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# Cross-Border Initiatives on HIV/AIDS, TB, Malaria and Kala-azar

*Report of an Intercountry Meeting  
Kathmandu, 6-9 March 2001*

WHO Project: ICP OCD 041

# World Health Organization

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## 1. BACKGROUND

Cross-border problems in health such as HIV/AIDS, TB, malaria, kala-azar and Japanese encephalitis have emerged as major public health concerns along the international borders *inter alia* due to migration, inadequate and inefficient health delivery, and lack of coordination in the implementation of control strategies. The Terai region of Nepal has cross-border problems of malaria, kala-azar, Japanese encephalitis and HIV/AIDS with the Indian states of Uttar Pradesh and Bihar (West Bengal has small/narrow border) measuring a length of approximately 550 miles. Malaria and Japanese encephalitis are endemic throughout the Terai from the farwest to the eastern region. Kala-azar is endemic in the central and eastern region of the Terai in 10 districts. The disease is spreading to new areas and kala-azar cases are multiplying in Nepal and Bihar. JE is endemic in the rice-growing districts all along the international borders with epidemics. Cross-border movement is high because of very friendly relationship between the two countries. India-Myanmar, India-Bangladesh and Bangladesh-Myanmar cross borders have the problem of malaria and HIV/AIDS; and malaria at the India-Bhutan border. Drug resistant *P. falciparum* strains are encountered on both sides of the international borders. Several border meetings were organized by WHO between 1995-98 involving India, Bhutan, Nepal, Bangladesh on malaria and kala-azar. A synchronized plan of action was developed to tackle border malaria and kala-azar problems more effectively.

To address these issues, an interactive meeting was organized in Kathmandu, Nepal from 6–9 March 2001. High level officers from Bangladesh, Bhutan, India and Nepal participated in the meeting (See Annex 1 for list of participants). The meeting consisted of plenary presentations, group work and discussions to prepare joint plans of action (See Annex 2).

The following were the objectives of the meeting:

- (1) To review the cross-border issues in HIV/AIDS, TB, malaria and kala-azar in the participating countries;
- (2) To exchange experiences and lessons learnt on interventions to reduce the spread of these diseases across the borders, and
- (3) To prepare joint plans of action including pilot projects for dealing with cross-border issues in HIV/AIDS, TB, malaria and kala-azar.

## **2. OPENING SESSION**

Hon'ble Mr. Ramkrishna Tamrakar, Minister for Health, His Majesty's Government of Nepal inaugurated the Intercountry Meeting on Cross-border Initiatives. A message from Dr. Uton Muchtar Rafei, Regional Director, WHO South-East Asia Region was read by Dr. Klaus Wagner, WHO Representative to Nepal. Mr. M.B. Poudel, Director SAARC Secretariat and Chairman Mr. Padma Prasad Pokhrel, Secretary for Health, Ministry of Health, His Majesty's Government of Nepal delivered keynote addresses.

### **3. SITUATION IN THE SOUTH-EAST ASIA REGION**

#### **3.1 HIV/AIDS**

The first case of AIDS in the Region was reported from Thailand in 1984. Since then, more than 173 000 cases have been reported with Thailand, India and Myanmar accounting for more than 95% of these cases from the region. The AIDS epidemic began spreading during the late 1980s and by the end of 2000, more than 5.6 million persons were living with HIV. HIV prevalence is low in Bangladesh, Bhutan, India and Nepal, except in some parts of India and among injecting drug users in Nepal. However, the risk behaviours are present in all and there is a potential for rapid spread. Tools for prevention are well known and available. In Bangladesh, a substantial proportion of adults appear to have multiple sexual partners; condom use is low; drug users share and reuse needles, and professional blood donors donate more than 80% blood. A large number of migrant workers, truck drivers and trafficked women cross the porous border, thus increasing the vulnerability to HIV in the border areas. In Bhutan, the number of STIs is increasing especially at the border town of Phuntstholing which is the main transit point for traffic between Bhutan and India. Only one case of AIDS has been reported to date and the number of persons living with HIV at the end of 2000 was estimated to be less than 100. High risk sexual behaviours are prevalent in the country, particularly in the border areas which account for most of the reported HIV infections. In India, an expert group has estimated that more than 3.5 million persons were living with HIV at the end of 2000. The epidemic varies widely in the states. In the North-East, transmission is mainly through injecting

