




WORLD HEALTH ORGANIZATION

**SECOND MEETING OF THE
GLOBAL WORKING GROUP
ON TB/HIV**

**14-16 June 2002
Durban, South Africa**

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Stop TB Department, World Health Organization
(on behalf of the Global Working Group on TB/HIV)

This meeting was supported by the Global AIDS Program, Centers for Disease Control and Prevention, and by the Bureau for Global Health, Office of Health, Infectious Diseases and Nutrition, the United States Agency for International Development and by WHO.

The Global Working Group on TB/HIV, co-ordinated by WHO, is one of the six working groups established under the auspices of the Global Stop TB Partnership.

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TB:IV

Glossary of abbreviations

3TC	L AMIVUDINE
ABC	A BACAVIR
ACF	A CTIVE C ASE F INDING
AFRO	W HO R EGIONAL O FFICE FOR AFRICA
AIDS	A CQUIRED I MMUNODEFICIENCY S YNDROME
ART	A NTI- R ETROVIRAL T REATMENT
ARV	A NTI- R ETROVIRAL
CBO	C OMMUNITY- B ASED O RGANIZATION
CD4	A NTIGEN IDENTIFYING T HELPER LYMPHOCYTES
CDC-GAP	G LOBAL A IDS P ROGRAM, C ENTERS OF D ISEASE C ONTROL AND P REVENTION
CPT	C O-TRIMOXAZOLE P REVENTIVE T REATMENT
DOTS	D IRECTLY- O BERVED T REATMENT, S HORT C COURSE
EFV	E FAVIRENZ
FBO	F AITH- B ASED O RGANIZATION
GDF	G LOBAL D RUG F ACILITY (FOR TB DRUGS)
GFATM	G LOBAL F UND TO FIGHT A IDS, T B AND M ALARIA
HAART	H IGHLY A CTIVE A NTI- R ETROVIRAL T HERAPY
HBC	H OME- B ASED C CARE
HIV	H UMAN I MMUNODEFICIENCY V IRUS
JICA	J APAN I NTERNATIONAL C OOPERATION A GENCY
IEC	I NFORMATION, E DUICATION AND C OMMUNICATION
ILO	I NTERNATIONAL L ABOUR O RGANIZATION
IMF	I NTERNATIONAL M ONETARY F UND
INH	I SONIAZID
IPT	I SONIAZID P REVENTIVE T REATMENT
LCC	L ONG- C COURSE C HEMOTHERAPY
MAP	M ULTI-COUNTRY A IDS P ROGRAMME FOR AFRICA
MoH	M INISTRY OF H EAALTH
MSF	M ÉDECINS S ANS F RONTIÈRES
NAC	N ATIONAL A IDS C OUNCIL OR C OMMISSION
NACP	N ATIONAL A IDS C ONTROL P ROGRAMME

NAP	N ATIONAL A IDS P ROGRAMME
NEPAD	N EW E CONOMIC P ARTNERSHIP FOR A FRICAN D EVELOPMENT
NGO	N ON- G OVERNMENTAL O RGANIZATION
NRTI	N UCLEOSIDE R EVERSE T RANSRIPTASE I NHIBITOR
NNRTI	N ON- N UCLEOSIDE R EVERSE T RANSRIPTASE I NHIBITOR
NTP	N ATIONAL T UBERCULOSIS P ROGRAMME
OI	O PPORTUNISTIC I NFECTION
OPD	O UT- P ATIENT D EPARTMENT
PMTCT	P REVENTION OF M OTHER TO C HILD T RANSMISSION (OF HIV)
PLWHA	P EOPLE L IVING W ITH H IV/ A IDS
ProTEST	W HO CO-ORDINATED INITIATIVE AIMED AT P ROMOTING T ESTING FOR H IV AS AN ENTRY POINT TO ACCESS FOR A RANGE OF T B AND H IV PREVENTION AND CARE SERVICES
SADC	S OUTHERN A FRICAN D EVELOPMENT C OMMUNITY
PTB	P ULMONARY T UBERCULOSIS
Rx	T RATMENT
SCC	S HORT- C COURSE C HEMOTHERAPY
SATCI	S OUTHERN A FRICAN T B C ONTROL I NITIATIVE
SEARO	W HO R EGIONAL O FFICE FOR S OUTH- E AST A SI
SM+	S MEAR- P OSITIVE
SP	S ULFADOXINE- P YRIMETHAMINE (MALARIA TREATMENT)
STD	S EXUALLY T RANSMITTED D ISEASE
STI	S EXUALLY T RANSMITTED I NFECTION
SQV/r	S AQUINAVIR/ R ITONAVIR
TB	T UBERCULOSIS
TB/HIV	C O-INFECTION WITH BOTH T B AND H IV
TLC	T OTAL L YMPHOCYTE C OUNT
UNAIDS	U NITED N ATIONS P ROGRAMME ON A IDS
UNGASS	U NITED N ATIONS G ENERAL A SSEMBLY S PECIAL S ESSION
USAID	U NITED S TATES A GENCY FOR INTERNATIONAL D EVELOPMENT
VCT	V OLUNTARY C OUNSELLING AND T ESTING (FOR HIV)
WG	W ORKING G ROUP
WHO	W ORLD H EALTH O RGANIZATION
WPRO	W HO R EGIONAL O FFICE FOR THE W ESTERN P ACIFIC
ZDV	Z IDOVDUDINE

xecutive Summary



Effective action against TB/HIV coinfection is overdue. However, a number of important recent developments have created new opportunities for progress to be made, employing experience already gained and putting into practice new guidelines and recommendations.

The Global Working Group on TB/HIV (the WG) was established under the auspices of the Global Stop TB Partnership and held its first meeting in April 2001. The meeting highlighted the severity of the dual TB/HIV epidemic and the need to step up action against it. The ProTEST approach to addressing TB/HIV was discussed, and initial experiences with pilot ProTEST projects were shared. This first meeting also reviewed and endorsed the WHO Strategic Framework to Decrease the Burden of TB/HIV.

The second meeting of the WG was held in Durban, South Africa, 14-16 June 2002, and attended by 130 participants from 35 countries. The meeting objectives were to:

- share country and regional experiences
- produce practical recommendations for the expansion of joint actions especially in countries
- discuss and endorse guidelines for implementing collaborative TB and HIV programme activities
- make available to participant's new information to assist with their own activities.

New developments

The meeting took note of the publication of the Strategic Framework to Decrease the Burden of TB/HIV, and of the conclusions reached at a workshop, held in Nairobi in February 2002, which sought to build on the experience of pilot projects adopting the ProTEST approach and to plan further collaborative TB/HIV programme activities.

Also noted was the development of the Global Fund to fight HIV/AIDS, TB and Malaria (GFATM), launched in April 2001, which provides a major new source of financial support for action against TB/HIV.

Anti-retroviral treatment (ART) for HIV/AIDS is becoming more readily available and new funding seems likely to facilitate the introduction of further ART programmes.

The meeting heard a summary of WHO's new guidelines on the use of ART in resource-constrained countries. The potential use of mathematical models as a new tool to monitor the epidemic, and compare the cost-effectiveness of different interventions, was also described.

Experience shared

The meeting heard presentations on the TB/HIV situation from nine countries: Senegal, Nigeria, Malawi, Ethiopia, Kenya, South Africa, Cambodia and Brazil. The Brazilian presentation focused on the encouraging progress made in the national ART programme.

Several international agencies provided their perspectives: the World Bank, UNAIDS and USAID. Contributions were made by WHO regional offices (Africa, Southeast Asia and Western Pacific) and by WHO's Department of HIV/AIDS/STIs.

There was a summary of international progress with the ProTEST initiative, the formal evaluation of which is still under way.

