

Address

By
Dr Samlee Plianbangchang
Regional Director, WHO South-East Asia

At

*International Conference on Opportunistic Pathogens in
AIDS & 3rd National Conference of Laboratory Medicine*

AIIMS, New Delhi
27 March 2006

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REGIONAL DIRECTOR, WHO SOUTH-EAST ASIA**

Prof. P.N. Tandon; Dr R.K. Srivastava; Dr D.K. Sharma; Dr Sarman Singh; Honourable participants; Distinguished guests; Ladies and gentlemen;

It is my privilege to be here among experts in the field of HIV/AIDS, and I would like to thank the Organizing Committee for the invitation.

The urgency to address the challenge of HIV opportunistic infections is widely acknowledged. I must congratulate AIIMS for organizing this important Conference.

The Conference will take us a long way in improving medical technology to fight these infections. With the increased access to antiretroviral treatment, ART, attention should now be drawn to the management of opportunistic infections.

Information on the pattern of these infections in our Region is increasing. Among 236,000 AIDS cases in Thailand, the three most common opportunistic infections are tuberculosis, pneumocystic pneumonia, and cryptococcal meningitis. Similar evidence is also observed from cross-sectional hospital surveys in India and Myanmar.

Allow me to draw your kind attention to the impact of the most common HIV opportunistic infections on public health gains. HIV is the major factor for the progression of a TB infection to become an active disease. South- East Asia accounts for 34 per cent of the global tuberculosis burden, with 9 million new cases annually. Nearly 7 million of these cases are people living with HIV/AIDS. This is out of a total of 40 million world-wide. This makes our Region the second most affected, after Sub-Saharan Africa.

Regionally, four countries; namely, India, Indonesia, Myanmar and Thailand, account for 99 per cent of people living with HIV/AIDS. These countries, at the same time, are among the states with a high burden of tuberculosis.

The HIV prevalence among new TB cases amounts to 5.2 per cent in India, 6.8 per cent Myanmar, and 8.7 per cent Thailand. Data from Thailand show that a number of these cases are among the younger age groups. The number of TB cases has also increased due to the high HIV prevalence in some districts of Thailand.

An increasing HIV prevalence could adversely impact on tuberculosis trends. This will happen, if we do not take stringent action to stop the spread of HIV infection.

In recent years, some progress has been made in this Region in promoting cooperation between the TB and HIV control programmes. India, for example, under the Global Fund for Fighting AIDS, TB and Malaria has carried out activities which include cross-referral from HIV testing and counselling to active TB screening. The referral is also undertaken from TB treatment centres to HIV case finding facilities.

Important steps have been taken to address HIV care for TB patients who are HIV-sero-positive. HIV surveillance among new tuberculosis cases is being pilot tested in India.

Thailand is moving towards universal coverage for ART, which also include all tuberculosis patients with HIV infection. In north-east Thailand, the proportion of TB patients accepting HIV testing increased from 33 to 58 per cent over two years. It was also shown that nearly 90 per cent of those TB patients, who were HIV-positive, were in need of (antiretroviral treatment) ART.

The morbidity and mortality of TB patients is reduced by 50 per cent, when cotrimoxazole is given. Therefore, the WHO TB/HIV Strategic Plan recommends cotrimoxazole for all TB patients, who are HIV positive.

WHO also recommends that infants born to HIV-positive mothers receive cotrimoxazole for the prevention of pneumocystic pneumonia. During the early decade of the HIV epidemic, 60 to 80 per cent of HIV-positive adults developed this pneumonia, and up to 20 per cent of them died. Mortality was much higher among infants. This happened in the US and Western Europe, when ART was not yet available.

With simple methods for diagnosis and treatment the most common HIV opportunistic infections are now being put under control. We must urgently build up the capacity of medical institutions for effective management of these infections.

With the occurrence of these opportunistic infections, the capacity of health laboratories for correct diagnosis also needs strengthening. WHO/SEARO brought together experts in the field to develop guidelines for laboratory work in this area. These guidelines were published in 2000, and subsequently updated. These are available through the SEARO website.

A “hands-on” training course on diagnosis of these infections has also been organized from time to time.

The diagnosis of opportunistic infections is exclusively dependent on an efficient laboratory infrastructure. This is also true in the case of immunological monitoring of ART.

In 2004, WHO developed Guidelines on HIV Diagnosis and Monitoring of ART. These guidelines were revised last year. This is to keep pace with the evolving development in laboratory technology. The guidelines have been disseminated for widely use in all Member States.

Now, the National AIDS Research Institute in Pune, India, is being considered for designation as a WHO Collaborating Centre in this area. The centre will provide continuous support to countries in HIV diagnosis, monitoring of ART, and surveillance of drug resistance.

In conclusion, I would like to urge the distinguished participants to make optimal use of the knowledge gained so far in the fight against HIV-opportunistic infections. I would also urge that we pursue research for the development of tools for more effective management of HIV opportunistic infections.

We also have to devote more resources and efforts to further develop our laboratory medicine to ensure effective treatment of patients.

I wish the conference all success; and wish you all the best.

Thank you.