drug use, while it is mainly heterosexual in the rest of the country. The prevalence is much higher in Manipur in the North-East and some of the southern and western states than in other states. Commercial sex work is being carried out in red-light areas in major cities as well as clandestinely all over the countries. However, very little information is available about the situation in the border areas. In Nepal, the number of reported HIV infections has reached more than 1 800; however, the number of persons estimated to be living with HIV at the end of 2000 is estimated to be 25 000. A large number of people including truck drivers from either side cross the open border with India. About 200 000 Nepalese CSWs are working in India and every year about 7 000 join the trade. Drug use is a growing problem in the country including in the border areas. Poverty, illiteracy, lack of awareness about HIV, unemployment, large scale movement of the people, low status of women, trafficking of women and drugs are some of the factors that increase vulnerability to HIV infection.

### **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; 75% of this morbidity and mortality occurs in the age-group 15-45 years. Magnifying this loss is the tremendous social and economic impact of the disease in the Region; several thousand women are rejected or denied basic rights when affected, and an equal number of children withdrawn from schools to supplement family income when a parent is afflicted. No attempts have been made to clearly define the constraints and address the problems unique to implementing TB control services in border

areas. There is at present no mechanism for exchange of information or for coordination between the national programmes of bordering countries; policies and practices necessarily differ. At the present phase of expansion, several border districts in India do not have DOTS services; these services are available in corresponding districts in the three neighbouring countries.

### **3.3 Malaria**

In Bangladesh, Bhutan, India and Nepal, about 95 million people live in the border areas. DDT spraying during the malaria eradication phase uprooted *Anopheles minimus* from the erstwhile hyperendemic areas of the Western Himalayas extending over India and Nepal. These areas are still free of *An. minimus* but *An. culicifacies* on the Indian side and *A. fluviatilis* and *An. annularis* on the Nepal side are the major malaria vectors. Ecological succession of vectors impacted the endemicity of the Region. Areas have now become meso-endemic with variable with potential of epidemics. The cross-border malaria situation worsens as one moves from west to east. In the eastern region on the borders with Bangladesh and Bhutan with India, malaria has returned to its original strength. The problem is compounded by the emergence of multiple drug resistance in *P. falciparum* spreading across the borders to cover the entire countries, threatening serious outcomes.

In many countries of the Region, political commitment is not reflected in adequate allocation of resources. 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 and prolonged transmission season due to climate changes, land-use patterns by unplanned exploitation of natural resources, usually resulting in epidemics.

Countries of the South-East Asia Region adopted the revised global malaria control strategy in 1995. The objectives of the revised malaria control strategy are 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 problem in some parts of Bangladesh, India and Nepal. About 20 000 cases of kala-azar were reported in the Region in 1999. During the malaria eradication era, when blanket house-spraying was applied widely as the standard intervention for vector control, kala-azar was suppressed at very low levels. When the strategy was changed from eradication to control and areas covered by house spraying were shifted to areas with more malaria problem, kala-azar re-emerged in the sixties and by the seventies, the disease established itself in endemic form in Bihar, followed by West Bengal. In the absence of any organized control activity, the disease slowly spread to several areas in these states. Sporadic cases of kala-azar have been reported from some districts in Uttar Pradesh and the disease is becoming endemic in at least Kushinagar district. Kala-azar is now endemic in the Indo-Gangetic alluvial plains touching Nepal, the states of Bihar and West Bengal in India and the flood-prone plains of the Ganges and Brahmaputra in Bangladesh. Flood plains are non-malarious, but high soil moisture and constant high humidity (80% or more) provide opportunities for the breeding and extended survival of *Phlebotomus argentipes*, the vector of kala-azar.