Issues arising which were considered by the meeting to be of particular importance included:

- the need to pull together information from all the TB/HIV projects that are ongoing and ensure regular data collection from them
- the difficulties imposed by the nature of TB and HIV programmes and the need to address the problem of TB/HIV patients who are not "owned" by a separate programme but need to access, in an efficient way, services provided by both TB and HIV/AIDS programmes
- concerns that DOTS programmes are not being successfully implemented in many high HIV-prevalence countries, and thus the need to ensure that the introduction of new TB/HIV activities should not divert attention away from the importance of DOTS
- the difficulty of scaling up action against TB/HIV when capacity is inadequate, particularly as regards human resources
- the need to improve adherence to preventive treatment interventions
- the need to bring anti-retroviral treatment to more people with HIV and AIDS.

Guidelines endorsed

The draft version of the WHO guidelines for implementing collaborative TB and HIV programme activities was discussed. The guidelines describe the overlapping TB and HIV epidemics and the interventions which can control TB in high HIV-prevalence populations, with advice on how to plan and implement them at national and district level. The guidelines also provide accounts of experience with the implementation of ProTEST pilot projects.

It was agreed that the guidelines should be further shortened, mainly by focusing on the sections dealing with national and district level implementation. The remaining material could either be placed in an annex or a separate volume. The document should be completed within 3 months and brought into use as soon as possible. Further editions are foreseen after experience has been obtained from using the guidelines in the field.

Recommendations and next steps

Following discussion of the presentations and break-out session reports, a number of recommendations were made. In particular, recognising the scale of the TB/HIV problem and bearing in mind the improved resources now becoming available, workshop participants considered that the following steps should be taken as a matter of urgency.

1. In recognition that control of TB in high HIV prevalence settings requires full implementation of the DOTS strategy and incorporation of additional joint TB/HIV activities, the WG urges WHO:
 - to submit a resolution to the WHA in 2003 that urges governments to implement an HIV/AIDS care strategy and country-level implementation of joint TB/HIV activities, as set out in the Global TB /HIV Strategic Framework;
 - that the HIV/AIDS Department should finalise the development of its AIDS care strategy and share details of the principles on which it is based;
 - that the Stop TB Department of WHO should complete its TB/HIV guidelines within three months, in collaboration with the HIV/AIDS Department, and regional offices should then adapt the guidelines for use in their respective regions;
 - to continue working to establish the evidence base for TB/HIV interventions, through phased implementation of nationally defined joint TB and HIV activities, and including HAART as soon as possible;
 - to act urgently to determine the effectiveness, feasibility and impact of delivery of ART in resource poor settings, given that it is the most effective intervention for prolonging life in those living with HIV and has the potential to reduce the incidence of TB;
 - to develop indicators and targets for joint TB/HIV activities;
 - that all measures above should incorporate approaches that include the private sector, community-based organizations and industry.
2. The WG urges UNAIDS, with its cosponsoring agencies, to develop an advocacy strategy for TB/HIV that clearly illustrates the importance of TB control for reducing the impact of the HIV/AIDS epidemic and, conversely, the urgency to control HIV transmission in order to reduce the impact of TB.
3. The WG urges the governments of TB/HIV endemic countries to develop clear organizational frameworks for expansion of joint TB/HIV activities and, in particular to:
 - establish joint TB/HIV committees under the Ministry of Health
 - strengthen both NTPs and NACPs to carry out their respective core functions
 - ensure NTPs incorporate TB/HIV activities as part of national DOTS expansion plans
 - ensure NACs and NACPs introduce joint TB/HIV activities as part of national HIV/AIDS strategies
 - strengthen primary health care services so they are able to include TB/HIV activities
 - involve user-groups (patients and their families) and communities in the planning and running of TB/HIV activities.
4. The WG urges bilateral agencies, the World Bank, the GFATM and other financial partners to increase funding specifically for joint TB/HIV activities. Governments of endemic countries are also urged to increase their funding of TB/HIV activities and to ensure that these activities are included in requests made to these bodies.
5. The WG urges WHO to work with its partners to ensure that governments develop comprehensive human resource strategies to address the TB/HIV issue, and to work with the International Monetary Fund to encourage more flexible

policies for health staff recruitment and retention, with attention given to incentives. The WG further urges donors to ensure the demands they make on those countries with limited capacities, are realistic.

6. The Stop TB partnership was requested to investigate the potential for the GDF to catalyse scaling up of the TB/HIV strategic framework through supply of TB/HIV related products.

The agenda and all presentations are available over the internet at www.who.int/gtb.

1 Background and objectives

1.1

The Global Working Group on TB/HIV

The Global Working Group on TB/HIV (the WG) is one of six working groups established under the auspices of the Global Stop TB Partnership. The first meeting of the WG was held 9-11 April 2001 at WHO HQ, Geneva. That workshop, a full report on which has been published, emphasised the severity of the TB/HIV epidemic and the need to step up action against it. The ProTEST approach to addressing TB/HIV was also discussed, and initial experiences with pilot ProTEST projects were shared. The meeting reviewed and endorsed the WHO Strategic Framework to Decrease the Burden of TB/HIV.

1.2

New developments

The secretariat managed the following developments between the first and the second WG meetings.

- The Strategic Framework to Decrease the Burden of TB/HIV was published and disseminated. Two WHO regional offices (EURO and WPRO) have made progress in adapting the framework for their regions.
- The Scientific Panel of the WG prepared guidelines for implementing collaborative TB and HIV programme activities. These were presented to the second WG meeting at second-draft stage.
- In February 2002 a protocol development workshop was held in Nairobi, where eight countries (four from the original ProTEST group and four others) used the guidelines to develop phased implementation plans for joint TB and HIV programme activities. The draft report was available to participants of the second WG meeting.
- WHO's mathematical model for TB was adapted to assess the impact of HIV. Several papers and publications derived from this work are in preparation, two of which were presented to the second WG meeting: "Weathering the storm: managing TB in the era of HIV" and "Tuberculosis epidemics driven by HIV: prevention or cure?"
- A core group of the WG was established to accelerate decision making between WG meetings and support the secretariat.
- WHO has coordinated the production of updated estimates of the global burden of HIV-associated TB.

¹ First Meeting of the Global Working Group on TB/HIV, 9-11 April 2001, Geneva, Switzerland.

Significant changes in the policy environment that took place between the meetings included:

- In April 2001, the UN Secretary General issued a call to action for the creation of a Global Fund to fight HIV/AIDS, TB and Malaria (GFATM). Donor pledges to this fund have led to it becoming potentially a major new source of support for action against TB/HIV. Amongst the countries represented at the Nairobi workshop, Ethiopia and Malawi have already applied successfully for immediate funding, including support specifically for TB/HIV initiatives. South Africa and Zambia have also made applications which they are now revising and resubmitting
- In its first year of existence, the Global TB Drug Facility, set up by the Stop TB Partnership, has made grants of TB drugs to 23 countries, many of which have a high burden of TB and HIV.

1.3**Objectives**

The objectives of the second meeting were as follows.

- To determine progress with joint TB and HIV activities and identify opportunities and constraints at international and national levels.
- To produce practical recommendations for the expansion of joint actions against TB/HIV by TB and HIV/AIDS programmes.
- To share experiences (at country and regional level) regarding both the prevalence of TB/HIV coinfection and efforts (both ProTEST and other activities) to control the overlapping epidemics of TB and HIV.
- To identify ways of shifting the focus of the working group from global strategy development to implementation of joint TB and HIV activities at country level
- To finalise and endorse the guidelines for implementing collaborative TB and HIV programme activities.

2.1

Country presentations

2.1.1

Senegal

Dr Mandiaye Loume (Director of Health, Ministry of Health and Prevention Senegal) described efforts to integrate TB and AIDS control efforts. There have been an estimated 30,000 AIDS deaths in Senegal. HIV prevalence is estimated at 1.4%.

