World Health Organization

TB HIV

Scaling up prevention and treatment for TB and HIV

Global TB/HIV Working Group of the Stop TB Partnership

Addis Ababa, Ethiopia, 20–21 September 2004

The Fourth Working Group meeting was held on 20–21 September 2004 in Addis Ababa, Ethiopia, with the theme of "***Two diseases – one patient: scaling up prevention and treatment for TB and HIV***". The Global TB/HIV Working Group advises WHO and the Stop TB Partnership on TB/HIV issues and aims to reduce the burden of TB and HIV in dually-affected populations. The TB/HIV Working Group has met yearly since 2001. Information and experience on a wide range of issues to ensure patient-centred quality TB/HIV care were shared among nearly 200 participants from almost 40 countries. Networking and partnership between the TB and HIV communities were forged in a forum environment to realize a more effective response to the global TB/HIV epidemic.

Report of the Fourth Working Group Meeting

Stop TB Partnership

Progress – but more is needed

In opening the meeting, Gijs Elzinga, the chair of the Working Group (WG) since its inception, likened the WG to a thriving three-year-old child that has gained weight and reached many important developmental milestones. TB/HIV is now prominent on global health agendas, with celebrities such as Nelson Mandela advocating that, "*we can't fight AIDS unless we do much more to fight TB as well*". Collaboration between the TB and HIV communities is increasing at all levels. The WG has produced the minimum essential set of policy guidance to assist countries in implementing collaborative TB/HIV activities, and there is now global consensus on the importance of the 12 collaborative activities outlined in the Interim Policy on Collaborative TB/HIV Activities (http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330.pdf). The number of countries implementing collaborative TB/HIV activities is increasing rapidly.

Despite these efforts and achievements, the TB/HIV epidemic continues to accelerate not only in sub-Saharan Africa but also increasingly in Asia and Eastern Europe. The proportion of the population with access to the full package of collaborative TB/HIV activities in countries implementing the Interim Policy remains very low. Much more effort is needed to assist countries to implement collaborative TB/HIV activities.

Strengthening partnerships

For the first time, the TB/HIV WG meeting was held back-to-back with another scientific meeting, the US Centers for Disease Control and Prevention (CDC) cosponsored meeting on HIV surveillance in TB patients. This innovative approach maximized the number of participants who could attend both meetings and was a clear example of the closer collaboration between WHO and CDC on TB/HIV. Dr Julie Gerberding, Director of CDC, was among the dignitaries who opened the WG meeting, and reiterated the commitment of the US Government and CDC to addressing the TB/HIV emergency and accelerating the country-level response to the joint epidemics through close collaboration with all partners. The WG meeting benefited from much greater country-level representation from both TB and HIV communities as a result of linking the two meetings. The exciting collaboration resulted in draft action plans for HIV surveillance in TB patients for a number of countries with a high burden of HIV-related TB.

Participants applauded the increasing representation and heightened involvement of the HIV community in the WG and in the battle against HIV-related TB at all levels. However, it was emphasized that there is still a significant need to further consolidate and enhance the involvement of more HIV representatives in the WG.

Building bridges

The creation of an exciting new collaboration between the TB and HIV departments at WHO headquarters in Geneva was announced by Dr Mario Raviglione, Director of the Stop TB Department, and Dr Teguest Guerma, Associate Director of the HIV Department. The new HIV/TB Task Force (HTTF) will maximize collaboration between the two departments in order to accelerate coordinated antiretroviral therapy (ART) scale-up and DOTS expansion at country level.

The bridge between the TB and HIV communities is getting stronger, with heavy traffic now moving backwards and forwards across that bridge.

