemicity of malaria in the local area and spread to neighbouring districts.

All patients with fever or having fever in the last 72 hours without any apparent cause may be termed as malaria. Microscopy to be used for

diagnosis, follow up and monitoring of therapeutic effect, surveillance to be ensured. Dipsticks may be introduced where microscopy is not available or feasible, remote and inaccessible areas, areas with *P. Falciparum* infections and in epidemic or emergency situations.

For treatment of *P. Falciparum* cases, chloroquine in the dosage of 25 mg base/kg body weight over three days is recommended, a total of 10 tablets of 150 mg base, adult dose. *P. Falciparum* infections not responding to chloroquine, may be treated with Sulphadoxine/sulfaene-Pyrimethamine (SP), three tablets, single dose for adults, each tablet containing 500 mg of Sulfalene or sulfadoxine and 25 mg of Pyrimethamine.

All severe cases and treatment failure malaria cases may be referred to the nearest hospital/district health authority.

Complicated and severe malaria cases should undergo dipstick test and if found positive, should be immediately referred to the district hospital facility. The drug of first choice for such cases is Arteether, parentally, 150 mg per day for adults, and 3 mg/kg body weight for children for three days. The second choice drug is Quinine Hydrochloride, 20 mg/kg body weight in 5% dextrose over four hours, followed by 10 mg/kg body weight over 2-4 hours, every 8 hours (maximum 800 mg per day)

5.4 Kala-azar.

Major cross-border issues in the control of kala-azar include porous border, uncontrolled migration, and different diagnostic and treatment practices particularly among private practitioners, crossing the border frequently even during the treatment, thereby leading to dropouts and indiscriminate use of anti-kala-azar drugs. Synchronization of control activities in border districts, though planned earlier, could not become effective due to various reasons. The causative agent, *Leishmania Donovanii*, has become resistant to antimony compounds, requiring second line treatment. Kala-azar surveillance is passive, diagnosis inefficient and treatment cost high accompanied by serious adverse drug reactions.

Diagnosis can be made by identification of the parasites (L.D. bodies) from bone marrow or splenic smears. Serological tests like direct agglutination test and K-39 based dipsticks can also be used for confirmatory diagnosis.

Regarding treatment of kala-azar, Pentavalent Antimony Compound is recommended in doses of 20 mg /kg body weight for 30 days by intramuscular or intravenous route. In case of Antimony resistance, Amphotericin B, 0.75 –1 mg /kg body weight, given daily or on alternate days in the form of infusion for 15-20 days. Mitefosine, an alkyl phospo-lipid, has shown good results in the dose of 100 mg for 28 days for adults. This drug produces adverse reactions in the form of vomiting, diarrhoea, renal insufficiency (in high doses). This drug has teratogenic potential and cannot be used in pregnant women.

To conclude, diagnosis and treatment of kala-azar remains unsatisfactory, application of K-39 dipsticks and oral Miltefosine are likely to improve the situation.

6. OPERATIONALIZING CROSS BORDER INTERVENTIONS

Although considerable expansion of health services has taken place in these countries and significant gains made in the reduction of morbidity and mortality, people living in the peripheries, and the border districts have not benefited much due to non availability or no access to such services. Hence, it is necessary to strengthen the diseases control services in border districts, collaborate with adjoining and border districts, launch uniform programme synchronized in time, space and content Exchange of information in the bordering districts needs to be encouraged for appraisal, advance warning, planning and follow up. A step by step approach is necessary from planning to implementation, monitoring and evaluation processes.

6.1 Step 1: Planning

A quick situational analysis of the selected districts will indicate the nature, size of the health problem, ongoing programme activities, its impact, and constraints. A list of existing/functioning health facilities is essential for planning and carrying out control activities. A consensus meeting between the various stakeholders will help to work out the plan, fix time frame and resource requirements.

6.2 Step 2: Implementation

National level authorities will be responsible for programme approval, planning, standardization, technical and material support, funding, training, collaboration with other agencies, monitoring and evaluation. For effective coordination between the programme officers and the districts, a national level focal officer is also to be identified.

