Training of Trainers on TB/HIV

Report of the Second Intercountry Course

Bangkok, Thailand, 21-28 February 2006

HIV TB

World Health Organization
Regional Office for South-East Asia

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List of Acronyms

AIDS	Acquired immunodeficiency syndrome
APW	Agreement for performance of work
ART	Anti-retroviral treatment
BATS	Bureau for AIDS, TB and STIs
CAT	Counselling-AIDS-TB
CDC	US Centers for Disease Control and Prevention
CPT	Co-trimoxazole preventive therapy
DOT	Directly observed treatment
DOTS	Internationally recommended strategy for TB control
HIV	Human immunodeficiency virus
HQ	WHO Headquarters (Geneva)
IPT	Isoniazid preventive therapy
IT	Information technology
MoPH	Ministry of Public Health (Thailand)
M&E	Monitoring and evaluation
NAP	National HIV/AIDS Programme
NAPHA	National Access for Antiretroviral Drugs for People Living with HIV or AIDS (Thailand)
NGO	Nongovernmental organization
NTP	National Tuberculosis Programme
PLWH	Person/people living with HIV or AIDS
RIT	Research Institute of Tuberculosis
SEA	South-East Asia

SEAR	WHO South-East Asia Region
SEARO	WHO South-East Asia Regional Office (New Delhi)
STI	Sexually transmitted infection
TB	Tuberculosis
TUC	Thailand MoPH-US CDC Collaboration
VCT	Voluntary counselling and testing
WHO	World Health Organization
WPRO	WHO Western Pacific Regional Office (Manila)

Table of Contents

1 Introduction

The South-East Asia and Western Pacific Regions of the World Health Organization (WHO) carry the highest burden of tuberculosis (TB) globally together accounting for over half of all cases. The HIV epidemic is also posing major challenges to TB control efforts. With over six million cases estimated to be infected with HIV, South-East Asia is second to sub-Saharan Africa while HIV is also a major concern for several countries in the Western Pacific Region. A further spread of HIV may threaten to reverse the gains made in TB control in recent years. The extent of the TB/HIV epidemic in the regions will depend on the future course of the HIV epidemic as well as on efforts to control TB.

Addressing HIV-associated TB is also part of the new "Stop TB Strategy" which builds on the DOTS strategy. It includes preventing HIV infection, preventing progression of latent TB infection to active disease and the provision of HIV/AIDS care and antiretroviral treatment. Tuberculosis disease is the most common opportunistic disease in Asia among people living with HIV/AIDS. While the double stigma of HIV and TB leads to delays in TB diagnosis and treatment, the occurrence of other HIV-related diseases results in higher mortality among HIV-infected TB patients. With scaling-up antiretroviral therapy in the Region, management of TB/HIV will need high attention in both programmes. WHO has been instrumental in bringing the two programmes together and the need for further and intensified collaboration is to be supported at different levels.

The Second Intercountry Training of Trainers on TB/HIV was organized from 21 to 28 February 2006 in Bangkok with field trips to Chiang Rai and Ubon Ratchathani provinces. The following events have contributed to the development of the curriculum package of the course:

- Assignment of Dr Somsak Akksilp, Director of the Office for Disease Prevention and Control Region 7, Ubon Ratchathani, Thailand, to the WHO Regional Office for South-East Asia from 2 October to 25 December 2003.
- First Intercountry Training Course on TB/HIV, held in Bangkok from 14-28 January 2005.
- Informal Consultation on HIV Surveillance in TB patients held in New Delhi from 17 to 18 November 2005.

The course was the result of collaborating efforts between four agencies that made use of the comparative advantage of each individual agency. The four agencies were:

- Ministry of Public Health, Thailand, through the International Training Centre of the Bureau for AIDS, Tuberculosis and STIs, and the Office for Disease Control and Prevention (Region 7).
- The US Centers for Disease Control and Prevention, Atlanta (Division of Tuberculosis Elimination) and Bangkok (Thailand MoPH-US CDC Collaboration or TUC).
- The Research Institute of Tuberculosis, Tokyo, Japan, and its local branch in Chiang Rai.
- WHO's Regional Office for South-East Asia (SEARO) and the Western Pacific (WPRO), Headquarters (HQ) and the Country Office in Bangkok.

Facilitators for this course, provided by the different agencies, had extensive experience in the regions as well as in other parts of the world.

The participants were from seven different countries: Bangladesh (2), China (6), Indonesia (4), Lao PDR (2), Malaysia (2), Thailand (2) and Viet Nam (5). The experience of Myanmar was shared by the WHO Medical Officer for TB based in Myanmar. Participants were national and/or intermediate level officers responsible for TB and for HIV programmes. There were 12 TB and 11 HIV staff, 16 of them were men and seven women.

2 Inaugural Session

The training course was inaugurated by Dr William Aldis, WHO Representative to Thailand, who read out the address of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region.

In his address, the Regional Director reiterated the urgency of acting now to avert a reversal of the positive impact of TB control activities in case the HIV epidemic is allowed to spread unabated. The two WHO Regions – South-East Asia and Western Pacific – together, carry more than half of the global burden. He commended countries in the Region, and Thailand in particular, for the steps they have taken to initiate or expand TB/HIV collaborative activities. He also urged participants to use the knowledge and skills acquired during this training course and to advocate with their own national and local governments to increase the commitment towards fostering collaboration between the two disease control programmes. The Regional Director also hoped that this course will get replicated at the country level in order to accelerate crucial TB/HIV activities. The full text of the address of the Regional Director is in Annex 1.

Dr Sombat Thanprasertsuk, Director of the Bureau of AIDS, TB and STIs, also addressed the participants. He emphasized the high burden for both TB and HIV in Asia in terms of absolute numbers. In Thailand alone, more than one million people were infected with HIV and half of them have already died of the disease. One third of the nearly 50 000 new AIDS patients annually will also develop tuberculosis. He highlighted the need to develop innovative approaches to mitigate both the AIDS and TB problems that are most relevant to resource-limited settings. He also stressed that the policy of cross-screening for TB in HIV and HIV in TB should be routinely applied and called training of relevant cadres of staff to be a crucial starting point in this regard. The full text of Dr Sombat's address is in Annex 2.

3 Objectives

The main objectives of the training course were:

- To have an understanding of the WHO-recommended TB/HIV policies and strategies, including surveillance and interventions for TB/HIV collaborative activities; and
- To design and present a TB/HIV collaborative plan of action.

4 Programme

The course, designed to last for seven working days, was divided into three parts. A half-day facilitators' meeting preceded the course. During this meeting, the entire course programme was discussed and responsibilities for sessions revisited. A pre-test based on 10 questions in the "yes/no" format was conducted to assess the base knowledge of participants. The test was anonymous but coded so that individual comparison with the post-test was possible.

The first three days were mainly devoted to knowledge transfer as well as the sharing of experiences between countries and learning from them. Prior to the course, each country had prepared a poster, which was displayed during the entire tenure. The methodology used included formal teaching sessions supported by powerpoint presentations, focused group discussions (both plenary and in small units) and group work.