Therefore the intensity of transmission is very high in the border districts of eastern Nepal, the northern border districts of Bihar, and also along the Bangladesh borders. These borders also show a high degree of drug resistance.

#### **4. CROSS-BORDER INTERVENTIONS FOR COMMUNICABLE DISEASE CONTROL: COUNTRY EXPERIENCES**

##### **4.1 Bangladesh**

Out of 64 districts in Bangladesh, two districts share a border with Myanmar, while 30 districts share a border with four states of India i.e. Assam, Meghalaya, Tripura and Mizoram. Although the prevalence of HIV is still low in Bangladesh, the government has taken measures 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, not enough attention has been given to the implementation of interventions in the border areas.

The DOTS strategy in Bangladesh now extends to all 460 rural thanas and covers 95% of the population. Implementation of the strategy in the country has been of high quality with treatment success rates over 80%. Case detection, however, is still low and should improve through planned new partnerships with the private sector, medical colleges and improved implementation in large urban metropolises. Multi-drug resistance levels are low, as is the incidence of HIV among patients with tuberculosis.

Out of the 30 border districts in Bangladesh, 17 districts have the problem of malaria. As per the 1999 census, the population of border districts is 13.4 million. Four districts i.e. Jamalpur, Brahmanbaria, Comilla and Feni belong to rural areas and do not pose any problem in control. The remaining 13 districts are responsible for more than 90% total malaria cases in the country and 99% of the total *P. falciparum* cases. Among the 13 districts, four districts i.e. Bandarban, Rangamati, Khagrachai and Cox's Bazar are highly malarious and produce maximum number of malaria cases and *P. falciparum* with high number of deaths due to malaria. In malaria control, emergence of drug resistance is posing serious problems. Early case detection and prompt treatment with an effective drug regimen is being emphasized. Since 1984, Malathion EC for Indoor Residual Spraying (IRS) and deltamethrin EC for the impregnation of bed-nets have been used for malaria control. The impact of these measures on malaria control was very good. The support of the NGOs is being taken to sustain the ITN programme and community participation in malaria control is being solicited.

Seven districts of Bangladesh bordering West Bengal on the West side have reported kala-azar cases, and there is gradual increase in the number of reported cases in the border districts. Every year, new areas are coming under the grip of kala-azar. Low socioeconomic conditions, type of houses (mud houses and cattle sheds) population movement also seems to play an important role in the transmission of the disease. Major proportion of the cases are reported from the banks of big rivers or the places where there is change of water flow due to creation of embankments. Cases are diagnosed based on history, clinical examination and the Aldehyde test. Cases are treated with injection Sodium Antimony Gluconate

(SAG). Vector control by DDT spraying (@ 1 gm/m.sq.) is carried out in very selected areas.

## **4.2 Bhutan**

There are four Indian states with eight districts, which share a border on the west, south and east side of Bhutan. They are Sikkim, West Bengal with two bordering districts i.e. Darjeeling and Jalpaiguri, Assam with four bordering districts i.e. Kokrajhar, Barpeta, Nalbari and Darang, and finally Arunachal Pradesh with district Kemang. The Bhutan border extends over a linear length of about 600 km and include 0.15 million population in four districts i.e. Samste, Chukka, Sarpang and Samdrup Jongkhar. Forty per cent population of the country live in the border districts. Recognizing the need to adopt a multisectoral approach for the prevention and control of HIV/AIDS, a task force and working committee have been formed. The roles and responsibilities of the health sector have been well defined. The role of cross-border spread of HIV has been well recognized in Bhutan and priority has been given to interventions at the border areas.