Two governing bodies were established to deal with HIV/AIDS: the National AIDS Control Committee (NACC) and the National AIDS Control Programme (NACP). The NACC has now been replaced by the National AIDS Control Council, headed by the Prime Minister. The NACP has sections for epidemic surveillance, diagnosis and counselling, and treatment. Triple ART was introduced in 1999.

For TB, there is a national coordinator and also a national supervisor. There is a national TB reference laboratory. TB prevalence in 2000 was 373/100,000 (8,934 cases). The cure rate was 53%, with 29% of patients defaulting on treatment. Approximately, 40% of HIV-infected individuals seeking health care in Dakar are infected with TB.

There are plans for joint activities and integrated supervision, and objectives have been defined. However, no joint activities have been carried out due to the lack of funding and the absence of a governing body. There has also been a failure to keep the district level informed. It is essential for a joint committee to be established and for a five-year plan to be developed.

The two programmes should allocate some of their existing funds to TB/HIV, although new additional funding will also be required.

2.1.2

Malawi

Dr Biziwick Mwale, Director of Malawi's National AIDS Council, said Malawi, one of the world's poorest countries, was attempting to cope with competing priorities. HIV prevalence in adults now stands at around 15-25% in urban areas and 13% elsewhere. Half a million Malawians have died of AIDS. According to projections made in an AIDS impact study, 25-50% of people currently employed in the urban based sectors will have died of AIDS by 2005; the health sector will be amongst the hardest hit. A five-year National HIV/AIDS Strategic Framework was implemented in 2000. It has been costed at US\$160 million; so far \$110 million has been pledged. The National AIDS Control Programme has been replaced by a

National AIDS Council, in order to address problems with co-ordination and other issues. Links with the Ministry of Health & Population (MoHP) are also being strengthened but there are considerable challenges ahead.

There has been an upsurge in TB, which is largely attributable to HIV. There were 5,000 known cases in 1985 and 27,000 in 2001. Some 60% of TB cases are HIV positive.

Many difficulties will still have to be overcome to co-ordinate TB and HIV activities. There is still no HIV/AIDS unit within the MoHP. At district level there are no full-time AIDS co-ordinators. Weak district assemblies add to the difficulties. There must be a clearer agreement on the respective roles of the NAC, the Board of Commissioners, the MoHP, and the cabinet committee. However, the ProTEST pilot project in Malawi has been very helpful. It has catalysed TB/HIV activities by bringing together people from both programmes.

2.1.3

Nigeria

Dr P I Alade (of Nigeria National Action Committee on AIDS) said Nigeria had the fourth highest TB burden world-wide and the number of notified cases is continuing to rise. Case-finding efficiency is estimated at 29% (DOTS) and 36% (including non-DOTS.) DOTS has been introduced in 21 of Nigeria's 37 states but it is often not fully implemented, due to problems with drug supply, laboratory services and human resources. The greatest obstacle is lack of funds.

Estimated HIV prevalence was 5.8% in 2001, with HIV prevalence amongst PTB patients in the range 14-24%, varying with age group. The National HIV/AIDS Emergency Action Plan (HEAP) promotes a multi-sectoral, participatory, response to HIV/AIDS prevention and impact mitigation.

TB control effects are currently coordinated by the NTBLCP of the Federal Ministry of Health. HIV/AIDS National Coordination is the responsibility of NACA. The need for joint activities is recognised and TB/HIV will be integrated into the programme for HEAP. An estimated US\$37 million is required for TB/HIV activities in the period 2001-2006. Obtaining this funding is a priority.

2.1.4

Cambodia

Dr Khun Kim Eam (Deputy Chief of Planning, Statistic IEC & Unit, NTP, Cambodia) said his country (population 11.5m) had a heavy TB burden: 540 cases/100,000; 10,000 deaths per year. The NTP sees 20,000 cases per year. DOTS has been in use since 1994; a 90% cure rate was achieved in 2001. There is a system of contact screening. However, record keeping is often poor and the case detection rate is below 50%.

HIV prevalence is one of the highest in the region but has fallen from 3.9% in 2000 to 2.8% in 2001. HIV seroprevalence among TB patients was 2.5% in 1995 and 6% in 2000. Over half of AIDS patients develop TB. The number of cases of TB/HIV

coinfection is estimated to be over 120,000. In some parts of the country the death rate among TB patients has recently increased and this is attributed to AIDS.

Joint programme activities have included the establishment of a TB/HIV subcommittee, and HIV training for TB staff. A TB screening service for PLWHA began in November 2001 and, by May 2002, had seen 1017 clients. This service will be expanded.

A TB/HIV country framework, based on the regional framework, is now under development. Plans include expansion of VCT and of HBC, improved surveillance of TB/HIV, an IPT feasibility study, AIDS education for TB patients, and TB education for PLWHA. Improved collaboration with NGOs is also planned.

2.2

Presentations from international organizations

2.2.1

The World Bank

Dr K Hansen, Manager of the World Bank AIDS Campaign Team for Africa, outlined the position of TB/HIV in the Bank's Multi-country AIDS Programme for Africa (MAP). US\$1bn is available to scale up and intensify existing activities; 15 countries will be receiving \$517m and programmes for a further 12 countries are already in preparation. The Bank is thinking in terms of multi-sectoral, multi-stakeholder, long-term efforts that will strengthen the impact of AIDS control programmes and mitigate the impact of the disease in all sectors.

MAP supports capacity building, expansion of responses in the public sector, emergency AIDS funds, and project co-ordination. The need is to get projects under way quickly; over-detailed planning in advance is not required. Funding will be disbursed through two routes - a national AIDS fund (for sector ministries or their subcontractors) and a community fund (NGOs, CBOs, FBOs and the private sector).

MAP will highlight TB control as a priority and the most obvious "quick win" initiative. However, too little use is made of MAP on the policy side. There is competition for AIDS funding from other AIDS control areas - PMTCT, gender, education, blood safety etc. There is also a perception among AIDS workers that TB control is already a well resourced area.

TB must appear on the AIDS policy agenda, as well as on the technical agenda. Technical support teams must urgently be built up. Leadership at country level is vital.

2.2.2

The UN's Millennium Development Goals

Dr A Kochi (WHO's Special Representative on HIV/AIDS to the United Nations) reminded participants of the UN's Millennium Goals, which include combating HIV/AIDS, malaria and other diseases. To achieve success against

TB/HIV, it was necessary to win political support and build a global partnership. This would require a clear articulation of the issues, and agreement on simple indicators and targets. A consensus was also needed on simple, standardised approaches to TB/HIV control. Educational messages should also be simple and clear. Other requirements include: money, political support, improved capacity (in terms of human resources, technical requirements, and establishing flexible and accountable operations). Global leadership was important and WHO should take up this role.

2.2.3

UNAIDS

Dr C Sozi (of the UNAIDS Intercountry Team for East and Southern Africa) reminded participants that HIV/AIDS was a global emergency; in 2000 there were 36m PLWHAs, 70% of them in sub-Saharan Africa. She described the mechanisms UNAIDS was using to support TB/HIV activities, stressing the importance of TB/HIV interaction, the rights of PLWHA to receive care and support, and the gaps existing in the availability of care and support. Recent declarations (Abuja and UNGASS) had increased the resources available. She described some of UNAIDS' restructuring activities, which include transfer of some Geneva staff to WHO and the expansion of staff in regional offices.

Globally, with regard to TB/HIV, UNAIDS is engaged in advocacy and resource mobilisation for prevention and treatment and for action to lower the vulnerability of individuals. UNAIDS has published best practice documents on VCT and case studies relating to PMTCT and other topics. Regionally UNAIDS provides support to the Southern African TB Control Initiative (SATCI). It is also developing regional TB/HIV guidelines, which are about to be pretested. Linkages have been established with other agencies active in TB/HIV - both government agencies (e.g. JICA) and NGOs (e.g. Action Aid.).