Although the facilitators respected the guidelines for the powerpoint presentations in relation to lay-out and duration, it was felt that too much emphasis was put on knowledge transfer thereby reducing the time for active participation by the trainees.

The next two days included of a field trip to either Chiang Rai or Ubon Ratchathani province. The two sites were selected on the basis of their advanced stage of implementation of TB/HIV control activities. The Research Institute of Tuberculosis is using the Chiang Rai setting for its operational research. The key to success at the grassroots level is the involvement of nongovernmental and community-based organisations complementary to the public health services.

The last two days went into incorporating lessons learned during the field visit as well as adapting the key inputs from the more theoretical sessions of the first three days into an action plan. Each country presented its draft version, which was discussed in plenary.

A post-test, identical to the pre-test, was conducted. The closing session also included a course evaluation and a formal closing by Dr William Aldis, WHO Representative in Thailand, and Dr Daranee Wiryakitja, senior medical expert on preventive medicine (TB), who represented the Director-General of the Ministry of Public Health.

The programme schedule is in Annex 3.

5 Curriculum Package

The curriculum adopted for this course consisted of five modules, further subdivided into 12 sub-modules. The modules were adapted from those used in the First Intercountry Training of Trainers on TB/HIV. Each sub-module was assigned to one agency for updating. Compilation and final editing was done at SEARO and electronic copies were distributed at the end of the course to all participants.

5.1 Module 1: Introduction to TB/HIV programmes and policies

The first module consisted of two main parts: Sub-module 1.1 dealt with the global and regional policies and strategies and sub-module 1.2 was a situational assessment at the country level presented through posters. Countries were provided with a generic outline for their posters so that these could be more focused and comparable to each other.

The Interim Policy on Collaborative TB/HIV Activities was presented by Ms Rose Pray from WHO/HQ. She gave a global overview of the TB, HIV and TB/HIV problem. The global answer to address this problem is in line with the DOTS and new Stop TB Strategy, linked to the Global Plan to Stop TB (2006-2015). The Interim Policy builds on the field experience with the early ProTEST[1] initiatives and other TB/HIV pilot projects conducted in various countries in the world including Thailand. It complements the

Box 1: People reached with various TB/HIV collaborative activities (global data)

TB intensified case finding in PLWH (2004):	115 899
PLWH benefiting from IPT (2004):	12 017
TB patients tested for HIV (2003):	132 238
HIV-positive TB patients notified (2003):	27 788
TB/HIV benefiting from co-trimoxazole preventive therapy (2003):	8 305
TB/HIV benefiting from antiretroviral therapy (2003):	9 428

[1] ProTEST: WHO-led initiative to promote testing for HIV using voluntary counselling and testing as entry point to a range of TB/HIV/STI prevention and care interventions

Strategic Framework to Decrease the Burden of TB/HIV – providing the rationale for TB/HIV collaborative activities – and the Guidelines for Implementing Collaborative TB and HIV Programme Activities. The Interim Policy devolves around three objectives and ten major activities. Of all the countries in the world, 106 indicated that they are currently implementing a policy of offering HIV testing and counselling to all TB patients. Box 1 provides an overview of the coverage of various collaborative activities.

The group was split in two on the basis of the WHO Regions for the session on regional perspectives on TB/HIV. The Regional Strategic Plan On HIV/TB (countries of the SEA Region) and the Framework to Address TB/HIV Co-infection in the Western Pacific Region were simultaneously presented and discussed.

The SEAR strategic framework provides four main strategic directions: (i) preventing HIV transmission; (ii) preventing progression of latent TB infection to active TB disease; (iii) reducing morbidity and mortality of HIV-associated TB and (iv) strengthening health systems response to TB/HIV. Apart from offering a menu of potential activities, it also provides guidelines for prioritizing TB/HIV collaborative activities based on the country's (or sub-national entities in larger countries) epidemiology of HIV. The plan also provides a guideline for implementation.

The strategic framework for the Western Pacific is tailored to the "high TB, low HIV" burden prevailing in most of its Member countries as well as to the environment of a strong government ownership of the TB programme and multiple players in HIV/AIDS. It is based on the global framework and aims for collaboration between the TB and HIV programmes by making use of the strengths of each to complement each other. The strategy is conceptualized around four interlinked areas: Surveillance on TB/HIV; interventions for intensified case finding; interventions for treatment and care; and, collaboration between the TB and AIDS programmes which includes the establishment of appropriate referral mechanisms. Guidelines are provided to select the most important activities based on the epidemiological classification of TB/HIV.

The purpose of the regional sessions was to give an overview of the regional strategies. The details of the proposed strategies and collaborative activities were worked out in Modules 3 and 4.

5.2 Module 2: TB/HIV epidemiology and surveillance

The module was facilitated by staff from the US Centers for Disease Control and Prevention (CDC).

Sub-module 2.1, presented by Dr Jay Varma from the Thailand MOPH-US CDC Collaboration (TUC), recapitulated the epidemiology of TB, HIV and TB/HIV. The three levels of the HIV epidemic were elaborated as generalized, concentrated and low-level epidemic. The presenter highlighted the negative impact of HIV on TB through an increased risk of progression to TB disease, the increased difficulty for

diagnosing TB infection and disease as well as for treating TB and the additional social implications brought by HIV. He also explained the impact of TB on HIV and the implications on TB control programmes in settings with a high HIV burden. This was illustrated with data from Africa as well as from studies undertaken in the Region (Cambodia, Thailand and Viet Nam).

Sub-module 2.2 on TB/HIV surveillance was presented by Dr Kevin Cain from the Division of TB Elimination, CDC-Atlanta. He highlighted the different strategies for HIV surveillance including sentinel surveillance, population-based surveys, AIDS case reporting, mortality surveillance and behavioural surveillance. The TB surveillance system is a key component of the DOTS strategy based on cohort analysis from periodically submitted aggregated data which are compiled from individualized case notifications. The system allows determining individual patient outcomes, surveillance as well as programme performance monitoring.

HIV surveillance in TB patients is useful for HIV-related morbidity and mortality surveillance and to estimate the number of candidates for antiretroviral treatment. It contributes to a better understanding of the TB/HIV epidemiology. It also helps in planning and resource allocation as well as in evaluating impact of interventions. The WHO technical guidelines on HIV surveillance in TB patients – depending on the level of HIV epidemic – were explained (sentinel survey, periodic survey or routine data collection). This also included the strategic approaches to undertake serosurveys (linked or unlinked, anonymous or confidential).

The rationale with regard to TB surveillance in HIV care and treatment settings was explained. This included measuring an important cause of morbidity and mortality (TB is *the* opportunistic infection in this part of the world), measuring the impact of HIV/AIDS care and treatment programmes, and evaluating other interventions such as intensified case finding, isoniazid and co-trimoxazole preventive therapy and antiretroviral treatment. Methodological and logistical issues were also elaborated.

