COMBATING HIV/AIDS AND TUBERCULOSIS

Significant progress has been made in achieving the tuberculosis (TB) control goals set by the WHO Regional Committee for the Western Pacific at its fifty-first session in 2000, and in meeting the various goals that have been set for HIV/AIDS prevention, care and treatment.

The WHO Western Pacific Region was the first and only Region to achieve the 2005 global targets for TB control. With the development of the regional Strategic Plan to Stop TB 2006–2010, the Region aims to achieve the eventual goal of reducing TB prevalence and mortality by one half by 2010 as compared with 2000. The fight against multidrug-resistant TB is a major activity for WHO.

Following completion of the “3 by 5” Initiative in 2006, the HIV programme is now working towards universal access to care and treatment. Even though the treatment gap has been decreasing in recent years, a steep increase in the number of people starting treatment is expected.

The regional TB-HIV framework published in 2004 will be updated in 2007. High case-fatality rates of co-infected individuals calls for a rapid implementation of provider-initiated HIV testing policy to reduce diagnostic delays, new TB algorithms to diagnose smear-negative TB, specific action to speed up appropriate treatment and care for co-infected individuals and effective infection control measures in health care settings.

This paper is presented for the information of the Regional Committee and for discussion at its fifty-eighth session.
1. CURRENT SITUATION

1.1 Progress in achieving the regional goals for tuberculosis control

In the Western Pacific Region, 2006 was a memorable year for tuberculosis (TB) control. The Region achieved the 2005 global targets for TB control, making it the first and only Region to do so. The Strategic Plan to Stop TB in the Western Pacific 2006–2010, developed as a road map to achieve the eventual goal of reducing by half the number of cases and deaths by 2010 relative to 2000, was endorsed by the Regional Committee for the Western Pacific at its fifty-seventh session in September 2006.

TB continues to be a major public health problem in the Region. In 2005, the latest year for which data is available, countries and areas reported a total of 1.4 million new cases of TB, including 672 000 new pulmonary smear-positive TB cases which represents 78% of the estimated incident smear-positive cases. It is estimated that one quarter of the global burden of multidrug-resistant tuberculosis (MDR-TB) is in the Region with 140 000 cases in China alone.

In March 2007, WHO organized the fourth meeting of national TB programme and TB laboratory managers, involving seven countries in the Region with a high burden of TB and the host country, Malaysia. The meeting reviewed the progress towards the 2010 TB goal and identified areas that need further strengthening or prioritization to achieve the desired results.

1.2 Progress in HIV/AIDS prevention, treatment and care

The completion of the “3 by 5” Initiative led to 19% of people in need receiving antiretroviral treatment in East, South-East and South Asian countries. At the United Nations’ General Assembly High-Level Meeting on HIV/AIDS in 2006, Member States agreed to work towards the goal of “universal access to comprehensive HIV prevention programmes, treatment, care and support” by 2010.

In the Western Pacific Region it was estimated that 1.3 million people were living with HIV at the end of 2006, while almost 80 000 individuals died of HIV the same year. Despite some success in scaling up prevention interventions, the epidemic continues to grow. An estimated 167 000 new HIV infections occurred in the Region in 2006. Transmission of HIV infection through unprotected

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1 Cambodia, China, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines and Viet Nam.
heterosexual contact continues to be predominant in several countries in the Region. Cambodia has contained spreading of HIV among adults by implementing intensive multiple prevention interventions, including a 100% condom use programme (CUP). Other countries are expanding the 100% CUP—China, the Lao People's Democratic Republic, Mongolia, the Philippines and Viet Nam. In China, Malaysia and Viet Nam, injecting drug use accounts for most reported HIV infections. There have been clear policy shifts in these countries in recent years towards strong prevention approaches, such as the expansion of needle and syringe programmes and methadone maintenance treatment.

Encouraging trends in the scale-up of antiretroviral therapy have continued. By end of 2006 Cambodia was providing antiretroviral therapy to 20,131 patients (including 1,787 children); coverage rates for antiretroviral treatment in the other countries in the Region range from 11% in Papua New Guinea to about 20% in Viet Nam and 27% in China.