Success with DOTS implementation in Bhutan has been recognized worldwide. Phase-wise expansion, early community involvement through the establishment of DOTS committees, policies to involve other sectors such as the army, police, jails and the private sector early in national TB control efforts have led to this success. At present, 80% of the country's population has access to DOTS through 202 DOTS centers. Case notifications have been increasing; the current case detection rate is 67%. The treatment success rate is high at 89%. It is expected that 2002 will cover the entire country.

Border districts are forested and most malarious, and contribute >90% total cases of malaria. The problem of multidrug resistance is increasing in all the border districts. An estimated 30% cases of malaria in the border districts are imported from India. Malaria control activities in Bhutan include early case detection and prompt treatment (EDPT). A revised drug policy is in force and a consultant recently visited the country and made some recommendations to improve treatment and compliance. DDT spraying was replaced with deltamethrine spraying (@ 20 mg/sq.m.) since 1995 and terminated in 1997. Currently IRS has been withdrawn, although malaria situation has deteriorated and active malaria transmission is being reported every year. Kala-azar is not a problem along the India-Bhutan borders.

### **4.3 India**

India is sharing borders with Bangladesh, Bhutan, China, Myanmar, Nepal and Pakistan. Eleven states have international borders and in total, 59 districts are share borders with different countries involving 70.79 million population. Five Indian states, namely West Bengal, Assam, Meghalaya, Tripura and Mizoram have a border on three sides of Bangladesh. A total of 23 districts are located along the international border. In West Bengal, transmission occurs all along the border with variable intensity. The Government of India is concerned about the spread of HIV/AIDS epidemic in the country and has responded to the situation on a big scale. It has allocated the largest budget to HIV/AIDS among the various programmes within the Ministry of Health. HIV sentinel surveillance has been established in 230 urban and rural sites. Surveillance has been expanded to include

behavioural surveillance and STI surveillance. Syndromic management of STI has been accepted as a policy and a large number of health care workers have been trained in this approach. Changing risk behaviours is the main focus of attention, with emphasis on targeted, community-based interventions. AIDS education has been incorporated in the schools. Blood safety has been given a high priority. Feasibility of prevention of mother to child transmission is under study in 11 states. A continuum of care model has been accepted as a strategy for providing care to persons with HIV/AIDS. Because of the increasing spread of HIV in other areas, very little attention is paid to the response in border areas.

India accounts for a third of the global burden of tuberculosis. DOTS pilot projects were initiated in 1993 and under the revised tuberculosis control programme (RNTCP) in India, DOTS expansion has been rapidly scaled up since 1998; DOTS services are now currently available to over one third of the country's population. The impact of the revised programme has been a three-fold rise in the treatment success rate to 84% and a seven-fold reduction in TB deaths from 29% to 4% among TB patients.

Malaria is a serious problem in Jalpaiguri and Coochbehar districts, which have undulating terrain and terraced tea gardens. In the border areas of Assam, Dhubri district is the most problematic, whereas incidence is low in Karimganj and Cachar. In Meghalaya, malaria is high all along the borders in the three districts namely Garo Hills, W & E Khasi and Jaintia Hills. In Tripura, malaria is prevalent along the Bangladesh border in the three districts i.e. South Tripura, North Tripura and West Tripura. Similarly, high malaria prevalence is reported from the three

districts in Mizoram i.e. Aizwal (West), Lunglei and Chintuipui along the Bangladesh border. Malaria in the districts of India bordering Nepal involves four states with 17 districts, which have border on west, south and east of Nepal. There are eight districts in Uttar Pradesh, seven districts in Bihar and one each in Darjeeling (West Bengal) and Sikkim. Malaria control in the border districts is based on active and passive case detection, early detection and prompt treatment, and DDT spraying. Recently insecticide-treated mosquito nets have been introduced in malaria control.