5.3 Module 3: TB/HIV interventions

This module, to which an entire day was devoted, provided the bulk of knowledge that the course aimed to transfer to the participants. It was divided into four sub-modules: Review of TB and HIV interventions (facilitated by WHO/SEARO); HIV testing and counselling (WHO/WPRO); preventing progression of latent TB infection to active TB disease in HIV-infected persons (WHO/WPRO); and, HIV/AIDS care and treatment for TB/HIV co-infected individuals (WHO/SEARO). A handout on behavioural interventions prepared by RIT for the First Intercountry Training of Trainers on TB/HIV was included in the participants' folders, but this fifth sub-module was not discussed during this year's training course. Most of the sub-modules were presented in plenary using powerpoint followed by discussions.

Review of TB and HIV interventions

The first sub-module was further subdivided into four sections, systematically recapturing basic elements of TB and HIV control. Dr Erwin Cooreman from WHO/SEARO gave an overview of the basic facts of tuberculosis and tuberculosis control. He explained the difference between infection and disease, primary and post-primary disease, diagnostic investigations, differential diagnosis, principles of treatment and elements of TB control (covering DOTS and the new Stop TB strategy).

Dr Ying-Ru Lo of WHO/SEARO reviewed the most important knowledge points for HIV/AIDS. These included a natural history of AIDS and the proposed revised WHO clinical staging for adults and adolescents, and infants and children. She also elaborated on the continuum of care which covers the entire spectrum from prevention to care and treatment. The HIV epidemic as it occurs in this part of the world remains focused in specific populations. Focused interventions do work, as is clearly demonstrated in studies in the Region, she pointed out.

Dr Hans Kluge of WHO-Myanmar outlined the mechanisms for controlling TB transmission in health care facilities. There are three levels of infection control measures, in order of decreasing priority: (i) administrative or managerial measures; (ii) environmental control measures, and (iii) personal respiratory protection.

The last part in this sub-module included a presentation by Dr Ying-Ru Lo on controlling HIV transmission in health care settings. The discussion focused on treatment policies on occupational exposure to HIV and post-exposure prevention.

TB/HIV testing and counselling

Sub-module 3.2 was titled "HIV testing and counselling". Coordinated by Dr Michel Tailhades (WHO/WPRO), it comprised a powerpoint presentation followed by discussions and two role plays. Programmes are still confronted with the challenge that the overall majority of people infected with HIV do not know their status. The following guiding principles should be abided with: confidentiality, pre-test counselling, informed consent and post-test counselling. Four types of HIV testing can be distinguished: (i) Client-initiated voluntary counselling and testing; (ii) routine offer of HIV testing; (iii) diagnostic HIV testing (which includes offering HIV testing to all TB patients as part of routine management), and (iv) mandatory HIV screening. The latter three are initiated by the health care provider.

Identifying HIV carriers among TB patients may provide an opportunity for appropriate interventions such as co-trimoxazole preventive treatment or treatment of other opportunistic infections.

The rationale and spectrum of different HIV tests were elaborated. The topic for the counselling was also presented from a technical point of view. The session concluded that HIV testing and counselling must be implemented on a broader scale to meet the

increasing demand for access to care and prevention services. This would require moving to routinely offering HIV testing in clinical management services (including TB clinics) where HIV-infected people are more likely to be present. The scaling-up of testing and counselling services must be accompanied by comprehensive advocacy and communication efforts to destigmatise the people accessing such services.

Participants were divided into small groups. Based on examples taken from real-life practice, they were trained in providing appropriate pre-and post-test counselling. Participants acted as counsellor, patient or family member in different role plays. All participants worked together to identify questions and counselling. The main issues arising from these plays were discussed in plenary.

Isoniazid preventive therapy

Dr Pieter van Maaren (WHO/WPRO) in his presentation focused on the usefulness of isoniazid preventive therapy (IPT) for the individual patient as well as for national programmes.

Isoniazid reduces the risk of developing TB in HIV-positive persons and of recurrent TB in HIV-positive persons who completed a course of anti-TB treatment. However, the success of the intervention depends on the following factors: targeting appropriate individuals, excluding active TB, delivery of IPT, and compliance. The usefulness of IPT as a measure to reduce the burden of TB in communities with a high burden of HIV is not demonstrated.

IPT is safe when applied under recommended circumstances. It does not contribute to drug resistance. Active disease should, however, be ruled out at all times. Adequate capacity for HIV counselling should be available as well as linkages between HIV care and TB control services.

Antiretroviral treatment (ART) has a limited role in reducing the need for IPT, mainly because ART reduces the risk for TB most in patients with WHO clinical stage 3 or 4 or in those with a CD4 T-lymphocyte count of < 200/mm^3. ART may also provide additional benefits in reducing the risk of recurrent TB. The risk of TB in HIV patients in stage 1 or 2 may not be as high as in later stages, and therefore may make IPT less cost-effective. The presenter concluded that IPT may be beneficial for the individual but its overall benefit has not been proven.

HIV/AIDS care and treatment for HIV-infected individuals with active TB

In this sub-module Dr Ying-Ru Lo presented the current status of anti-retroviral treatment, its indications and mode of delivery.

The TB-related mortality rate among HIV-positive patients is higher than in HIV-negative patients. This rate may also be induced by late diagnosis or inefficient TB treatment. However, the big disparity is proven to be the direct result of the HIV co-infection. The lack of knowledge of HIV status denies HIV-positive patients the access to prevention or treatment of other common opportunistic infections as well as to ART. Co-trimoxazole preventive therapy significantly decreases mortality as well as hospital admissions in HIV-associated active TB.

The correct combination of antiretroviral drugs has resulted in dramatic decreases in HIV-related morbidity and mortality. As most HIV-positive TB patients are in stage 3 or 4, they are eligible to receive ART, which also reduces the TB case-fatality rate, TB treatment under DOTS needs to be initiated promptly regardless of the HIV status.

The presenter gave an overview of the most recent guidelines of providing ART to TB patients, both adults and children. This includes identifying the time of starting ART (as soon as TB drugs are tolerated, at the end of the intensive phase or after completing the treatment), the combination of antiretroviral drugs and the role of CD4 T-lymphocyte counts. The co-management of both diseases is challenging due to drug interactions, pill burden, drug toxicity and immune reconstitution syndrome. Adherence to ART is even more important than in TB due to the extremely quick development of drug resistance. More than 95% adherence is required to avoid treatment failures.

Following the presentation, participants were asked to work in small groups on facilitator-guided exercises for which worksheets were provided.

5.4 Module 4: TB/HIV planning, management, monitoring and evaluation

There was no formal teaching session for sub-module 4.1 on planning and management coordinated by CDC. Participants were working in small groups according to their country or a group of countries. Each group was assigned a facilitator who provided a brief introduction. Instructions for the group activity were outlined in an activity sheet. The handout provided a chapter which served as reference material. Participants had a fair idea of the most important elements in the planning cycle of collaborative TB/HIV activities after a perusal of all the questions and exercises.

The roll-out of these activities would broadly follow the following five steps: (i) Establishing collaboration through setting up a TB/HIV coordinating committee; (ii) conducting a situational assessment; (iii) developing a policy and strategic plan; (iv) preparing the health services and the community to implement the policies and strategies, and (v) monitoring and evaluation. Each topic was accompanied by a set of key questions which were discussed in group sessions. The process of answering those questions guided participants in their thinking on how to carry forward the

implementation of the most important TB/HIV collaborative activities in their own settings.