At country level, UNAIDS seeks to influence policy and it considers that collaborative programming on TB/HIV is still not strong enough. Angola is now the only country in the region without an HIV/AIDS policy. However, Kenya is so far the only country developing a policy specifically on TB/HIV. UNAIDS wants to see TB included as a specific component of HIV strategies. UN theme groups at country level play an important role. Support is given to preventive activities based on a national strategic plan (NSP). UNAIDS promotes resource mobilisation to launch activities included in NSPs and advocacy is needed to ensure TB/HIV is included.

The launch of GFATM has provided a new opportunity for joint planning for the three diseases. Another encouraging development is ILO's proposed recommendations for care in the workplace.

UNAIDS plans to expand its regional advocacy efforts focusing on bodies like SADC and NEPAD. It wants to see more involvement of PLWHA in the advocacy process. Other areas in which more can be done include the armed forces, faith-based organizations and youth groups.

The strategic gathering of information should be expanded in order to: document best practices, develop technical networks, disseminate information on the TB/HIV epidemic and responses, and to develop a communications strategy.

Leadership and coordination are also seen as key issues by UNAIDS. Theme groups and national AIDS committees must take the lead here.

2.2.4

USAID

Amy Bloom, of USAID Global Programme for Health, provided a donor's perspective on leveraging financing for TB/HIV activities. She outlined the agency's funding mechanisms and how funds were disbursed regionally and globally. She listed the constraints faced by USAID in its allocation of funds:

- competing priorities (e.g. GFATM, Stop TB, GDF, and local needs)
- the need to preserve and use specific funds
- reporting requirements to Congress
- the lack of universal indicators
- difficulties in reporting results for investment in infrastructure.

Country missions receive many requests and many mixed messages! Staff may lack the familiarity with the issues required in order to make decisions. Governments should identify TB/HIV as a priority and make requests for support to the US mission, stressing that TB offers an "investment opportunity". They should indicate how collaboration between vertical programmes should be achieved.

Questions on Ms Bloom's presentation included whether USAID had a role in basket funding. In fact it is unable to participate in this kind of support because of reporting requirements to Congress. Delegates urged USAID to address TB/HIV through UN theme groups.

2.2.5

WHO, AFRO

Dr Wilfred Nkhoma of WHO-AFRO said Africa was disproportionately affected by the HIV epidemic. TB rates were also rising across Africa, with much steeper rises seen in countries where HIV prevalence is highest. Factors holding back "traditional" actions against the overlapping epidemics of TB and HIV in Africa include weak NTPs, poor DOTS coverage, scarce resources, uncoordinated efforts, and stigma. There is need for an integrated approach, as separate TB and HIV strategies have not been successful. The ProTEST initiative is important and has been designed so that lessons can be learned from it, both in low and high burden countries. Some things are already clear; there must be phased implementation of joint TB/HIV activities and district level managers must play a key role in planning and implementation. However, the pilot projects may not be easy to replicate on a large scale. Some projects have been run outside government institutions, so creating a sense of government "ownership" may be hard.

Nevertheless, AFRO wants to see joint TB/HIV programme activities across the region. Following the Nairobi workshop, a meeting has been scheduled for November 2002 to facilitate the development of implementation plans in francophone African countries.

Dr E Nyarko, Regional TB Adviser, WHO-AFRO, said AFRO had adopted the DOTS strategy in 1992. In 1998 AFRO convened a meeting in Pretoria to develop a proposal for ProTEST pilot sites in four African countries. The regional office has also been involved in a number of technical actions; a home-based care kit has been developed and also a guide for consultants.

Strategies envisaged by AFRO include: well functioning national TB/HIV programmes, adoption of a phased approach, availability of diagnosis and treatment, accessible VCT and support services, effective monitoring and evaluation systems, promotion of IEC, and operational research.

AFRO has been involved in a number of policy level actions including the OAU Summit of 2001, which led to the Abuja Declaration. A regional committee for health ministers and the WHO Secretariat has been planned for September 2002, and a joint strategy for TB/HIV is scheduled to be endorsed by the regional office in 2003. AFRO believes that future action against TB/HIV should involve the adaptation of strategy and guidelines at country level, monitoring and evaluation of phased implementation at country level, and relevant operational research to feed into policy and guidelines.

2.2.6

WHO, WPRO and SEARO

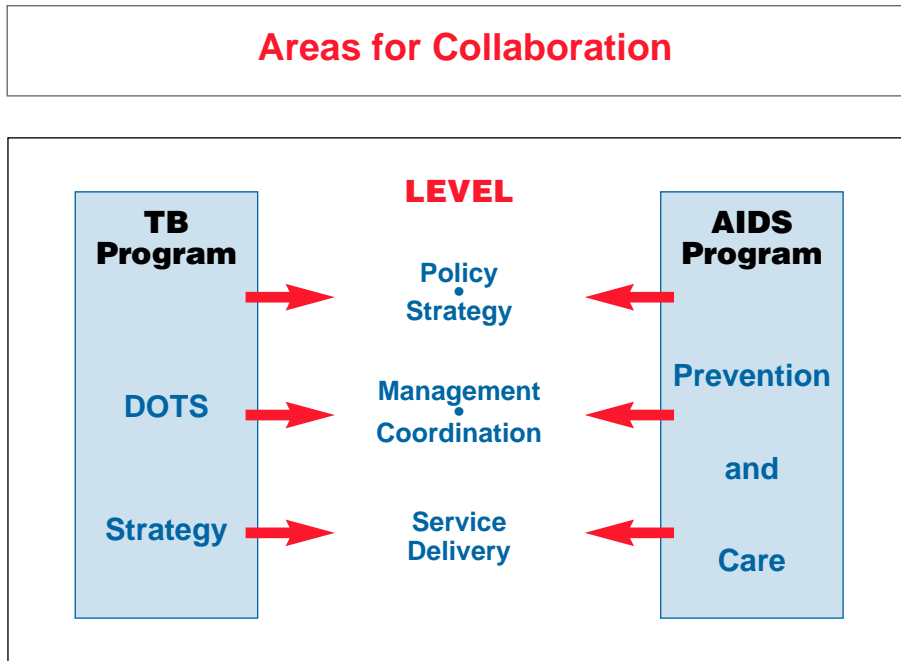
Representatives from WHO's WPRO and SEARO offices discussed the TB/HIV situation in their regions. The TB burden is high and increasing. HIV prevalence varies considerably between countries but generally is low as yet. HIV prevalence among TB patients also varies greatly. There is strong health infrastructure and good DOTS implementation, comprehensive AIDS care is in place (Thailand) or under development (Cambodia, China, India, Myanmar, Viet Nam). Governments play a major role in both DOTS and AIDS programmes.

The regional response strategy involves facilitating collaboration of TB and AIDS programmes and the development of comprehensive HIV/AIDS care. A draft regional framework has been developed in WPRO and SEARO, together with draft regional guidelines for comprehensive HIV/AIDS care and treatment. The objectives of the regional framework are to clarify the interaction between TB and HIV for countries in the regions, assist countries to identify mechanisms for collaboration to address TB/HIV, and facilitate the implementation of surveillance and interventions for prevention and care of TB/HIV. Surveillance will include HIV prevalence among active TB patients (with the inclusion of TB patients in HIV sentinel surveillance and case reporting) and the prevalence of TB among HIV-infected people. Principles have been agreed for intensified case finding, VCT and referral: the NAP should be responsible and accountable for VCT; the NTP should be responsible and accountable for TB case finding; and effective referral mechanisms must be established between NAP and NTP that have been developed and agreed upon by both programmes.

Principles of TB treatment and HIV/AIDS prevention and care outlined in the regional guidelines include:

- the NAP is responsible and accountable for any intervention directly related to HIV/AIDS
- the NTP is responsible and accountable for any intervention directly related to TB
- the NAP and NTP can complement each other in the areas of prevention and care, and must agree on “who does what”.