1.3 Addressing TB-HIV: two diseases, one patient

In the Western Pacific Region, an estimated 1% of adult incident TB cases in 2005 were co-infected with HIV, a low proportion that hides a large heterogeneity of the TB-HIV distribution among countries. TB-HIV co-infection is of serious concern in Papua New Guinea (where around 10% of TB cases are estimated to be infected with HIV), Cambodia (although the HIV epidemic has been declining since 1997, the prevalence of TB-HIV co-infection remains at around 11%), Viet Nam (prevalence of TB-HIV co-infection is about 4%) and Malaysia (the measured prevalence of TB-HIV co-infection is 8% among the 70% of TB patients who agreed to be tested for HIV). In Viet Nam, the HIV epidemic is probably responsible for the stagnation in the decrease in incidence of TB despite good performance. While good progress has been made in implementing TB-HIV collaborative activities in Cambodia and in some areas of high HIV prevalence in Viet Nam, other countries need to strengthen TB-HIV collaborative activities through a formally established mechanism and plan.

WHO and the Secretariat of the Pacific Community jointly organized the Pacific TB-HIV meeting in the Pacific in August 2006. Attended by representatives from all Pacific island countries and areas, as well as partners in the Pacific, the meeting established the need to strengthen policies on HIV, TB and TB-HIV co-infection. Participants agreed to review existing national policies relevant to TB-HIV and, as appropriate, incorporate TB-HIV policies in existing policies or develop national policies and operational guidelines for TB-HIV that are in line with regional and global frameworks.
The regional TB-HIV framework, *Tuberculosis and HIV: A framework to address TB/HIV co-infection in the Western Pacific Region*, published in 2004 will be updated in 2007 to take into account recent progress and data from the Region. Those settings in which there are case-fatality rates of over 20% call for a rapid implementation of a provider-initiated HIV testing policy to reduce HIV diagnostic delays, new TB algorithms to diagnose smear-negative TB to reduce TB diagnostic delays, specific action to speed up appropriate treatment and care for TB-HIV co-infected individuals, and effective infection control measures in health care settings.

2. ISSUES

2.1 Tuberculosis

2.1.1 The need for improving access to directly observed treatment, short-course

Despite 100% directly observed treatment, short-course (DOTS) coverage, many TB patients often face significant barriers in accessing DOTS services. This is a particular problem among the poor, other vulnerable populations and those who seek care from the private sector or other non-national TB programmes facilities. National TB programmes are increasing their efforts to address these issues. The Philippines, and to a certain extent, Viet Nam and Cambodia, are engaging the private sector to improve access and the quality of care for TB. China has undertaken a major initiative to address the needs of its huge migrant populations. Mongolia is collaborating with prison authorities to manage TB among prisoners, and prison populations are the focus in Viet Nam. Many countries in the Region also implemented community-based DOTS to improve the reach of services.

WHO, in collaboration with the Korean Institute of Tuberculosis, organized an advanced training course on public-private mix DOTS and MDR-TB in December 2006. The course was attended by representatives from the host country, the Republic of Korea, and from all seven countries with a high burden of TB in the Region. In July 2006, WHO organized a workshop on advocacy, communications and social mobilization in the Philippines. Advocacy, communications and social mobilization is being promoted as a strategy to raise awareness for better health seeking and to empower and mobilize affected people and their communities to play an important role in achieving equitable access to TB services.
2.1.2. The need for addressing the potential threat of multidrug-resistant TB

A major activity of WHO in 2006–2007 was supporting countries in establishing the necessary infrastructure for programmatic management of multidrug-resistant TB (MDR-TB). Strengthening the laboratory network and laboratory capacity is a crucial step before embarking on MDR-TB management. The first regional training course on MDR-TB was held in the Republic of Korea with participation from the host country and the seven countries with a high burden of TB in the Region. In collaboration with the Regional Office for South-East Asia, the Regional Office for the Western Pacific organized a TB laboratory course in Beijing in October 2006 with the aim of improving the managerial and technical skills of senior TB laboratory managers from the Asia Pacific region. Several visits were also made by WHO consultants to China, Mongolia and the Philippines in support of the preparation and implementation of MDR-TB management.

The Philippines, which was the site of the first DOTS-Plus project, has made good progress in expanding management of MDR-TB under its national TB programme. In China, where MDR-TB has reached alarming rates in some areas, a national plan has been developed for pilot testing and scaling up activities. Viet Nam is planning its strategy along the same lines, while Cambodia and Mongolia are at the initial stages of implementation.

During 2006, reports emerged of extensively drug-resistant TB (XDR-TB), which has also been documented in the Philippines and the Republic of Korea. There is great urgency to prevent XDR-TB—firstly, by a good DOTS programme, and secondly, by effectively implementing programmes designed to diagnose and treat MDR-TB.