Ms Rose Pray, WHO/HQ, coordinated the sub-module on monitoring and evaluation (M&E). Working along a well-defined plan and monitoring the implementation of the different steps is increasing the efficiency and effectiveness of the programme. While progress can be documented and problems identified, it also promotes accountability of the programme managers at various levels. This in turn will contribute to attracting necessary funding allocations from government or donor sources.

The presenter explained the difference between monitoring and evaluation and the steps in developing an M&E plan were elaborated. The M&E framework is directly linked to the programme goals and objectives. Relevant indicators need to be selected that allow monitoring input, process, output, outcome and impact. It is important that programmes select only the most relevant indicators that can be adequately measured. Information should be available with no or only minimal need for additional data collection.

5.5 Module 5: Translating knowledge and lessons learned into action planning

Sub-module 5.1 reviewed the field visits (see chapter 6).

In sub-module 5.2, participants were asked to write, according to their country, an action plan for implementing TB/HIV activities. They were allowed to work on a real or fictitious project in their country. The knowledge and skills acquired during this course and in particular the examples observed first-hand during the field visits helped them to understand their respective settings from a very pragmatic perspective.

The participants spent a day on the preparation of their action plan. One or two staff facilitated the session in each country group. Most groups held extensive discussions among them to come up with an action plan even for a fictitious project. In fact, for some countries this was the first time that the NTP and NAP manager were working closely together.

Participants were given a hand-out with a simple guideline on how to structure an action plan. This outlined the following elements: Title, justification, goal/objectives, implementation area/level of implementation, beneficiaries, duration, responsible persons/stakeholders, steps for implementation and timeline, evaluation, and budget.

On the second day, the participants were given time to make a short powerpoint presentation on their country action plan. This was then presented in a plenary session where critical peer review was provided by all other participants and facilitators. Proposed plans varied from conducting selected TB/HIV activities in one hospital or district to a comprehensive set of collaborative TB/HIV activities at the national level.

In spite of the fact that the participants were not formally mandated or not in a position to decide on the execution of their action plans, it was considered a useful exercise that strengthened their capacity to write their own setting-specific proposals. Some of the proposed plans were of very high quality and could be ready for implementation.

6 Field Visits

6.1 Introduction

Two field visits were organized by the Research Institute of Tuberculosis (RIT), Chiang Rai branch (Chiang Rai province), and the Office of Disease Prevention and Control Region 7 (Ubon Ratchathani province) respectively. The participants were divided into two groups: Those from Bangladesh and Thailand went to Ubon Ratchathani and the participants from Lao PDR and Malaysia joined the Chiang Rai group. Participants from China, Indonesia and Viet Nam were divided equally between the two destinations.

Dr Somsak Akksilp, Director, Office for Disease Prevention and Control Region 7, outlined the objectives of the field visits and provided an overview of the organizational set-up of the healthcare system in Thailand and the TB/HIV situation in the country. The HIV burden in Chiang Rai province is considered as quite high while it is relatively low in Ubon Ratchathani province.

The field visit lasted for two days during which both groups visited the Regional Office of Disease Prevention and Control, the provincial public health office, one regional (referral) hospital, one community or district hospital, one rural health facility (only in Chiang Rai), an NGO and a PLWH group.

The objectives of the field visits were to: (i) observe and discuss TB/HIV collaborative activities implemented in the public healthcare system, particularly at the provincial, district and community levels; (ii) learn lessons relevant to implementing TB/HIV collaborative activities in the participants' respective countries based on enabling factors and barriers identified in the places visits, and (iii) formulate recommendations for improving TB/HIV collaborative activities in the places visited.

6.2 Chiang Rai province

The following sites were visited: Chiang Rai Prachanukroh regional hospital, Chiang Saen district hospital, Chiang Saen district health office and Wiang sub-district health centre.

The participants were welcomed at Chiang Rai Regional Hospital by Dr Supak Pitipakorn on behalf of the Director. Dr Surin Sumanapun, Deputy Provincial Chief Medical Officer, gave an overview of the provincial health system and disease profile. The provincial TB coordinator interacts and coordinates with the regional hospital, all 18 community hospitals and the two private hospitals. Health centres are also linked to either a community hospital or the regional hospital. Dr Sumanapun also gave an overview of the HIV/AIDS epidemic in Chiang Rai province and the response to it by the health sector. Pulmonary tuberculosis is the most frequent opportunistic infection. The incidence of new HIV infections in high-risk groups – particularly in female sex workers, pregnant women and blood donors – has been brought down substantially through specific planned interventions. This was possible through the implementation of targeted interventions at all levels and appropriate strategies tailored to the local level with the cooperation from all sectors.

Dr Norio Yamada from RIT presented the results of the TB/HIV research project supported by RIT that was conducted in Chiang Rai province. Routinely collected data that provided information allowing for trends analysis over the last 15 years shows the overall number of new TB cases, co-infected with HIV, to have peaked in 1998. A retrospective study reveals the effect of IPT on reducing the incidence of TB: enrolment in a day care centre programme reduces the drop-out rate in IPT by almost 50%. The introduction of ART led to a significant reduction in the incidence of TB among PLWH. With the increase in the number of HIV co-infected TB patients receiving ART before or during TB treatment, the mortality rate of HIV co-infected TB cases also shows a declining trend.

Dr Pacharee Kantipong, Chief of the Department of Medicine, made a presentation on the challenges of integrating TB and HIV care in Chiang Rai Prachanukroh Regional Hospital. HIV figured in the top five of indications for hospital admissions in 2003 along with accidents, pneumonia, COPD, hypertension and chronic renal failure. All TB patients are offered HIV counselling and testing, enabling more than 85% of them to know their HIV status. Although default and mortality rates are still unacceptably high, the treatment success rate has increased to 43% and 72% in HIV-positive and HIV-negative TB patients respectively. The hospital has also prepared its own strategic plan for TB control tailored to area-specific needs. This includes a chapter on TB/HIV with relevant activities and indicators which is overseen by the "CAT (counselling-AIDS-TB) team", a local coordinating body. Antiretroviral treatment is provided with support from NAPHA[2]. The hospital provides clear guidelines for diagnostic investigation, treatment and care as well as a referral mechanism between the TB and HIV programmes. These are in line with national and international recommendations. The participants visited different sections of the hospital, including

[2] NAPHA: National Access for Antiretroviral Drugs for People Living with HIV/AIDS. Napha in Thai means "sky", which indicates ad degree of hope and aspiration that went into the acronym.

the TB clinic, VCT unit, TB/HIV clinic, laboratory and patients' ward, in smaller groups.

Dr Ittipol Chaita, Director, Chiang Saen district hospital, presented the epidemiological data on TB, HIV and TB/HIV for Chiang Saen district. The same methodology as in the regional hospital was followed. The treatment results are still negatively influenced by high mortality due to the large number of patients co-infected with HIV and a high default rate, particularly in patients residing in Lao PDR or Myanmar. Operational research to address issues most relevant to the district is also coordinated by the hospital and RIT. Current operational research activities focus on increasing the coverage of the PLWH network through regular activities at the day care centre, ensuring TB education for PLWH and improving treatment adherence.