Areas for collaboration between TB and HIV programmes are shown in the Figure below.



The situation in Thailand, which has the highest HIV prevalence in the region (10%), is receiving particular attention. The number of TB patients who are HIV-positive is increasing and HIV now accounts for 60% of the TB burden. TB workers and HIV workers now meet at programme level. Guidelines for comprehensive care are being developed. Good IPT adherence is reported. There are day care activities for INH registered clients. There is strong peer support and counselling. Responsibilities are well defined in both programmes and referral points include VCT, HBC, STI and OPD.

The next steps are to finalize the regional framework, strengthen collaboration between regions, support countries to establish and strengthen TB/HIV coordination mechanisms, facilitate development of national plans of action for TB/HIV in more countries, strengthen HIV/AIDS prevention and care, and support countries to implement TB/HIV activities through phased expansion.

2.2.7**WHO Department of HIV/AIDS**

Dr Charles Gilks (Department of HIV/AIDS, WHO) spoke on TB as a core element in comprehensive HIV/AIDS care. He reminded the meeting that one of the targets of the UNGASS Declaration was, by 2003, to “make every effort to provide progressively and in a sustainable manner the highest attainable standard of treatment for HIV/AIDS including prevention and treatment of OIs”. TB is the most important OI in HIV and must be the core target in this strategy.

As each case of HIV infection advances, the patient needs progressively more care and support. Current prevention and control strategies focus on people who know they are HIV-positive and are willing to declare themselves as such. The aim of VCT is to increase the proportion of infected people who know they are positive. TB control aims to identify cases and enter them into a vertical programme. However, in a typical high-burden TB/HIV country the majority (over 90%) do not know their HIV status and many of those who know they are infected are not receiving care. Most active TB cases in the community are also unrecognised.

Many patients who are part of the “general medical take” are sick because they have TB/HIV but they are unaware of their status for either infection. They are not receiving care from either the TB or the HIV services. The precise extent of this problem is unknown but it is considerable. For example, 25% of unselected admissions in Nairobi have TB/HIV. TB is also found in 40% of autopsies in Abidjan. In Hlabisa, South Africa, in a six-month period there were 51 TB deaths within the TB service but 123 such deaths on medical wards. There is potentially a huge additional TB/HIV disease burden which is currently ignored. Ways must be found of addressing this burden, otherwise TB will continue as the biggest killer of HIV-infected individuals. More optimistically, in a project involving 1400 HIV-positive patients in Entebbe, standard TB detection and treatment methods were used and, of the 400 deaths during the next four years, only 7% were due to TB. (Cryptococcus was the commonest cause of death at 23%).

The positive message is that effective TB control provides the best opportunity for immediately improving outcome and survival for TB/HIV.

3.1

ProTEST

3.1.1

A summary

Dr Philip Onyebujoh, from Stop TB, WHO, looked at achievements made so far in the ProTEST projects, supported by WHO, USAID and CDC-GAP. The strategies of ProTEST are: to reduce HIV transmission through quality VCT services, promotion of condoms, and, where possible, to treatment of STIs; to reduce TB transmission through active case finding (ACF) and enhanced case-holding; to reduce TB reactivation through appropriate use of preventive therapy; to link HIV prevention services more closely to HIV care; and to increase collaboration between TB and HIV stakeholders.

The ProTEST projects in South Africa, Malawi and Zambia succeeded in increasing VCT uptake and in recruiting a considerable number of clients for isoniazid preventive therapy (IPT). Adherence to IPT was, however, disappointing and further work was needed to understand the constraints.

Nevertheless, the projects have demonstrated that there is a window of opportunity to implement preventive measures. Intensified case finding for TB still needs to be optimised, but the projects have demonstrated the potential of utilising VCT as an entry point to TB case finding. Other services linked through the projects include STI screening utilising a syndromic approach, and management of other opportunistic infections through improved general health care access and services.

Several lessons have been learned. Action at district level is a key requirement and collaboration of programmes at district level has been shown to be possible. There is, however, much that is not yet known. The cost-effectiveness of district-level interventions has not yet been fully determined, particularly with regard to IPT and CPT. The impact of VCT on sexual behaviour is not yet clear and the impact of HAART on TB/HIV is quite unknown. The sustainability of TB and HIV/AIDS programme collaboration will be dependent on the degree of commitment by the two programmes to carry out joint TB/HIV activities. This may be achieved through the appointment of a TB/HIV working group or committee, and focal persons dedicated to the implementation of joint programme activities. Ways must be found to improve the adherence to preventive interventions, including IPT and CPT.

The next steps will include: submission of proposals for phased implementation activities (PIA) by eight countries so far identified (Ethiopia, Kenya, Malawi, Mozambique, South Africa, Tanzania, Uganda and Zambia); brokering of linkages

with programmes supported by other agencies such as GFATM, CDC and USAID; the holding of implementation workshops; capacity development; the standardisation of indicators; improved monitoring and evaluation; and the provision of technical assistance to countries implementing joint TB and HIV/AIDS programme activities. WHO/HQ will work with WHO, AFRO in bringing francophone countries into the PIA strategy.

3.1.2

Formal evaluation

Dr Peter Godfrey-Faussett and Dr Lilani Kumaranayake, both of the London School of Hygiene & Tropical Medicine, described the progress being made with the formal evaluation of ProTEST. The ProTEST approach can be summed up as: preventing TB transmission, preventing TB reactivation, preventing HIV transmission, and reducing morbidity. They stressed that the benefits of the ProTEST projects were already felt by those involved to extend beyond the individual and his/her immediate network to include the health system, the community, and the national and international policy making arena.

Targeting the individual helps to coordinate and integrate programmes; it reduces stigma, builds capacity, and catalyses national discussions. Within the health system, ProTEST seeks to: empower nurses by increasing their confidence and improving their awareness; provide training in VCT; develop the health system, particularly through reducing fragmentation; and improve collaboration and stakeholder involvement at district level.

The purpose of the formal evaluation is to learn lessons from all the project sites, within the broader context of TB, HIV and VCT. There are some variations between sites in the approach used and it is necessary to develop a generic protocol to assist in the implementation of the ProTEST approach elsewhere. It is also important to learn about the cost and cost-effectiveness of specific interventions (VCT, IPT, HBC etc.) in the project sites. Components of the evaluation include: a behaviour survey, a cost-analysis survey, model development, and economic analysis. Some of these activities have already started: cost-effectiveness evaluation has been conducted in Malawi and Zambia, and a behaviour survey is under way in Malawi with another starting soon in South Africa. Preliminary cost-effectiveness results from two sites in Zambia are now available.

3.2

Country experiences

3.2.1

Ethiopia

Dr Berhane Kidane-Mariam (TB and Leprosy Programme Manager, Ethiopia) spoke on TB/HIV collaborative efforts in Ethiopia, where only 52% of the 65 million population are covered by health services. The estimated incidence of TB

is 260/100,000 (all forms) and 109/100,000 (smear-positive). HIV prevalence stands at around 7%. There have been 105,781 reported AIDS cases. An estimated 960,000 people are coinfecting with TB/HIV. As regards treatment outcome, in 2000 the success rate for new sm+ PTB patients was 78% (SCC), 71% (LCC). Success rate for re-treatment cases was 74%. The defaulter rate was 19% (LCC), SCC (10%).