2.1.3 The need to sustain commitment and adequate financing

The Global Fund to Fight AIDS, Tuberculosis and Malaria remains an important source of grant funding for TB. With strong WHO support in the preparation of proposals, all countries with a high burden of TB have had grants approved from the Global Fund. In total, 13 TB grants have been approved by the Global Fund, amounting to US$ 260 million. Although very significant, the Global Fund covers less than 10% of the resources needed for TB control in the Region. More than half of the resources required are provided by domestic government funding. Member States need to continue to prioritize and further increase their investment in TB control.

WHO has supported the preparation of comprehensive and technically sound proposals. Increasingly, WHO is supporting the implementation of activities funded by the Global Fund through
its participation in the Technical Working Group of the Country Coordinating Mechanisms and the provision of technical assistance through staff and consultants.

2.1.4 The need to improve surveillance, monitoring and evaluation.

Concerns about the accuracy of published estimates in the Pacific have been raised by TB experts and national TB programme managers. In July 2006, WHO organized a workshop on estimating the TB burden in 20 Pacific island countries and areas, the first meeting of its kind in the Pacific. Better estimates derived from the workshop will be incorporated into the WHO database and updated annually.

With a strengthened focus on measuring TB control programme implementation and evaluating its impact, the need for guidelines on prevalence surveys has become increasingly important. The Regional Office for the Western Pacific took the lead in developing international guidelines for the standardization of methods and procedures on prevalence surveys of TB. Experts discussed the first draft during a workshop held in February 2007.

Since the endorsement of the regional Strategic Plan to Stop TB 2006–2010, several countries have updated their national plans to tackle the MDR-TB and TB-HIV epidemics in a more ambitious manner and have incorporated those plans into Global Fund applications for Round 7. During 2006–2007, WHO participated in or led joint external reviews of national TB programmes in Cambodia, China and Viet Nam.

2.2 HIV/AIDS

2.2.1 The need to further expand access to effective care and treatment of HIV

Access to HIV treatment continues to expand but significant obstacles to achieving universal access must be overcome. Universal access by 2010 will require a steep increase in the number of people starting treatment every year. Even though the treatment gap has been decreasing in recent years, people currently living with HIV/AIDS will progress towards symptomatic HIV disease and eventually require treatment. As antiretroviral therapy must continue for life, it is imposing significant burdens on already overwhelmed health systems, which are grappling with human resources and financial sustainability issues.

Higher priority must be given to equity in access to services, including access for injecting drug users (IDU) and other marginalized groups. For example in China, where approximately 50% of HIV
cases are associated with injecting drug use, IDU represent less than 2% of the people on antiretroviral treatment. Only rough estimates are available on how many patients from most-at-risk groups are receiving antiretroviral treatment as national data collection regularly does not include a breakdown of the numbers of IDU, sex workers or men who have sex with men.

2.2.2 The need to further expand coverage of HIV prevention programmes

Pregnant women with HIV are at risk of transmitting HIV to their infants during pregnancy, birth or breastfeeding. Without interventions, 20%–45% of infants may become infected. An estimated 22,000 children in the Region were living with HIV at end of 2006. Coverage rates for prevention of mother-to-child-transmission services in countries such as Cambodia and Papua New Guinea (with generalized epidemics) and China, Malaysia and Viet Nam (with concentrated epidemics) are still low and range from 1% in Papua New Guinea to 10% in Malaysia.

The health sector needs to increase efforts to improve access to prevention services for most-at-risk populations, including more effective outreach interventions. Based on the Biregional Strategy For Harm Reduction 2005–2009 – HIV and Injecting Drug Use, technical assistance was provided in the collection of data (rapid assessment and response in Malaysia, Mongolia and the Philippines) and in the development of several regional and national guidelines for methadone maintenance treatment and needle and syringe programmes, including harm reduction interventions in closed settings. Despite encouraging trends to implement comprehensive harm reduction programmes in China, Malaysia and Viet Nam, coverage of prevention interventions for IDU remains very low throughout the Region. Less than 5.4% of IDU are reached by HIV prevention services which need to be expanded to a sufficient scale to have a major impact on HIV transmission.

WHO continues to provide technical support to interventions for sex workers and their clients. In 2006, training workshops on the 100% CUP were conducted in China, the Lao People's Democratic Republic, Mongolia and the Philippines. A WHO/UNFPA biregional meeting on the expansion of the 100% CUP was held in Manila in October 2006.