On the second day of the field trip the participants visited the district health office in Chiang Saen. The role of the health office and health centres for TB/HIV activities was explained to them during the visit. The group moved then to the Wiang sub-district health centre where they visited the day-care centre Ban-Sop-Kham. They attended the PLWH meeting to observe the TB/HIV-related activities undertaken by the PLWH groups in the district and the role of health volunteers and local government was impressed upon them.

6.3 Ubon Ratchathani province

The following places were visited: Office of Disease Prevention and Control Region 7, Ubon Ratchathani; Provincial Public Health Office, Ubon Ratchathani; Sapphasittiprasong regional hospital; Warinchamrab community hospital and Sa-Dao-Wan (PLWH group) office.

Drs Somsak Akksilp and Opart Karnkawinpong presented the national, regional and provincial programme activities in relation to TB/HIV. Capacity building of various levels of health staff through training, supervision and providing feedback on M&E findings is given due attention. A clear policy stipulating the role played by different actors and referral mechanisms is available, which serves as a guideline for the different health institutions. A wealth of meticulously recorded data is available for further analysis, which will provide additional evidence for strategizing programme activities.

Dr Wuttikrai Mungmai, Provincial Chief Medical Officer, and Dr Suwit Rojjanasaksotorn, Deputy Chief Medical Officer, outlined the TB and HIV situation in Ubon Ratchathani province. Their presentation included a statement on the province's vision and mission as well as an overview of the infrastructure, staffing and disease profile. The number of AIDS notifications has registered a declining trend since 2000. The DOTS programme is now implemented in all districts. Provincial targets focus not only on improving success rates but also on reducing default and mortality rates. Though these targets have not yet been reached, there is a positive

trend for all indicators. Clear guidelines, functional team work and effective supervision are key to improving results.

Dr Kawee Chaisiri, Director of Suppasitthiprasong Hospital, welcomed the group. Dr Prapis Theparakkul, Chief of Internal Medicine Section, briefed them on the hospital's policy and activities related to TB and HIV. All TB patients are offered HIV counselling and testing. More than two thirds of the patients agree to the test, which is a definite improvement over the past few years. Treatment results have also shown discernible improvement. As the hospital is a well-established referral facility, patients are recruited from beyond the proper catchment area making it more difficult to monitor individual follow-up. The group toured the TB clinic, the HIV clinic, the laboratory section and the patient wards.

The group was welcomed at Warinchamrab community hospital by Dr Charoen Serirattanakorn, Director of the hospital. Dr Nonthaya Pookphan shared the experiences of the hospital's TB/HIV activities. The clinical department provides TB and HIV services through its TB clinic and HIV counselling clinic with the hospital having a clear policy on the management of both diseases. This includes organizing VCT services, screening for TB and other opportunistic infections, conducting sputum, X-ray and CD4 tests, referring patients between the two clinics as well as to the day care centre and the Sa-Dao-Wan group. The latter is supported through the international NGO SHARE.

Ms Shirota Kanae from SHARE explained the role played by the NGO in supporting the HIV programme. SHARE interacts closely with people affected by HIV through its ability to reach out to small groups and individuals. The set-up of the Sa-Dao-Wan group contributes to destigmatizing HIV and empowering patients and families affected by it. The Sa-Dao-Wan group runs a health counselling clinic at the community hospital. They also provide support to all HIV patients attending the hospital and conduct home visits. The Sa-Dao-Wan group and SHARE render important services that are complementary to the more clinically-oriented hospital activities. The team visited the Sa-Dao-Wan group adjacent to the hospital for a first-hand look at their activities.

6.4 Feedback

The two groups were asked to present the main findings of their field visits to the plenary following their return to Bangkok.

The group that visited Chiang Rai province reviewed each place visited on the basis of three parameters: Mechanisms for collaboration, decreasing the burden of TB in PLWH and of HIV/AIDS in TB patients. They concluded that the stated results can be achieved through an intensive collaboration between the TB and HIV programmes at all levels. There were several key factors contributing to the current success: Since HIV/AIDS

preventive activities were well established, incorporating TB-related activities into the routine programme was not too difficult. The province has a strong primary healthcare infrastructure and the 30 Baht scheme had further improved the access to TB and HIV services. The programmes also receive substantial external support (both financial and technical) and benefits from strong partnerships. The team recommended that the strengths of the current programme are improved and the voluntary activities undertaken formalized. It also called for the strengthening of the management aspects for implementing TB/HIV collaborative activities and stressed the importance of the human resources component, in terms of numbers of staff, tasks to be performed and role of oversight. The evidence generated through the RIT-supported operational research should be maximally used for guiding implementation of routine activities in the province and beyond, it was recommended.

The group that visited Ubon Ratchathani province reviewed each place visited in the light of identical parameters. The most important gains listed included a commendable series of local initiatives and "learning by doing" approach, the availability of clear guidelines and the capacity of the service points. The programme benefits from the strong commitment of the public health system, support at the grassroots level through a patient group and an NGO, and an excellent data surveillance system. Weaknesses evaluated included the sub-optimal links between the regional hospital and lower tiers of the healthcare system. The visiting team's recommendations included improving the linkages between the regional hospital and other health facilities, further raise levels of involvement of the community, promote specific interventions for early case detection, start the ART delivery earlier and strengthen the DOT component in TB control.

7 Local Arrangements

Logistics and other local arrangements were taken care of by the International Training Center of the Bureau for AIDS, TB and STIs. For this purpose an Agreement for Performance of Work (APW) was concluded between the WHO-Thailand office and the Bureau.

The APW covered the following elements: Coordinating in-country travels for the field trips; organising for hotel accommodation and lunch, preparing an information packet;; setting up meeting rooms for the plenary and breakaway sessions; contacting additional resource persons in Bangkok as well as in Chiang Rai and Ubon Ratchathani; facilitating payment of daily allowances; purchasing training supplies; providing soft copies of all training material and presentations at the conclusion of the course; setting up of adequate IT infrastructure with internet facilities and providing for secretarial support during the entire course.

7

8 Assessment

A formative evaluation was conducted at the end of the course using a form. In addition, participants were requested to provide feedback on the modules on a daily basis. A facilitator's meeting that was held daily summarized the key areas of strength and weakness that emerged during the day while chalking out a basic plan for the following day. Annex 5 provides the course evaluation form and the response obtained from 20 participants. The evaluation was anonymous. Overall feedback from the responders was satisfactory with all rating the course as either 'excellent' or 'good'. Technical issues were rated very highly by the participants.

Course evaluation for training material

All participants who submitted the questionnaire rated the training material (folder and handouts) as 'excellent' or 'good'. Only one respondent rated the powerpoint presentations and lectures as 'fair', two marked the same for the exercises and worksheets.

Answers to the close-ended questions revealed that all sessions, modules and sub-modules were found to be useful. Only a couple of respondents evaluated the various sub-modules as 'somewhat' useful. While only one person thought that the course cannot be replicated at the country level, one other opined that only some sections could be adapted. Thirteen participants were convinced that the course can be tailored for country use. One person did not agree with the inclusion of the development of an action plan in the course. There was, however, full agreement on the appropriateness of all exercises.