Along the Indo-Bangladesh border areas, kala-azar is endemic only in West Bengal. Of the 10 bordering districts of West Bengal, kala-azar is not endemic in Jalpaiguri and Coochbehar. Six districts of West Bengal along Indo-Bangladesh border; seven districts of Bihar and one district of Uttar Pradesh along the Indo-Nepal border are recording kala-azar cases. None of the districts along Indo-Myanmar border and the Indo-Bhutan border is reporting kala-azar cases. Kala-azar control is based on selective vector control with two rounds of DDT, early diagnosis and complete treatment and health education and community involvement.

The major constraints faced by the National Anti-Malaria Programme of India in the control of kala-azar is:

- (a) Failure to organize periodic active case detection (searches) that enabled under-reporting to continue. Since the last two years, a kala-azar fortnight and an IEC campaign coupled with case search has been initiated. This helped in detection of 33% of the total annual incidence in Bihar within a fortnight during December 1999-January 2000; interruption in implementation of vector control (insecticide spray) as per recommended strategy due to

inadequacy of funds for operational cost (state share). This also led to under utilization of the Government of India funds provided for material assistance to the states;

- (b) Early diagnosis and inadequacy of potent drugs at an affordable cost.
- (c) Complacency and gradual decrease in commitment at various levels of programme implementation, and
- (d) Major cross-border issues include migration, different diagnostic and inappropriate treatment practices particularly among private practitioners, crossing of borders frequently even during the treatment, thereby leading to dropouts and indiscriminate use of anti kala-azar drugs. Synchronization of control activities though planned during border meetings, could not become effective for various reasons and needs to be established and made functional.

#### **4.4 Nepal**

The Government of Nepal has responded to the HIV situation with a multisectoral approach with the active involvement of nongovernmental organizations (NGOs). HIV surveillance is being carried out at six sites. A number of NGOs are actively engaged in interventions targeted at specific population subgroups, such as CSWs, truck drivers, IDUs, young people and others. Blood safety, counselling and care of persons with HIV are other interventions included in the national plan. However, very little attention is being paid for implementing the interventions at the border areas.

Challenges to TB control in Nepal are the emergency of HIV/TB co-infection, MDR tuberculosis, and large population movements

across the India–Nepal border and the extension of DOTS to the hard-to-access hill districts in Nepal. DOTS is available in Nepal since 1996. Treatment success is high at 90%; case detection activities need to be enhanced to improve this from the current 24%, although the population denominator is still unclear. The initial phase of treatment is still hospital-based; ambulatory DOTS will be gradually established; a major challenge lies in ensuring treatment adherence among patients in far-flung communities in the difficult mountainous terrain.

Out of 75 districts in Nepal, 64 districts are malarious, 26 districts have borders with four states of India i.e. Uttar Pradesh, Bihar, West Bengal and Sikkim involving 9.5 million population. Early case detection and prompt radical treatment is followed to reduce morbidity and mortality due to malaria. Kala-azar is not a serious problem in the districts of Uttar Pradesh bordering Nepal. Sporadic occurrences have been recorded in this area. However, kala-azar is highly endemic in the border districts of Bihar. There is no active case detection system for kala-azar. The first line of treatment is sodium antimony gluconate (SAG) and the second line of treatment is pentamidine or amphotercin B. Treatment failures are common. Vector control for malaria and kala-azar is based on the indoor residual spraying of insecticide, and synthetic pyrethroid insecticides are sprayed for this purpose.

## **5. MAJOR ISSUES AND BORDER LEVEL INTERVENTIONS NEEDED**

### **5.1 HIV/AIDS**

People move across the border for various reasons, the most prominent being economic reason. Border areas usually receive low priority and hence, very little attention. Illicit drug trade and trafficking of girls and women along with marginalization and criminalization increase vulnerability to HIV. Involvement of all concerned sectors, integration of prevention and care into primary health care are some of the challenges that need to be addressed. They call for situation analysis, identifying effective suitable policies and strategies, and designing and implementing appropriate interventions and activities.