Technical support for sexually transmitted infections (STI) prevention and control was provided to Pacific island countries, following up on a regional meeting in Fiji in November 2005. Expertise on STI prevention and control has been strengthened at the regional level, in view of the implementation of the WHO Global Strategy for the Prevention and Control of Sexually Transmitted Infections for 2005–2010.
2.2.3 The need to address other sexually transmitted infections

High rates of prevalence for sexually transmitted infections were found in several countries, even in low-risk groups. For example, in Fiji, where 29% of pregnant women tested positive for chlamydial infection in a 2005 survey. Resurgence of STI has been reported by China. Syphilis, which reportedly disappeared from the Chinese mainland for the two decades ending in 1980, is now re-emerging and increased nearly fivefold between 1993 and 2005 among adults and 72% in newborn children.

2.2.4 The need to enhance HIV surveillance systems

Improving strategic information and knowledge of the epidemic at the national and regional levels is essential to guide planning, decision-making, implementation and accountability of the health sector’s response to HIV/AIDS. Data provided by HIV surveillance systems have been vital for advocacy and policy decisions to identify priority prevention interventions, as well as in providing reliable estimates for care and treatment needs. In 2000, UNAIDS and WHO launched the HIV second-generation surveillance (SGS) methodology for improving HIV surveillance. Accordingly, Cambodia, China, Mongolia, the Philippines and Viet Nam have fully established surveillance systems. Other countries have partially implemented SGS. The Lao People’s Democratic Republic has implemented two SGS rounds and seven Pacific island countries (Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu) have completed their first round. Papua New Guinea has made good progress, but it is still confronted with major difficulties in accurately monitoring the epidemic. In Malaysia, surveillance relies essentially on case reporting and case finding through screening interventions.

2.3 TB-HIV

In the Western Pacific Region, the overall HIV prevalence rate among TB patients is 1% as estimated by modelling. HIV prevalence rates in TB patients from different sources were found to be 11% in Cambodia, 10% in Papua New Guinea, 8% in Malaysia, 3% in Viet Nam, less than 1% in China and the Philippines. HIV surveillance in TB needs to be strengthened to better monitor trends.

The health sector should put a high priority on ensuring that TB patients receive HIV testing and counselling. Where appropriate and when resources are available, HIV tests should be offered to all patients diagnosed with TB (provider-initiated HIV testing for TB patients). Data suggest that since 2003, there has been a threefold increase in both HIV testing of TB patients and the detection of TB-HIV co-infection. Nevertheless, the total coverage of HIV testing and counselling for TB patients
is still very low in the Region. As TB patients already are in the health care system, this represents a major missed opportunity for HIV prevention, treatment and care. Likewise, all patients identified with HIV should be screened for all forms of TB as part of their routine medical follow-up to ensure prompt and adequate treatment.

3. ACTIONS PROPOSED

The following actions by Member States are proposed for consideration by the Regional Committee:

For TB

(1) To sustain and optimize the quality of DOTS, the performance of laboratory networks and diagnostic facilities need to be improved through quality assurance programmes. The basic elements of the DOTS strategy need to be strengthened to further increase case detection and cure rates.

(2) Programmatic management of multidrug-resistant TB urgently needs to be scaled up to ensure quality-assured diagnosis and care of multidrug-resistant TB.

(3) To ensure equitable access to high-quality TB care for all people, special attention should be given to migrant populations, the poor and other at-risk groups. Advocacy activities should be prioritized to encourage policies that promote equitable access to services for all TB patients.

For HIV/AIDS

(1) Treatment and prevention services must be scaled up. In particular, the health sector must increase efforts to establish and improve access to well-targeted prevention services for most-at-risk populations. This includes comprehensive STI management, including the 100% condom use programme and outreach activities, harm reduction services for injecting drug users and positive prevention for people living with HIV.

(2) The health sector should expand its role in HIV testing and counselling for HIV through the establishment of provider-initiated HIV testing and counselling services, and continued scale up of client-initiated voluntary counselling and testing services.
(3) As cohorts of patients receiving antiretroviral therapy expand, attention should be given to the sustainability of treatment protocols, including issues related to drug toxicity, prevention, surveillance and monitoring of HIV drug resistance, as well as the development of effective second-line regimens.

(4) Strategic information for HIV/AIDS including surveillance, estimates, monitoring of health sector interventions, as well as monitoring of TB-HIV co-infection and co-morbidity, need to be strengthened.

For TB-HIV

(1) The high case fatality of TB-HIV individuals observed in the Region needs to be addressed through early diagnosis of both conditions, including diagnosis of the smear-negative forms of TB, and prompt implementation of adequate treatment, care and support, with planning, monitoring and evaluation led by a national TB-HIV collaborative body.

(2) Comprehensive infection control strategies in health care settings need to be implemented to avoid further transmission of TB in HIV-infected individuals.