Course evaluation for learning methodology

The interplay of formal lectures with powerpoint presentations and small-group plenary discussions was considered very useful although several participants would have preferred a less formal method of teaching and more time earmarked for discussion. Of 19 respondents, 11 thought the duration of the course (seven working days) was optimal; three people voted for five days as sufficient while five participants said they preferred a 10-day course. The formula of plenary sessions in Bangkok and field visits was considered the best by 14 out of 20 respondents. Three respondents voted for a field visit in or around Bangkok and two said they would prefer to have the entire

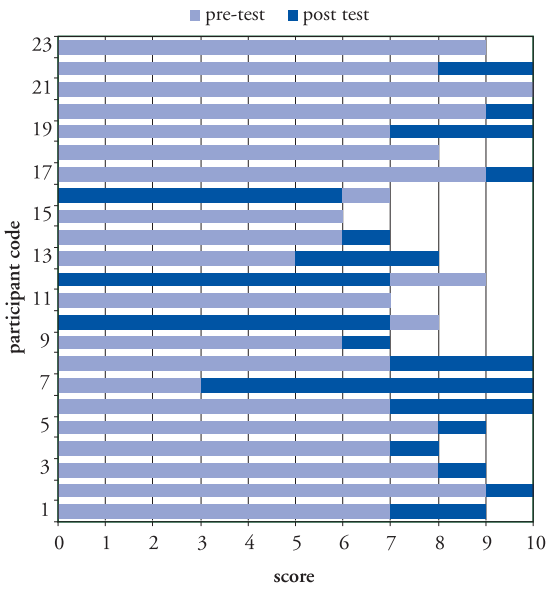
course conducted at one of the field stations. Though one participant found the field visit dispensable, 13 others explicitly voted it the "best liked activity". The group work activities, select modules, training methodology, the possibility of learning about another country's health system and the scope for interaction with participants from other countries were also rated highly. However, participants felt that that too much information was sometimes given in lectures that were too long, leaving inadequate time for group work and different modules or sub-modules. The expertise of some of the interpreters during the filed visits was also found wanting by some of the participants.

Pre- and post-tests

The participants' level of knowledge was assessed in a pre-test consisting of 10 questions to be answered in the 'yes/no' format. The same set of questions was asked in a post-test. The pre- and post-tests were "anonymous but linked" i.e. participants could not be individually identified but the improvement in each of them after the course could be assessed since the pre- and post-test papers were coded identically.

The pre-test showed an average score of 7.4 with a median score of 7. The post-test results showed an average of 8.6 and a median of 9. The individual performance in pre- and post-tests is shown in Figure 1. In the post-tests five questions were correctly answered by all participants. The tests were very similar to those conducted in the First Intercountry Training of Trainers on TB/HIV, wherein participants scored 6.3 on average in the pre-test.

Fig.1: Results of pre- and post-tests



Logistic arrangements

Participants stayed at Hotel Maenam Riverside in Bangkok, which was rated as 'excellent' and 'good' by 3 and 15 participants respectively. All participants expressed happiness with the transport facilities while only two disapproved of the quality of meals and the recreation opportunities offered. The administrative support and the infrastructure at the training venue was appreciated by all those who attended.

9 Conclusions and Recommendations

9.1 Conclusions

Participants and facilitators were very satisfied with the proceedings of this training course. Participants expressed their confidence in supporting the roll-out of appropriate TB/HIV activities in their countries and said the objectives of the training session had been achieved..

This training course could benefit from contributions from the different partner agencies. The presence of facilitators and participants from the WHO Western Pacific Region also contributed considerable to the success of the training course. The collaboration between the organizing agencies may be deemed excellent and should be further exploited for participation in and strengthening of each others' activities.

It was felt that the participants may not be equipped to act on their own as trainers and hence there was the need to devolve this course independently at the country level. However, in order to have a wider impact within countries, some of them would like to conduct similar courses at the national level with participation from provincial- or district-level staff.

The modules were considered appropriate after having been field-tested twice. The field visits were conceived as a very crucial element of the training course and an increase of their number was recommended.

9.2 Recommendations

The following activities were recommended in order to improve the efficiency and effectiveness of the course and the expansion of TB/HIV collaborative activities:

(1) The collaboration between the WHO South-East Asia and Western-Pacific Regions should be enhanced functionally since countries in both regions have common ground to tread in the field of TB and HIV control.

(2) Technical partners, particularly WHO, CDC and RIT, should continue extending technical and scientific support to specific TB, HIV and TB/HIV operational research activities to generate further evidence from within countries in the region.

(3) Countries should with support from WHO and its partners replicate and tailor this course to allow in-country training to accelerate the implementation of TB/HIV collaborative activities down to the operational level. Countries should be given, as part of a national training course, the opportunity to organise a study tour to Thailand for participants to experience the actual TB/HIV programme implementation.

(4) The title of the training course should be changed so as not to create expectation that participants would emerge as full-fledged master trainers.

(5) The training methodology should be reviewed by a specialist so that an optimal mix of knowledge and skill-building training methods based on principles of adult learning can be adopted. More group activities should be provided for during the first two days of the course.

(6) A facilitator's guide should be prepared.

(7) The deadline for nominations by countries should be respected, so that the final list of participants is known in advance and relevant materials can be distributed ahead of the course.

Annex 1

Address by Dr Samlee Plianbangchang,

Regional Director, Who South-east Asia Region
(Delivered by Dr William Aldis, WHO Representative)

I have the honour to present greetings from Dr Samlee Plianbangchang, Regional Director of the WHO SEA Region, to the organizers of this training course and to its distinguished participants. As the Regional Director is unable to be present, I have the privilege of delivering his address. I quote:

It is with great pleasure that I welcome you all to the Second Intercountry Training of Trainers on TB/HIV in Bangkok. I welcome, in particular, those who have joined us from countries in the WHO Western Pacific Region. I also welcome our partner agencies and observers.

That there is an urgency to address the challenge of HIV-related tuberculosis is widely acknowledged and understood. As the HIV epidemic spreads in our Member countries it threatens to destabilize already overstretched health systems. Major gains achieved in disease control, and in particular TB control, may be undone. The achievements over the last 10 years through the implementation of the DOTS strategy can be reversed if HIV is allowed to spread unabated.

As you all know, our two Regions – South-East Asia and the Western Pacific – together count for more than half of the global tuberculosis burden. The number of HIV cases is also increasing dramatically is some countries which already suffer from a high tuberculosis burden. This could adversely impact trends in tuberculosis incidence if we do not take stringent action to stop the spread of HIV infection.

Some progress in TB/HIV control has been seen in both Regions in recent years. Thailand has achieved universal coverage for antiretroviral treatment, including all HIV-infected tuberculosis patients; there is an increased uptake in voluntary HIV testing after routine counselling and offering of HIV testing to tuberculosis patients. Myanmar and India are also strengthening their surveillance systems for HIV among TB patients. Nepal and Indonesia, both countries with concentrated HIV epidemics, have plans to expand their initial TB/HIV pilot programmes. Countries located in the Western Pacific Region have documented major progress as well.