The main challenges are decentralisation and expansion of DOTS within the health service network, coping with the rise in HIV-related TB, and improving collaboration between the two programmes. A TB/HIV advisory group was formed early in 2002. Organizations participating include: USAID, CDC, universities, research institutions, the MoH, WHO, UNAIDS and NACS. Defined objectives are to initiate or improve the quality of VCT in selected sites, increase TB case-finding in VCT centres, reduce TB incidence in HIV-positive people, and detect and treat STIs in VCT centres. Collaborative activities will also serve to strengthen the health system as a whole. So far, three hospitals and three health centres have been selected for this new programme of joint activities. Essential elements for progress have been identified as: commitment of both TB and HIV/AIDS teams at MoH, a strong HIV/TB advisory committee, and effective communication with international partners. The group has submitted its proposals to the GFATM for support. The constraints that will have to be overcome in implementing the proposals include:

- the overall approach to HIV/AIDS control is not conducive for incorporating TB/HIV initiative
- selection of pilot sites is a difficult process; there are many different interests and opinions
- there is uncertainty as regards the modality of GFATM grant disbursement.

3.2.2

Kenya

Dr Kenneth Chebet (Director NASCOP/NLTP Division Kenya) described the phased implementation of TB/HIV collaboration activities from national to peripheral levels in Kenya.

Kenya's annual health expenditure per capita is less than US\$4. HIV prevalence is estimated at around 13%. Only 5–10% of HIV-infected individuals are aware of their HIV serostatus. The impact of HIV is demonstrated by the fall in life expectancy from 60 to 50 years over the last decade. Around one million children have been orphaned by AIDS. Kenya reported 73,000 new TB cases in 2001 and it is projected there will be 150,000 new cases in the year 2002. Some 40–50% of TB patients are HIV-infected. Since the introduction of short-course chemotherapy, the country is achieving a 78% rate of treatment success.

The low TB case detection rate and the fact that most TB patients do not know their HIV status add to the problems. HIV-positive people have limited access to care, including screening for TB.

There has so far been limited cooperation between the National AIDS and STD Control Programme (NASCOP) and the National Leprosy and TB Control Programme (NLTP). The main challenge of joint TB/HIV activities in Kenya is to improve the level of collaboration. It is intended to expand access both to TB

screening diagnosis and treatment, and to HIV counselling and testing. Preventive therapies will be promoted among HIV-positive VCT clients. Progress made so far in the implementation of these activities includes:

- formation of a division overseeing both TB and HIV programmes
- joint training and supervision, with the support of the World Bank, DARE and CDC
- harmonisation of core functions of administration, supplies, logistics and procurement
- incorporation of TB in HIV/AIDS policy documents/guidelines
- drafting of an IPT policy document
- rapid scaling-up of VCT sites.

Dr Chebet said there was still a gap between the TB and HIV programmes. He emphasised the need to refocus integration efforts to 'lower implementers' (i.e. districts and provinces). Donors/development partners should be encouraged to support joint activities. Resource gaps should be filled. TB programme managers should be integrated within National AIDS Control Council structures. Overall health system development, including decentralisation and other reforms was crucial.

3.2.3

South Africa

South Africa faces one of the world's worst TB/HIV epidemics. TB notification increased by 250% between 1989 and 2001, with 150,696 cases reported in 2001. HIV prevalence among TB patients is estimated around 50%. In 2000 a joint TB/HIV strategy was adopted. Dr Nono Simelela (Chief Director of TB/HIV/AIDS and STDs, Department of Health, South Africa) described the efforts under way, as part of this strategy, to expand from four pilot ProTEST projects, which began in 1998, to national implementation of joint TB/HIV activities.

Experience so far has shown that consultation with and involvement of community structures is important for successful implementation. Political commitment and ownership are also important, to mobilise funding and to ensure sustainability. Human resources are a key constraint, although improvements in management of human resources have been made in the course of this intervention. Active case finding and management, through joint programme efforts, has emerged as playing an important role in the control of TB in HIV-positive clients. TB control has not been negatively affected by the introduction of joint TB/HIV activities.

However, a number of challenges have emerged:

- quality assurance for rapid HIV testing. This will be particularly important if, as planned, lay counsellors are trained in HIV testing
- the need for standardised prophylaxis and treatment of opportunistic infections
- ways to improve poor adherence in INH treatment
- logistics issues associated with the supply of tests and drugs
- establishing effective recording and reporting systems
- integration of TB/HIV activities with PMTCT
- ways of ensuring community mobilisation
- insufficient human resources.

The criteria for expanding TB/HIV interventions include well-functioning TB services (e.g. good sputum conversion rates, high cure rates, low interruption rates) and

sufficient personnel in the districts. TB/HIV collaboration committees are needed at all levels. The following areas where TB and HIV programmes can collaborate have been identified:

- training of healthcare workers, home-based care givers and DOT supporters in TB/HIV management
- involvement of home-based care givers in TB activities and VCT promotion
- involvement of DOT supporters in VCT promotion
- education and awareness campaigns to include both TB and HIV.

The package of services provided will vary according to the availability of resources but will include: enhanced district collaboration between TB and HIV service providers (including both government and NGOs), and mobilisation of communities, increased access to VCT services with a focus on self referred clients. Services are largely provided in comprehensive health care facilities. The same primary healthcare nurse may provide VCT, TB, HIV and STI services. At district level there may be one person responsible for TB and HIV, or there may be individual coordinators for TB and for HIV. TB coordinators should take responsibility for ensuring that TB patients have access to VCT and condoms. HIV coordinators should take primary responsibility for VCT, condoms, cotrimoxazole, management of opportunistic infections and HBC.

Targets that have been set include the coverage of all districts by 2006, HIV testing of 12.5% of adults and 80% of TB patients by 2005, as well as screening of 90% of VCT clients with HIV infection for TB, and providing CPT to 90% of those who are eligible including HIV-positive TB patients by 2006.

A phased expansion plan has been drawn up. The coordinating structure is provided by the National TB/HIV Task Team, National TB/HIV Working Group, nine Provincial TB/HIV Working Groups, and District Management Teams. A system for monitoring and evaluation has also been established.

Political commitment should be as strong for TB as it is for HIV/AIDS. Financing at district level for both programmes should be integrated so that resources can be shared. Health awareness programmes should be conducted jointly. VCT services need to be 'marketed'. There is still a need for separate programmes but it is crucial to identify areas of collaboration.

3.2.4

Malawi: lessons to be learned

Dr Anthony Harries (Project Advisor, Malawi National TB Programme) discussed the constraints in implementing joint TB/HIV activities with reference to experience in Malawi.

VCT services for TB patients

Voluntary counselling and testing (VCT) services require health-facility-based counselling (properly staffed with counsellors) that TB patients can access at or soon after registration, and rapid and convenient HIV testing services. Major constraints in providing VCT services in most resource-constrained countries include the difficulty

of creating a special cadre of VCT counsellors, and quality assurance in both counselling and HIV testing. Lack of infrastructure and insufficient space in clinics are other issues. HIV testing at time of TB registration might also be too much for the patient to cope with.

National AIDS programmes should take responsibility for VCT and meet the costs. TB officers should be trained regarding VCT. Regular supervision is essential for quality assurance.

Cotrimoxazole preventive therapy

Implementation of CPT requires access to VCT for all TB patients at, or soon after, registration. CPT must be continued during the intensive and continuation phases of anti-TB treatment. It must also continue after TB treatment is complete. Treatment cards should be marked to show the patient is receiving CPT, though this does add to the difficulties of maintaining patient confidentiality. The drug supply must be regular and protected. One concern is the possible development of resistance to SP treatment for malaria. (Dr C Gilks said a WHO consultation on CPT was planned to help resolve remaining questions.)

Care for HIV-related illness

This should include: management of opportunistic infections and tumours, management of STIs including provision of condoms, nutritional support and palliative care. A two-way referral system should be established between hospital and community. VCT units could play an important role here by acting as the gateway for referrals to the community.

Constraints include: a lack of in-patient and out-patient care for TB patients, a lack of drugs for treating HIV-illnesses, poor nutritional support in hospital and at home, and a poor palliative care system.