But … TB programmes are from Mars, HIV programmes are from Venus

The collaboration between TB and HIV programmes was likened to a marriage many times during the meeting. Like all relationships, it requires a lot of effort to make it successful. The different histories and cultures of the TB and HIV commu-

nities raise many challenges in achieving an effective and productive partnership. Experience from a TB/HIV project in Khayelitsha, South Africa, demonstrated some of these differences. TB services are geared towards chronic-care services with simple and standardized technical procedures, while HIV/AIDS services are clinically oriented and tend to be more individual-patient-oriented. Likewise, experience from Thailand highlighted the differences between the well staffed but poorly funded TB programme and the younger, more dynamic and well-funded HIV programme. Although collaboration exists on paper, the differences between the programmes are one of the main barriers to HIV-infected TB patients accessing ART.

The WG concluded that the differences between TB and HIV programmes need to be addressed at all levels, building on strengths and eliminating weaknesses, in order to ensure effective collaboration between the programmes and joint delivery of comprehensive services to coinfected patients. Where possible, providing this care in a "one-stop shop" should be the aim of the collaboration between TB and HIV programmes. Integration of the programmes is not necessary for this purpose.

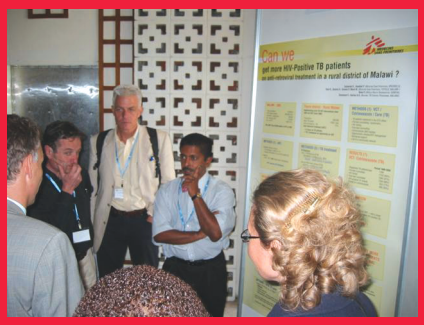
Why is more money still not buying us better health?

In recent years, there has been an unprecedented increase in the resources available to tackle TB and HIV through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the US President's Emergency Plan for AIDS Relief, the World Bank and other sources. However, with money itself being less of an obstacle, other bottlenecks hamper effective implementation at country level. The recruitment freeze and ceiling placed on salaries in the public services, as recommended by donor and international financial agencies, makes it difficult to attract and retain competent health professionals in the public sector. This limits health service capacity to absorb new funds and translate them into health improvement in the population.

The WG identified the following donor and country (government) factors as key barriers for the money supply (see box).

International funding initiatives, such as the GFATM, should be considered only as an emergency interim response to the escalating global TB/HIV crisis. Longer-term, more sustainable funding strategies should be developed, including longer commitment by donors, but it is essential that governments find ways to allocate adequate funding for health in the future. Conditional debt cancellation for health, education and social security, and international trade balance should assist long-term commitments by governments.

The GFATM is likely to remove the TB/HIV category as a separate entity for future proposals. Instead, countries will be expected to explicitly address TB within all HIV proposals, and vice versa. The WG expressed concern that this may give the message to countries that TB/HIV activities are no longer a priority. It was recommended that the GFATM makes very clear on its website and in all guidance for the 5th round proposals that all TB proposals should contain activities to address HIV, and vice versa.



Donor factors

- Imposition of detailed, lengthy processes and conditions hampers smooth and timely disbursement and utilization of resources.
- Lack of harmonization with national policies and systems and bypassing well established in-country coordination mechanisms undermine the stewardship and leadership roles of national bodies.
- Tendency for very selective funding without due focus on strengthening the health system and improving the health workforce crises.

Country factors

- Lengthy bureaucratic procedures and restrictive financial management mechanisms.
- Limited financial management capacity at all levels, particularly at district level.
- Concerns about sustainability and exit strategies in the context of lifelong treatments and time-bound funding.

Two diseases – one patient

Treatment for both HIV and TB provides a lifeline to millions of coinfected people worldwide. Lucy Chesire, a Kenyan activist who has lived with HIV/AIDS for almost 10 years, shared her traumatic personal experience with TB and pleaded with the participants to accelerate patient-centred action in order to reduce the suffering and deaths of HIV-infected TB patients. TB and HIV programmes need to look beyond their rigid boundaries and take on expanded roles in order to deliver better prevention, treatment and support services for their clients.