All these initiatives contribute to the growing body of evidence on TB/HIV in the Region. We recognize that the HIV epidemic and its overlap with TB in Asia differs from other regions in the world and, therefore, necessitates an approach tailored to effectively address TB/HIV in this part of the world. I believe that the way the TB/HIV issue is being addressed in this part of the world, through a set of collaborative activities in line with regional strategic plans, is an excellent and very relevant entry point to foster collaboration between our two Regions.

This course is building on the first course held here a year ago. It incorporates the new evidence that has emerged over the last year from the pilot projects that were set up in the Region. It aims at building capacity to adequately address the problem of TB/HIV at the country level. The planned field visits will offer you an opportunity to gather first-hand experience and to observe the "real life" situation. There are lessons to be learnt from how Thailand is tackling TB/HIV as well as from experiences in other countries to help you in drafting your own country-specific action plans.

I expect that participants will return to their countries and make good use of the knowledge and skills acquired for developing sound country-specific policies, formulating strategies and plans, and translating these plans into concrete activities. All participants should advocate with their own national and local governments to increase the commitment towards fostering collaboration between the tuberculosis and HIV programmes.

I would like to thank the collaborating partners who are contributing in the development of the training package for this regional course, and in particular the Ministry of Public Health, Thailand through its Bureau for AIDS, TB and STIs; the US Centers for Disease Control and Prevention, Bangkok and Atlanta; the Research Institute of Tuberculosis; as well as our colleagues from the WHO Western Pacific Regional Office and from WHO Headquarters.

I am confident that the curriculum package, as it is presented this year, can be further tailored to country needs. It can be considered as a generic package based on which country-specific modules can be developed. WHO and its partners are committed to support this process. Devolving this regional course into country courses is the next logical follow-up and should lead to an accelerated roll-out of the most crucial activities.

I also would like the partner and funding agencies who have taken up this cause to generously support activities emerging as a result of this course.

Finally, let me wish all of you a fruitful course, valuable exchange of information and experiences and a pleasant stay in Bangkok. Thank you very much.

Unquote.

I will, of course, apprise the Regional Director of the outcome and recommendations of this training course. I too would like to take this opportunity to welcome you all and wish you fruitful interaction and a pleasant stay in Bangkok.

Annex 2

Address by Dr Sombat Thanprasertsuk,

Director
Bureau of AIDS, TB and STIs

It is my great pleasure to be present here among experts on TB and HIV from WHO/SEARO and WPRO, from CDC and RIT, as well as distinguished participants from countries in the two regions who are participating in the Second Intercountry Training of Trainers on TB/HIV. On behalf of the Director-General of the Department of Disease Control and on my own behalf, I wish to extend my warmest welcome to all of you to Bangkok and the training course, locally organized by the International Training Center (or ITC) which was recently established under the Bureau of AIDS, TB and STIs. Dr Thawat Suntrajarn, Director-General, sends his greetings and regrets that he is unable to be here today to meet with all of you due to other urgent business.

As you are all well aware, the present situation of TB and HIV/AIDS still poses a serious threat to the public, particularly in countries in South-East Asia and the Western Pacific. It is here in this Asia region that a tremendous number of HIV/AIDS and TB patients are found, a number that has increased rapidly during recent years. For example in Thailand alone more than one million people have been cumulatively infected with HIV. Of these, approximately 500 000 have passed away while nearly 570 000 are still living with the infection. It has been estimated that every year for at least another five years, 40-50 000 new AIDS cases will emerge. It is interesting to observe that approximately one third of these new AIDS patients will also suffer from tuberculosis. Similar to the Thai experience, the number of TB/AIDS patients has increased much in many countries with a high TB burden.

It is especially a great challenge for us, from countries with limited resources, to seek innovative programmes and interventions to mitigate both AIDS and TB. WHO/SEARO is to be lauded for introducing policy and implementation guidelines to integrate and combine TB and HIV/AIDS activities. I am sure that it is most rational that screening of TB be applied and offered to all HIV-infected patients. If people infected with HIV are found to have TB, a proper TB and AIDS treatment should be

provided without delay. Similarly, the TB control programme should be prepared to offer voluntary counselling and testing for HIV and follow-up and treatment for both TB and HIV/AIDS as well.

Training to improve skills and practice for trainers in these regions to facilitate the development of TB/HIV/AIDS policy and the implementation of TB and HIV/AIDS work in each country, I believe, is a good start. However, a lot depends on the countries' determination, commitment and political will as well as on TB/HIV health professionals. Therefore, I would like to urge all of you to make full use of your time here at the training course and learn from the experts as well as from each others' valuable experience.

I would like to take this opportunity to thank all involved in making this training course possible, particularly the World Health Organization, SEARO and WPRO, Thailand MoPH-US CDC Collaboration, the Research Institute of Tuberculosis as well as all resource persons for their contribution and valuable guidance and support to the course. I am very appreciative that the Thai Department of Disease Control has been given the role of hosting the training course and ITC that of the local organizer.

Finally, on behalf of the Department of Disease Control, I wish all participants and organizers a successful training session. I also do hope that all of you will enjoy this intercountry training programme and your stay in Thailand. There are a lot of pleasant things Thailand is offering and I do hope you will bring back fond and lasting memory home.

I now declare the Second Intercountry Training of Trainers on TB/HIV open.

Annex 3

Programme

Duration	Sessions	Specific Objectives	Content	Responsible agency
Day 1 – Tuesday 21 February 2006				
Inaugural session				
0800-0900	Registration			
0900-1000	Opening of training session Introduction of participants Objectives of training Group photograph	 Participants introduced Trainees oriented to the programme	RD address Address by local host Introduction of participants Introduction to training	WHO MOPH WHO WHO MOPH
1030-1045	Pre-test	Establish baseline knowledge of trainees	Pre-test	CDC
Module 1: Introduction to TB/HIV programs and policy				
1045-1200	Sub-module 1.1 - Global policy on TB/HIV Regional strategies on TB/HIV (per region)	Participants will have an understanding of the Interim Policy Participants will have an understanding of the regional strategic plan/regional framework	Global TBHIV Interim Policy Regional Strategic Plan On HIV/TB (SEAR) TB/HIV Regional Framework (WPR)	WHO/HQ WHO/ SEARO WHO/ WPRO
1200-1230	Fixing of posters			MOPH
Module 2: TB/HIV epidemiology and surveillance				
1330-1430	Sub-module 2.1: TB/HIV epidemiology	Participants will be able to discuss the epidemiological implications of HIV on TB epidemic	Epidemiology of TB/HIV in Asia	CDC
1445-1700	Sub-module 2.2: TB/HIV surveillance	Participants will be able to describe the rationale and methods for conducting TB/HIV surveillance	Methodologies for TB/HIV surveillance Tools: recording and reporting	CDC