Preventing recurrent TB

Secondary isoniazid preventive treatment was recommended by Dr Harries. However, he also called for a meta-analysis of existing data to determine if IPT was effective in this role. More operational research and more clinical trials would also be necessary. If implemented, TB patients who are HIV-positive would complete TB treatment, then start isoniazid 5mg/kg daily. However, the effectiveness of IPT in this role is still not clear, as the evidence base is small. There is no agreement as to whether the IPT is for life. Other issues include the question of who takes responsibility (including financial responsibility) for providing treatment, and who monitors compliance.

Intensified case finding

The focus should be on household contacts, given the high incidence of TB among

household contacts of TB cases. Household contacts of HIV infected smear-positive pulmonary TB should be offered VCT. HIV-positive contacts with TB should be given TB Rx; HIV-positive contacts with no TB should be offered IPT. NTPs should ideally be responsible for household screening but they may lack the capacity for this extra duty. Again operational research is needed.

TB/HIV management capacity

TB/HIV management requires improved capacity, particularly an increase in human resources. Nationally, there should be a TB/HIV technical group and also a steering committee. At district level there should be a TB/HIV coordinating group; district health management teams should be conversant with TB/HIV activities. Clear lines of responsibility must be established in NTPs and NACs. A vertical programme structure for TB/HIV should not be established.

Monitoring and evaluation

This is crucial. There must be agreement on what needs to be routinely recorded and who is responsible for monitoring, both nationally and at district level.

3.2.5

Malawi: an NGO experience

Dr Rony Zachariah, from Médecins sans Frontières, Luxembourg, presented MSF experiences with implementing joint TB/HIV intervention in Thyolo district in Malawi. TB patients are registered in the district TB office before starting treatment. They are offered VCT, and HIV-positive patients are offered CPT. There is screening for STIs. TB patients are discharged to a network of home-based care volunteers. There is a trained HBC volunteer who can cater for at least five patients. HBC volunteers are supervised by a team of peer leaders, a nurse, an HBC coordinator and a doctor. The HBC volunteer supports the patient during treatment (preventive and curative), refers clients when necessary (e.g. for diagnosis and management of OIs), facilitates income generating activities and social mobilisation.

The programme has enrolled 2673 TB patients, of whom 96% were pre-test counselled for HIV, 91% were tested for HIV, 88% received their HIV result back, and 77% were found to be HIV-infected. Of the HIV-infected patients, 94% accepted CPT. Of all the patients who were referred from VCT for HBC, 96% were integrated into the community network.

In an average month 900 patients are being catered for by the HBC programme, 44% with both TB and HIV, 43% with HIV-infection only, and 10% with TB only. Community activities, particularly with orphans, are also part of the programme.

Dr Zachariah discussed the constraints faced and the part played by MSF in addressing them.

Human resources were inadequate in the public service; staff leave 'in search of

greener pastures' and those who remain in the service often have weak capacity and are poorly motivated. MSF provided additional staff (counsellors, clinicians, ward nurses and home-based coordinators). It was considered important that these staff were integrated as much as possible into the public sector and that there should not be two parallel 'human resource pools'. This was achieved by establishing a joint commission for employment that included MSF, the public sector and representatives of the community. New individuals were integrated within the district hierarchy and schedules. Steps were taken to motivate MoH staff working alongside NGO staff; this included performance linked incentive payments. MSF made every effort to avoid being 'nationalistic'. MSF T-shirts were not worn by staff.

Financial resources are always a problem. Each year, budgets seem to dwindle at district level, despite decentralisation. New resources are needed to be able to set up infrastructure, provide drugs for opportunistic infections, materials for HBC, food (53% of TB patients in this setting were malnourished on admission), training and supervision. MSF provided: infrastructure (e.g. VCT centres, follow-up clinics and a community coordination centre), drugs for opportunistic diseases plus some essential drugs, food and nutrition services, and logistical support.

Communities have been isolated from TB/HIV interventions. MSF has endeavoured to work with community based organizations and help to bridge this gap. NGOs often have the resources to catalyse community initiatives. Community involvement can assist with compliance to treatment, early case detection, the role played by traditional healers, achieving acceptability for VCT. It can also catalyse the involvement of PLWAs, who can have an important influence on the acceptance of VCT.

Collaboration between TB and HIV programmes

MSF supported the district TB officer in case detection, diagnosis, and treatment. Support was also provided to the District AIDS Committee in VCT HBC, opportunistic infections, and cotrimoxazole after anti-TB treatment. MSF helped organise monthly meetings between the two programmes plus the HBC coordinator and members of other teams.

In summary, the NGO involvement provided: an opportunity for bridging existing gaps, a new dynamic that facilitated the delivery of joint TB/HIV activities, and a decentralised political force that improved access for care/support.

3.2.6

Discussion

Discussion on the country experiences evolved around the following:

- the impact of IPT on resistance to INH and CPT on resistance to co-trimoxazole and SP
- how to improve adherence to preventive treatment interventions
- how to plan for scaling up interventions in the face of constraints – notably low adherence rates and insufficient human resources.

The consensus view of the group was that the issues of resistance needed to be studied and taken into consideration before scaling up interventions. With regard to adherence, it was agreed that all strategies to improve adherence needed to be evaluated, including patient counselling, community mobilisation, and education.

Finally, the group agreed that scaling up interventions would require prerequisites such as: strategies to improve human resources (through training and the use of incentives), adherence to prophylaxis, and community involvement.

TB:IV

Endorsement of the draft WHO guidelines for implementing collaborative TB and HIV programme activities

4.1

Presentation of the guidelines

Dr Fabio Scano (Stop TB Department, WHO) reminded participants of the philosophy of the global strategic framework to decrease the burden of TB/HIV: TB and HIV/AIDS programmes had largely pursued separate courses, despite overlapping TB/HIV epidemiology, but now there was a shift to a strengthened unified health sector strategy to control TB/HIV as an integral part of the response to HIV/AIDS. This new approach would involve: full implementation of the DOTS strategy; additional interventions against TB (including intensified case-finding and TB preventive treatment); interventions to decrease HIV transmission (e.g. condom promotion, STI treatment, safe-injecting drug use and ARTs); and interventions to decrease morbidity and mortality in co-infected cases (e.g. cotrimoxazole preventive treatment, OI treatment).

The rationale for developing guidelines for joint programme activities is that most health districts, whilst recognising the need for reducing the burden of the two overlapping epidemics, may not be aware of potential collaborative activities and their benefits. The guidelines are intended for district policy-makers and health providers (for whom they need to be simple, practical, evidenced-based and adaptable, to enable rational planning and priority setting) and national policy makers and programme managers (who need information for policy consensus and strategy, advocacy and technical assistance). Collaborative TB and HIV programme activities should build on TB and HIV interventions and learn through the process of implementation.

The guidelines outline the following steps which should be taken:

- situation analysis of baseline data and stock-taking of existing services
- co-ordination of stakeholders (coordinating body, TB/HIV committee)
- development of a district work-plan, with objectives and budget for each partner
- costing activities
- steps to implement activities; the use of prioritised activity charts is recommended
- monitoring and evaluation.

Key activities should be built up (depending on the human and financial capacity of each district) as discussed in the prioritised activity charts. Specific activities for which guides have been developed include:

- promotion of VCT to TB, HBC and STI patients
- promotion of safer sexual practices and condoms to TB patients
- intensified TB case-finding by the NTP
- CPT
- TB screening at VCT centres

- STI screening at VCT centres, and VCT promotion by STI treatment services
- STI treatment at VCT centres
- TB sputum smear-microscopy at stand-alone VCT centres
- TB treatment at stand-alone VCT centres
- community involvement in TB treatment
- PLHA support group involvement in TB (or STI) activities
- IPT
- ART.