At the district level, the district health chief will act as focal point for the district and will coordinate between the district programme officers, plan and organize each activities in the district and liaise with the authorities at the national level as well as across the border. He will be solely responsible for programme implementation in the district. He will be authorized to contact his counterpart across the border, exchange diseases-related information, act as required and organize border meetings every six months.

An agreement will be reached to treat migrants across the borders on the basis of health /referral cards and provide treatment when asked for.

Following joint consultation, diseases control programmes would be launched along the border and in the district in an harmonious, synchronized manner for obtaining best possible result.

6.3 Step 3: Logistics Management

Based on the work plan, chemicals, equipment, and insecticide may be procured as well as manpower arranged. A quick facility survey of existing health facilities will be helpful for proper planning and implementation of work. Patient's record, referral cards are to be printed. IEC materials are to be designed, field tested and finalized.

6.4 Step 4: Communication Process

A mechanism needs to be established for ongoing process of communication within the selected district, to national authorities and across the border for information generation, information gathering, information sharing, sending advance notices on ongoing diseases outbreaks, or threat of outbreaks, measures adopted or likely to be enforced.

This will also be necessary for planning and launching joint plan of action on either side of border.

6.5 Step 5: Monitoring and Evaluation

While baseline data are available in the district or can be collected, all activities performed, must be recorded daily, compiled monthly, reviewed every quarter at national level for further modification, and improvement. Cross-border meeting to be organized six monthly for programme review and work out new plan of action.

WHO will organize once a year programme review through the mechanism of inter-country meeting.

7. RECOMMENDATIONS

- (1) Considering the cross-border diseases situation and regular spread of priority communicable diseases across the border, early launching of cross-border diseases control programme in selected districts is recommended.
- (2) Ministry of health in all the four countries may approve the scheme of cross border diseases control, set up administrative mechanism to implement the programme.
- (3) National and district-level focal points may be identified for programme planning, coordination and implementation.
- (4) Diseases control programmes like DOTS or others, which have not been extended so far to border districts, may be done at the earliest.
- (5) The deficiencies in existing control programmes in the selected districts in the form of manpower, equipment and supplies may be identified and replenished.
- (6) Patients seeking treatment may be provided with treatment cards. People desiring to migrate and wishing to continue or complete treatment may be provided with referral cards.
- (7) Any migrated person seeking treatment in the host country must not be denied treatment but treated as per schedule suggested in his own country.
- (8) While major funding and technical support for the cross-border will be available from respective country programmes, WHO may support capacity building, monitoring and evaluation components of the programme. WHO is also requested to provide generic material for training, IEC etc, to each country who will further improve, modify, translate, print and supply to the selected districts.

Annex 1

LIST OF PARTICIPANTS

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Annex 2

TENTATIVE PROGRAMME

24 July 2001

- 0900 to 1230 hrs
- Welcome, introductions and objectives of the meeting
 - Plenary: Situation analysis and issues related to population movements across borders
 - HIV/AIDS & TB – Dr Jai P Narain
 - Malaria/kala-azar – Dr V P Sharma
- 1400 to 1700 hrs
- Plenary: Technical policies relating to cross-border intervention for the control of TB, HIV/AIDS, malaria and kala-azar (BAN-IND), (BHU-IND), (IND-NEP)
 - Dr Jai P Narain
 - Dr V P Sharma
 - Discussions (Contd.)

25 July 2001

- 0900 to 1230 hrs
- Plenary : Introducing operational guidelines on cross-border interventions followed by discussions
 - Dr K B Banerjee
 - Briefing on formulation of joint plans of action
- 1400 to 1700 hrs
- Group work: Formulating joint plans of action

26 July 2001

- 0900 to 1230 hrs
- Group work: Formulating joint plans of action (contd.)
- 1400 to 1700 hrs
- Plenary presentation and discussion on joint plan of action: Bangladesh–India
 - Plenary presentation and discussion on joint plan of action: India–Nepal

27 July 2001

- 0900 to 1230 hrs
- Plenary presentation and discussion on joint plan of action: Bhutan–India
 - Plenary: Discussion on next steps of joint plan of action including support required
 - Closure