Duration	Sessions	Specific Objectives	Content	Responsible agency
Day 2 – Wednesday 22 February 2006				
Module 3: TB/HIV interventions				
0830-1030	Sub-module 3.1: Review of TB/HIV interventions	Participants will be able to describe medical interventions and to discuss relevance for national and district level	Review of TB and HIV/AIDS interventions	WHO/ SEARO
1045-1230	Sub-module 3.2: HIV testing and counselling		HIV testing and counselling	WHO/ WPRO
1330-1430	Sub-module 1.2: Situational analysis of TB/HIV policy and collaborative activities in country	Participants will be able to present country policy and collaborative activities on HIV/TB	Country policy and collaborative activities on HIV/TB	RIT
1430-1500	Sub-module 3.3: Preventing progression of LTBI to active TB	Participants will be able to describe medical interventions and to discuss relevance for national and district level	IPT	WHO/ WPRO
1515-1700	Sub-module 3.4: HIV/AIDS care and treatment for HIV/TB co-infected individuals		HIV/AIDS care and treatment	WHO/ SEARO
Day 3 – Thursday 23 February 2006				
0830-0900	Recapitulation of previous days	Full understanding of modules	Questions and answers	WHO/ SEARO
Module 4: TB/HIV programme planning and management				
0900-1130	Sub-module 4.1: Programme planning / management	Participants will be able to outline key activities for implementing HIV TB collaborative activities at national and district level	Steps for implementation of national and district level activities	CDC
1130-1230	Sub-module 4.2: Monitoring and evaluation	Participants will be able to discuss indicators for baseline assessment and monitoring to key activities and to describe recording and reporting system	M&E guidelines HQ	WHO/HQ
1330-1430	Continued			
Module 5: Development of action plans from pilot to programme implementation				
1430-1530	Sub-module 5.1: Learning from field visits	Participants will be able to understand design of interventions for pilot project / national action plans	Introduction to field visits	MOPH
1530--	Departure for field visit			

Dura-tion	Sessions	Specific Objectives	Content	Responsible agency
Day 4 – Friday 24 February 2006				
0800-1700	Sub-module 5.1: Learning from field visits	Participants will be able to understand design of interventions for pilot project / national action plans	Field visit	MOPH/RIT
Day 5 – Saturday 25 February 2006				
0800-1700	Sub-module 5.1: Learning from field visits	Participants will be able to understand design of interventions for pilot project / national action plans	Field visit Travel back to Bangkok in the afternoon of Day 5	MOPH/RIT
Day 6 – Sunday 26 February 2006				
holiday				
Day 7 – Monday 27 February 2006				
0830-1000	Sub-module 5.1: Learning from field visits	Participants will be able to understand design of interventions for pilot project / national action plans	Feed-back from field visits	MOPH/RIT
1030-1700	Sub-module 5.2: Translating knowledge and lessons learned into action planning	Participants will be able to design projects / action plans	Writing proposal for projects and action plans	WHO/CDC
Day 8 – Tuesday 28 February 2006				
0830-1230	Sub-module 5.2: Translating knowledge and lessons learned into action planning	Participants will be able to design projects / action plans	Writing proposal for projects and action plans	WHO/CDC
1330-1500	Sub-module 5.2: Translating knowledge and lessons learned into action planning	Participants will present action plan	Preparing of presentation	WHO/CDC
Closing session				
1500-1600	Post-test Course evaluation Closing	Knowledge of trainees established Evaluation of training materials		CDC WHO/ SEARO

Annex 4

List of Participants

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Annex 5

Course Evaluation

1. Please rate the quality of the training course:

	Excellent	Good	Fair	Poor
Overall course	10	11		
Slide presentations and lectures	6	15	1	
Exercises and worksheets	3	16	2	
Binder and handouts	9	12		
Accommodation	3	15	2	
Meals	4	12	4	1
Transport	10	11		
Social activities	6	9	2	2
Administrative support prior to the course	4	13	3	
Administrative support during the course	7	14		
Training venue	8	13		

2. **Please rate the usefulness of each course component with regard to developing skills as a public health professional working on TB/HIV:**

		Very Useful	Useful	Somewh at useful	Not Useful
Module 1: Introduction to TB/HIV policies and programmes					
1.1	Global policy and regional policy on TB/HIV	8	11	1	
1.2	Poster display and discussion	4	12	4	
Module 2: TB/HIV surveillance					
2.1	TB/HIV Epidemiology	10	9	1	
2.2	TB/HIV Surveillance	10	9	1	
Module 3: TB/HIV interventions					
3.1	Review of TB/HIV interventions	9	9	2	
3.2	HIV Testing and Counselling	10	9	1	
3.3	Preventing progression of latent TB infection to active TB disease	10	8	2	
3.4	HIV/AIDS care and treatment for HIV/TB co-infected individuals	10	9	1	
Module 4: TB/HIV planning and management					
4.1	TB/HIV Planning and Management	9	9	1	
4.2	Monitoring and evaluation	11	8	1	
Module 5: Translating knowledge and lessons learned into action plan					
5.1	Learning from the field visit	13	6	1	
5.2	Developing an Action Plan	12	8		

3. **How long do you think this course should be? (working days)**

☒ 5 days: 3 respondents ☒ 10 days: 5 respondents

☒ 7 days: 11 respondents ☐ other (specify): nil

4. **Which format of the course would you prefer?**

   ☒ Instruction in Bangkok and field visit to Chiang Rai or Ubon: 14 respondents

   ☒ Instruction in Bangkok and field visit in Bangkok: 3 respondents

   ☒ Instruction in Bangkok, no field visits: 1 respondent

   ☒ Instruction and field visit all in Chiang Rai or Ubon: 2 respondents

5. **Do you think you could replicate this course in your country?**

   ☒ Yes: 13 respondents

   ☒ No: 1 respondent

   ☒ Other: only some sections: 1 respondent

6. **If you can replicate this course, please describe the anticipated duration of the course, content of the course, challenges to running this course and potential sources of funding.**

   a) *Duration of the course:* 2-3 days (one), 3-5 days (two), 5 days (five), 7 days (five), 10 days (two respondents)

   b) *Content of the course:* Same as this course (five), treatment and care (four), policy, activities, surveillance, monitoring, epidemiology, collaboration (different respondents)

   c) *Challenges to running the course:* Budget (six), materials (three), facilitators (five), collaboration between TB and HIV programme (three), preparation (two), time (one), choosing participants (one), advocacy (one), participation by WHO or senior staff (one respondent)

   d) *Potential sources of funding:* Government/MoH (nine), Global Fund (five), WHO (four), local government (two), USAID/CDC (one respondent)

7. **What did you like best about the training course?**

   Field visit, exercises and group work, lectures, development of action plan, participants from different countries, learning about the health system of another country

8. **What did you like least about the training course?**

   Lectures too long, too much information, module 4, module 2, not enough time for group discussions, posters, field visit

9. **Is there anything else that should be included in future training courses about TB/HIV?**

   More time for group work, more time for field visit, visiting facilities of TB cluster, ART regimens, treatment of opportunistic infections, reporting on TB/HIV, poster discussion

10. **Is there anything from this course that should be taken out for future training courses?**

    Action planning (one respondent)

11. **Additional comments. Please provide us with suggestions about how to improve this course for future participants.**

    - Include a full session on the organization of the health system in Thailand (this will lead to a better understanding during the field visit).
    - Qualified interpreters during field visit.
    - More practical information to be given to participants before the course.

World Health Organization

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