The DOTS strategy alone is not sufficient to control TB in high HIV prevalence settings where, for example, smear-negative and extrapulmonary TB are much more common. The WHO *Expanded DOTS framework for effective TB control* lays out additional elements that are needed under different circumstances to bring about TB control, including collaborative TB/HIV activities, addressing drug-resistant TB and expanded involvement of the private sector. This framework has been insufficiently communicated and implemented by policy-makers and health workers. The flexibility and inclusiveness of the DOTS strategy to provide patient-centred care should be better communicated. Beyond this, the existing guidelines on the diagnosis and management of smear-negative and extrapulmonary cases of TB should be reviewed. New ways of accelerating accurate diagnosis and treatment are urgently needed in the HIV era.

"Of all the years I lived with HIV, the worst time of agony, suffering, hopelessness and social ostracism has been when I was diagnosed with TB. The climax of all this was when I had to take about 20 antiretroviral (ARV) and TB drugs a day on an empty stomach. Today, thanks to my diagnosis of TB … I am on ART and alive. Although TB has induced an insurmountable suffering on me, it is ironic that I am indebted to it, because it has created the door for my ARVs".

Lucy Chesire, a Kenyan activist who has been living with HIV/AIDS since 1994, speaking at the opening of the meeting.

Data presented from Cambodia showed that previously undiagnosed TB was detected in 15–25% of people living with HIV/AIDS (PLWHA) who were screened for TB. HIV programmes must prioritize intensified TB case-finding for PLWHA and treat latent TB infection in those who have no evidence of active TB disease.

TB – the technological vacuum

The diagnosis of TB depends largely on a smear microscopy test that is more than 100 years old, yet within 20 years of its discovery a simple test can accurately diagnose HIV in minutes from a single drop of blood. The long duration and high pill-count of current TB drug regimens coupled with the spectre of increasing drug resistance to existing drugs requires urgent development of new drugs, in addition to new, rapid and more reliable diagnostics for TB.

Very strong advocacy at the highest levels is required to stimulate emergency responses from governments and the international community to encourage the development of new drugs and diagnostics for TB that can be used in field settings. In the meantime, we must ensure the maximal use of existing tools by improving laboratory capacity and standards of diagnostic protocols and drug regimens.

"3 by 5" by DOTS?

The "3 by 5" initiative, which plans to put three million PLWHA on ART by the end of 2005, is an ideal opportunity to stimulate improved access to ART for HIV-infected TB patients, thus reducing morbidity and mortality. However, HIV programmes face a major challenge in transforming HIV/AIDS from a killer into a chronic disease through public provision of ART to all those in need. Such a transformation will require a strengthened HIV programme supported by strong political commitment that is able to detect a high proportion of PLWHA eligible for therapy, guarantee reliable diagnosis and drug supplies, ensure adherence to standardized treatment regimens, and be able to accurately monitor, record and report response to treatment on an individual and national basis. Clearly, the DOTS strategy can provide many lessons for ART and the "3 by 5" initiative, and TB control programmes can provide valuable assistance to HIV/AIDS programmes in setting up and manag-

ing many of these key elements in delivering treatment.

Effective collaboration between HIV/AIDS and TB control programmes in the context of "3 by 5" was demonstrated in Malawi, which is now rapidly heading towards nationwide coverage of collaborative TB/HIV activities and ARV scale-up. Regional TB officers in Malawi will be responsible for monitoring the new ART programme in the same way they monitor the recording and reporting of TB diagnosis and treatment from their respective districts. The TB officers were trained on ART delivery systems and use of the newly developed monitoring and evaluation tools that build on the cohort analysis approach of TB control. Central units of the national TB control and HIV/AIDS programmes conduct joint analysis of the data collected. HIV and TB control programmes can work effectively together to use the lessons from the DOTS strategy to achieve the ambitious "3 by 5" target.