## **5.2 Tuberculosis**

Problems specific for tuberculosis control in the border areas are (i) constant and large-scale migration making both case-finding and ensuring treatment completion difficult; (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 policy and practices across borders; the absence of mechanisms for cross-referral and coordinated activities compounding the difficulty in transferring patients across borders and in ensuring adherence to treatment; (iv) border districts are often the last to have DOTS programmes established and (v) poverty, lack of basic facilities and often, compulsion to adopt high risk behaviour put migrants at increased risk for disease.

## **5.3 Malaria**

During malaria resurgence, cross-border problems increase due to large scale population movement, which facilitate malaria

outbreaks and the spread of drug resistant *P. falciparum*. The Indo–Nepal border being open, there is large–scale annual movement of agricultural Nepali labour from border areas to Punjab in the west and Assam in the east. This results in frequent outbreaks of malaria in both countries. On the Indo–Bhutan border, significant number of (sizable) Indian labourers work as "non–national and non–resident" category in all border towns of Bhutan, on various mining commercial projects and as domestic help. These labourers are required to work by day in Bhutan and sleep by night on Indian soil, which is located in reserve the forestland. They are denied public health care by India being "encroachers" on reserve forestland. This perpetuates the transmission of drug–resistant malaria and threatens to negate the efforts of the Bhutanese Government on their side of the border. On the Indo–Bangladesh border, unnatural demarcation of boundary, which in many cases run through the centre of villages, makes movement of people much easier with all cross–border problems of malaria.

#### **5.4 Kala–azar**

Major cross–border issues in the control of kala–azar include porous borders, uncontrolled migration, different diagnostic and treatment practices particularly among private practitioners, crossing of borders frequently even during the treatment, thereby leading to dropouts and indiscriminate use of anti–kala–azar drugs. Synchronization of control activities, though planned during border meetings, could not become effective for various reasons. The causative agent, *Leishmania donovani* has already 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.

## **5.5 Interventions Needed**

Based on the experiences above, it is important to realize that all these services must be integrated at the border district level. These include a situation analysis of the problem on both sides of the borders. A joint plan of action should be made operational on both sides of the borders. For HIV, exchange of health education materials, provision of care package for those living with HIV/AIDS, would be important, while TB control requires uniform treatment regimen and knowledge of DOTS centres on both sides of the border and a system of referral for follow-up of patient already put on treatment who may move from one side of the border to the other. For example, focal spraying of an effective residual insecticide in high endemic/epidemic affected areas, widespread use of insecticide-treated mosquito nets and repellents with synchronized field operations in regard to the distribution of drugs. Information, education and communication; political commitment; exchange of information and meetings of district level officers would strengthen coordination in control operations in the border districts.

## **6. JOINT PLANS OF ACTION –HIGHLIGHTS**

### **6.1 General Objective**

To improve the health of the people living along the border areas with emphasis on prevention/reduction of transmission and disease burden of malaria, HIV, TB and kala-azar.

## **6.2 Specific Objective**

- (1) To initially translate political commitment to action i.e. to develop cross-border collaboration between India-Nepal, India-Bangladesh and India-Bhutan;
- (2) To evaluate/implement the existing intervention technology for diagnosis, treatment and monitoring;
- (3) To strengthen information exchange;
- (4) To strengthen human resources for health development in HIV, TB, malaria, and kala-azar;
- (5) To develop mechanisms for further and sustained active collaboration, and
- (6) To facilitate the generation of new knowledge and technology for the diagnosis, treatment and control of HIV, TB, malaria, and kala-azar.

## **6.3 Strategies**

- (1) Combination of integrated approach with disease specific intervention;
- (2) Inter- and intra-country increase in communication;
- (3) Involvement of regional, national and local health officers, and
- (4) Harmonization of the operational process(es) involved allowing differences to exist.