ART to TB patient is feasible but still a dream for most

The high prevalence of HIV among TB patients (over 75% in some settings) indicates that TB programmes can be an important entry point for ART where high numbers of PLWHA who would be eligible for ART are already in contact with the health service. Preliminary data presented from Durban, South Africa, demonstrated that integrating ART into existing TB clinic services is feasible and improved treatment outcomes for both diseases. Similarly, joint delivery of TB and HIV services (including ART) in Khayelitsha, South Africa, benefits both patients and staff. Patients receive care for both TB and HIV in one visit and staff develop expertise in managing both diseases, while improved treatment outcomes boost staff morale. However, in reality, access to ART for HIV-infected TB patients remains very limited in most countries. In Malawi, the mismatch between TB treatment that is decentralized, down to primary health centres, and centralized hospital-based ART limits access to ART for many TB patients, especially those furthest from the hospitals. In Thylo district, only 13% of eligible HIV-positive TB patients were eventually started on ART. Decentralization of ART from hospitals to primary care would greatly improve ART access and equity.

The choice of using generic or branded drugs for ART scale-up is a country choice. There is concern, however, about establishing parallel systems for ART delivery (one generic, the other for branded drugs), particularly where multiple partners are involved. This compromises standardized treatment and drug access for patients.

Stigma – double trouble

HIV-infected TB patients often bear a double burden of stigma, one for TB and another for HIV. Lack of training on HIV and TB resulted in negative attitudes of service providers and further fuelled the stigma experienced by coinfected patients in Ukraine, for example. In the Russian Federation, it was reported that up to 90% of PLWHA reported stigmatization. In the United Republic of Tanzania, many HIV-infected TB patients preferred to stay at home due to fear of stigma. Provision of home-based care for TB/HIV by community volunteers from a faith-based nongovernmental organization (PASADA) in the United Republic of Tanzania was instrumental in improving the care provided to HIV-infected TB patients, including enhancing community awareness against stigma. It was particularly recognized that the double stigma poses a huge challenge in scaling up universal and high-quality HIV testing and counselling for TB patients in high-HIV prevalence settings.

UNAIDS/WHO joint policy statement on HIV testing

The recent UNAIDS/WHO joint policy statement on HIV testing was applauded for responding to the need for a paradigm shift in HIV testing policy. This accelerates knowledge of HIV status in those at risk and thus ensures their access to the most appropriate prevention, treatment, care and support.

The policy statement (http://www.who.int/hiv/pub/vct/en/

Type	Target groups
VCT	Individuals or couples who wish to know status for planning or prevention
Routine	Patients at high risk for HIV (STI clinics) or for whom an important intervention is available (PMCT)
Diagnostic	Patients with signs or symptoms that are consistent with HIV or AIDS (e.g. TB)
Mandatory	Body fluids, blood or tissue donors, pre-recruitment

hivtestingpolicy04.pdf) does not support mandatory testing of individuals on public health grounds. It recommends that HIV testing be confidential, accompanied by counselling and only conducted with informed consent.

Adoption of the UNAIDS/WHO joint policy statement into a national policy and development of national operational guidelines and training curriculum are essential for both HIV care and treatment of TB patients, and for HIV prevention. The positive impact of post-test counselling on behaviour change and HIV transmission should not be forgotten, and participants were encouraged to add another letter to the familiar ABC of HIV prevention.

- **A**bstain and delay getting sexually active
- **B**e faithful – reduce number of partners
- **C**ondom use – must be consistent
- **D**iagnosis – know your status

Kenya is rapidly scaling up counselling and testing services and implementation of routine and diagnostic HIV testing in clinical settings. It has recently published updated guidelines on HIV testing following the joint WHO/UNAIDS policy statement that strongly support diagnostic testing.

"Failure to provide HIV testing when symptoms or signs of HIV disease may be present is substandard care and is not acceptable".

Guidelines for HIV Testing in Clinical Settings – Kenya Ministry of Health (2004)

HIV testing and counselling – the door to care and prevention

HIV testing and counselling is the doorway through which TB patients and the general population can access the most appropriate prevention, treatment and support services for TB and HIV. It was recognized, however, that ensuring nationwide universal coverage of high-quality rapid HIV testing and counselling for TB patients and the general population in high-HIV settings would be a challenge. Malawi is heading towards nationwide coverage of HIV testing for TB patients and has an ambitious plan for testing 750000 people for HIV between 2004 and end of 2005. To meet this target during the first two quarters of 2004, 240 health workers have been trained as full-time counsellors and in the use of rapid HIV testing. Furthermore, strengthening referral networks between TB, HIV, PMTCT, STI and VCT services, and establishing reliable supplies management (e.g. HIV test kits) are also crucial for rapid scale-up of HIV testing and counselling services.

Enablers for nationwide expansion of HIV testing for TB patients

- Availability of knowledgeable, trained and committed health workers at service delivery points.
- Availability of diagnostic HIV testing at TB service delivery points.
- Facilities conducting HIV testing in the consulting (counselling) room.
- HIV testing for TB suspects in addition to confirmed TB patients.
- HIV testing earlier in the course of TB illness.
- Increasing availability of services such as isoniazid and co-trimoxazole preventive therapies and ARV for HIV-positives.
- Increasing community awareness of the TB/HIV link and the benefits of testing.
- Participation of PLWHA in the planning and implementation of activities.
- Uninterrupted supply of HIV test kits.

The peril of health workforce crisis: who is going to do it?

The serious shortage of human resource capacity is a major constraint to the rapid scale-up of collaborative TB/HIV activities. The dearth of technical and administra-

tive staff throughout the health sectors of most countries affected by the dual TB/HIV epidemic needs urgent intervention. Salaries and incentives need particular attention. Key stakeholders – for example, the WHO Evidence and Information for Policy (EIP) cluster and the Rockefeller Foundation – are already working to address the issue of human resource capacity constraints, and the WG must collaborate with them to contribute and implement their recommendations for TB/HIV. Solutions should include ensuring that existing staff members are competent to carry out their tasks, and must address clinical, counselling and laboratory staff needs that need to be developed, as well as the advantages of expanding the traditional workforce to include community health workers, lay counsellors and PLWHA. These efforts should be linked with strong advocacy activities at all levels. Communities need to be involved to establish what they can contribute in terms of human resources to support scale-up. Ministries of health need to ensure that acceptable services are in place to prevent transmission of HIV and TB to health-care workers. Health-care workers should be encouraged to consider their own HIV status.

Costing TB/HIV activities: who is going to foot the bill?

WHO has estimated the cost for implementing collaborative TB/HIV activities in the 34 priority countries of the "3 by 5" initiative at US$ 250 million per year. Governments and funding agencies need to be lobbied to identify the necessary funds.

Act up and involve the community

The meeting benefited from much greater involvement of HIV activist and community groups, but even more effort is needed to truly engage communities in the fight against TB and HIV. Zackie Achmat, who heads Treatment Action Campaign in South Africa, spoke about the role of advocacy and activism for effective TB/HIV response. He acknowledged that much information is already available for patients and community groups to act on and help ameliorate the TB/HIV epidemic, but TB communities still do not know enough about HIV, and vice versa. Informed community groups and patient populations are critical to effective implementation of collaborative TB/HIV activities.

Governments must be held accountable to their TB and HIV/AIDS commitments made at the Millennium Summit, the UNGASS, the Abuja Summit and the World Health Assembly, and in the Amsterdam Declaration. Access to TB and HIV prevention, diagnosis and treatment services must be seen as an essential human right. Governments should be pressured to take responsibility for delivering the best TB and HIV/AIDS services available under existing circumstances. Joint delivery of TB and HIV prevention and treatment services including ART must become the standard of care and be centred on the patient.