A meeting of the programme managers and officers of the districts is being organized to draft the joint plan of action for

cross-border interventions based on the above objectives and strategies.

## **7. BORDER DISTRICTS SELECTED**

The following border districts were selected for the control of cross border HIV/AIDS, TB, Malaria and Kala-azar in the first phase:

- (1) **India** (Jantia Hills in Meghalaya) and **Bangladesh** (Sylhet)
- (2) **India** (East Champaran and Lakhimpur Kheri) and **Nepal** (Kailai, Bara and Rauthat)
- (3) **India** (Darjeeling and Jalpaiguri) and **Bhutan** (Samtsa and Chukha)

## **8. CONCLUSIONS AND RECOMMENDATIONS**

The meeting concluded that HIV/AIDS, TB, malaria and kala-azar are closely linked with the vicious circle of poverty and disease. Experience has shown that migrating populations are at a greater risk of contracting infectious diseases, and this problem is pronounced along the international borders. WHO attaches the highest importance to combating cross-border problems of disease and poverty. The meeting of health ministers' have also voiced concern and highlighted the need for intercountry collaboration in planning and implementing cross-border interventions. The meeting was seized of the prevailing situation of cross-border diseases; and considering all aspects of the issues arising out of discussions made the following recommendations:

***To National Governments***

Ministries of Health and other related ministries of the four countries should accord high priority to the control of cross-border communicable diseases, by:

- (1) Endorsing the joint cross-border plan of action prepared during the meeting;
- (2) Forming national coordination committees, and identifying national focal points, for integrated cross-border communicable disease control, and
- (3) Initiating implementation of joint plans of action in selected border districts, and use this experience to further expand cross-border interventions in other districts.

***To WHO/SAARC/Partners***

- (1) Operational guidelines for integrated cross-border communicable disease control should be developed, and discussions initiated on standardization of technical policy guidelines. **(by July 2001).**
- (2) A meeting of technical experts and programme managers from countries should be organized to finalize joint action plans. **(by July 2001).**
- (3) Joint action plans and operational and technical policy guidelines should be endorsed at a regional meeting of secretaries and directors general of health. **(by August 2001).**
- (4) Joint action plans and operational and technical policy guidelines should be endorsed at the Health Ministers' meeting to be held **in September 2001.**



## **Annex 1**

### **LIST OF PARTICIPANTS**

#### **Bangladesh**

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**SAARC TB Centre**

Dr Prahlad Kumar  
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SAARC TB Centre  
Thimi, Bhaktapur  
Nepal



**Annex 2**  
**PROGRAMME**

**6 March 2001**

0900 to 1230  
hrs

Registration

Inaugural session

Business session including introduction

- HIV/TB/malaria/kala-azar situation in South Asia
- Country situation and experiences related to cross-border transmission of HIV, TB, malaria and kala-azar

Bangladesh

Bhutan

India

Nepal

1400 to 1700  
hrs

- Major issues and interventions related to Cross-Border Transmission of HIV and TB
  - Dr Supang Chantavanich
  - Dr Fraser Wares
- Border malaria and kala-azar situation and rational control strategy
  - Dr N.L.Kalra
  - Dr Shyam Sunder
- Introduction to Team Work to prepare Joint Plan of Action including Pilot Project

**7 March 2001**

0900 to 1230 hrs

- Team Work to prepare Joint Plan of Action including Pilot Project for Prevention of Cross-Border Transmission of HIV, TB, malaria and kala-azar  
Bangladesh/India  
Bhutan/India  
India/Nepal

1400 to 1700 hrs

- Team Work (continued)

**8 March 2001**

0900 to 1230 hrs

- Team Work (continued)
- Presentation of joint plan of action and pilot project followed by discussion on the next steps in the implementation of the joint plans of action

1400 to 1700 hrs

- Team Work (continued)
- Presentation of joint plan of action and pilot project followed by discussion on the next steps in the implementation of the joint plans of action
- Closing session