The involvement of activists and community groups should particularly be sought to accelerate the implementation of collaborative TB/HIV activities in countries with high TB and HIV. This country-level activity should embrace building the pressure on country programmes to enhance their accountability with regard to addressing the TB/HIV epidemic.

"Our work should be measured by how many people we put on antiretroviral therapy through our TB programmes and by how many people we put on TB drugs and IPT through our HIV/AIDS programmes in each country".

Zackie Achmat, Treatment Action Campaign of South Africa

PLWHA activists in the TB/HIV front in Uganda

The National Forum of PLWHA Networks in Uganda shared their experiences of an emerging TB/HIV advocacy movement from Uganda. They recognize that TB is not yet on the advocacy agenda of PLWHA and HIV is not yet fully on the agenda of the TB community, and they aim to address these gaps. Uganda has yet to develop a national policy or plan to support the implementation of collaborative TB/HIV activities and they are fighting for this. They have made a presentation to the national HIV/AIDS Partnership to educate them on the need for TB/HIV collaboration and to seek its technical, financial and moral support for collaborative activities. This PLWHA-led activity is also geared towards influencing pe-

ripheral service providers and organizations (e.g. NGOs) to deliver joint TB and HIV services.

African Union calls for scaling-up TB/HIV activities

The WG meeting was an excellent opportunity for high-level advocacy to garner political support for collaborative TB/HIV activities both locally and internationally. Dr Jack Chow, Assistant Director-General of WHO, and Dr Julie Gerberding, Director of CDC, met with H. E. Meles Zenawi, Prime Minister of Ethiopia, to highlight the importance of TB/HIV in Ethiopia. With the appointment of a national TB/HIV coordinator, the availability of a substantial amount of resources and the initiation of activities in seven pilot sites, Ethiopia is ready to take on its scale-up of activities. These high-level dignitaries also spoke with a delegation from the African Union. The Union has recognized that HIV-related TB is a serious problem facing the continent and called for all Member States to embrace and scale up implementation of collaborative TB/HIV activities. Press conferences were conducted in Addis Ababa and Nairobi during the meeting, with wide

Experience from the field

Beyond the plenary presentations, country-level experiences in implementing collaborative TB/HIV activities were shared in an interactive forum with poster displays and moderated discussions. Presentations were made by Cambodia, the Democratic Republic of the Congo, Ethiopia, India, Kenya, Malawi, Mozambique, Nigeria, the Russian Federation, South Africa, Sudan, Thailand, the United Republic of Tanzania, Uganda, Ukraine and Zambia. They included activities run by ministries of health, partner organizations and technical agencies, NGOs and community-based organizations. Country-level implementation is accelerating but still falls short of national coverage of all the collaborative TB/HIV activities defined in the interim policy. There are no longer valid excuses for countries with a high burden of HIV-related TB not to plan to implement collaborative TB/HIV activities, particularly with clear policy recommendations and greatly increased opportunities for scaling-up through the international funding opportunities.

TB/HIV data are scarce in Europe

Eastern European nations are experiencing particularly high levels of TB

Need to explore the link between HIV and MDR-TB

The worrying situation in eastern Europe offers the spectre of an HIV-fuelled epidemic of MDR-TB, which is also possible in other settings such as South Africa, where it could occur in a more localized way. Clearer definition of the extent of this lethal combination is urgently needed.

Nutritional support is important for TB/HIV care

In Cambodia, the World Food Programme provides nutritional support for TB patients. This has contributed to the improvement of TB care. Nutritional support was emphasized as a component of TB/HIV care that could improve the adherence and livelihood of HIV-infected TB patients.

Lack of national TB/HIV policies impedes activities

Weak or non-existent national policies and operational guidelines to support programme implementation in many countries impede the accelerated implementation of collaborative TB/HIV activities, particularly by NGOs and community-based organizations. Countries are urged to develop the necessary delivery, support and monitoring systems that will ensure quality delivery of serv-