Monitoring and evaluation activities should include:

- data collection, which should be as much as possible within routine systems and involve agreed indicators for each intervention and standardised data collection tools
- reporting to all partners at district and national level
- an annual review that includes the next annual work-plan.

Challenges that remain include, prioritising interventions, developing capacity to deliver interventions, cost-sharing and resource mobilisation, and the effective coordination of the many role players.

The guidelines are due to be finalised in the third quarter of 2002. They will be field tested in quarter four, when country proposals will also be evaluated. In the first quarter of 2003 training tools will be developed to be utilised in conjunction with the guidelines. It is envisaged that further editions of the guidelines will be required in the light of experience with their use in the field.

4.2

Discussion

Participants were agreed that the first volume of the guidelines would make a valuable contribution to joint TB/HIV activities. (This volume provides background information and deals with the planning and implementation of joint programmes.) Discussion largely focused on the usefulness of the second volume, which dealt with the evidence and experience base (from ProTEST and other sources) that was used to compile the activity guidelines. A range of views was expressed. Some participants considered it to be useful and appropriate for inclusion in the guidelines as an annex. Others, especially those from regions other than Africa, took the view that much of it was not helpful and that, if published at all, it should be as a separate document. The former was, however, the view of the majority.

The WHO secretariat stressed, however, that this was a generic document intended to be adapted to specific country requirements. The guidelines have already been circulated widely (including among the HIV/AIDS community) and discussed at the Nairobi meeting.

It was agreed that the guidelines should be completed within three months and subsequently field tested. Ways should also be found to present the guidelines in a simplified and user-friendly format.

Anti-retroviral treatment (ART)

5.1

Experience in Brazil

Dr Marco Vitória of the Brazilian STD/AIDS Programme described Brazil's action against HIV/AIDS, focusing on strategies implemented to provide universal, free anti-retroviral therapy to people living with HIV. This initiative began in 1991, with limited distribution of ZDV capsules, and was extended in 1996, when a presidential decree guaranteed free access to essential medication to all HIV-infected individuals. The Ministry of Health has set up three AIDS task forces, which keep treatment criteria under review in the light of new medical advances. Specific guidelines for TB/HIV coinfection have been established.

As of December 2001, approximately 113,000 patients had received ART through the public health system, at a cost of roughly US\$235 million. It is projected that 160,000 individuals will be treated with HAART in the public health system by the year 2004. A computerised system has been established for distribution and control of the drugs. A network comprising more than 1000 public care and laboratory facilities has been set up to improve the monitoring of HIV infection and the diagnosis and medical observation of HIV-related opportunistic diseases. Expenditure on anti-retroviral programmes represents 1.6% of the total budget of MoH and less than 0.05% of Brazilian GDP in 2001.

By the end of 2001, the MoH was distributing 14 anti-retroviral drugs of three different pharmacological classes to all patients meeting the criteria set down in national guidelines. Eight of the ARVs are produced locally. In some cases, local production has cut prices by over 80%.

The results of the prevention and care strategies are impressive. A recent evaluation has shown that the survival of AIDS patients has increased substantially since 1996, particularly since the introduction of universal access to HAART. Before the availability of combined therapy, median survival time was under six months; it is now close to five years. The MoH estimates that more than 90,000 AIDS-related deaths have been avoided. The incidence of HIV-related opportunistic infections has fallen by around 60–80%. In the State of São Paulo, which has roughly 50% of Brazil's AIDS cases, the number of TB cases among HIV-infected individuals has dropped by 65% over the last five years. Nevertheless, TB remains one of the most important causes of death among HIV-positive patients in Brazil.

The prevalence of ARV drug resistance in Brazilian patients under HAART is around 44% -very similar to the rates found in international studies. However, the prevalence of primary resistance in drug naive patients is less than 5%, which is significantly lower than the rate in Western Europe and the US.

Implementation of the policy has achieved cost savings. In the period 1997-2000 an estimated \$1.8 billion was saved on inpatient and ambulatory care.

The Brazilian experience demonstrates that effective AIDS treatment is feasible in a middle-income country - Brazil's GNP per capita for 1999 was \$4790. It has been shown that it can alter the natural history of coinfections, including TB. Whether the same results can be repeated in countries with significantly higher HIV prevalence rates, and lower incomes, remains to be seen.

5.2

Experience in Malawi

The presentation of Dr A Harries (see 3.2.4) included an account of Malawi's experience with the use of ART. Challenges include safeguarding the drug supply and ensuring routine laboratory monitoring. The criteria for starting ART are crucial: too late in the decline of immune function and it will prevent little TB. If ART starts two months after TB treatment, it will not address the high percentage of TB deaths that occur in the first two months. There is a need for demonstration projects at district and country level, and for operational research to determine whether immediate joint treatment, or delayed HAART, yields better results.

5.3

WHO guidelines

Dr Charles Gilks (Department of HIV/AIDS/STIs, WHO) gave an overview of WHO's recently published guidelines on the use of ART in resource-constrained countries.¹ Primary audiences for the guidelines are national treatment advisory boards, AIDS programme managers, and other senior policymakers. They are not intended to be a clinical manual for patient management.

Key considerations in the development of the guidelines were:

- the need for potent regimens (including at least three drugs) to prevent resistance and maximise benefit
- standardisation to allow use in settings where HIV/AIDS specialists and tests to monitor treatment are not readily available, and facilitate continuous availability of the drugs
- recommendations should be made on best available evidence
- flexibility should be incorporated in regimens to allow for toxicity
- specific groups should be included: children, pregnant women, intravenous drug users, and cases with co-pathology.

The guidelines indicate that treatment should be initiated once the patient presents clinical symptoms of immunodepression. However, some countries may choose to start treatment earlier.

The first-line regimen includes a combination of two nucleoside reverse transcriptase inhibitors (NRTIs) and one non-nucleoside reverse transcriptase inhibitor (NNRTI).

It is hoped that the publication of these guidelines will help achieve the target of treating three million HIV-infected individuals by 2005.

It is recognised that in many developing countries, HIV-infected individuals will be identified following TB diagnosis. The guidelines recommend the following:

- for patients with CD4 counts below $50/\text{mm}^3$ and/or disseminated TB, simultaneous dual treatment for both TB and HIV is indicated (e.g. ZDV/3TC backbone; with ABC or EFV or SQV/r added)
- for patients with CD4 $50\text{--}200/\text{mm}^3$ or TLC $<1000\text{--}1200/\text{mm}^3$, completion of two months of induction TB therapy is suggested before starting HIV treatment (with the same regimen as above)
- for patients with TB and CD4 $>200/\text{mm}^3$ or TLC $>1000\text{--}1200/\text{mm}^3$, treat TB, monitor clinical status; start ARV if necessary, or start 'standard' ART after therapy when indicated.

Given the limited data yet available, evidence and experience from the first wave of TB/HIV treatment centres must be reviewed as soon as possible and the guidelines revised accordingly.

Reference

1. WHO. Scaling up antiretroviral therapy in resource-limited settings; Guidelines for a public health approach. WHO, Geneva, 2002.

www.who.int/HIV_AIDS/HIV_AIDS_Care/ARV_Draft_April_2002.pdf

5.4

Discussion

The discussion that concluded this session centred on the WHO guidelines for ART. Participants expressed the need for a sharing of national and regional experience in adapting the guidelines to local situations. The need for training health workers in the use of ART was also stressed; WHO is already engaged in the development of guidelines.

Participants concluded that the data from Brazil (especially when combined with a South African report of an 80% reduction in TB incidence with the use of HAART²) - provided ample evidence to justify efforts to increase access to ART. The WG should, therefore, specifically aim to include HAART as soon as possible in the planned establishment of joint TB/HIV activities.

² Badri M, Wilson D, Wood R. Effect of highly active antiretroviral therapy on incidence of tuberculosis in South Africa: a cohort study, *The Lancet*, 2002; 359:2059

TB:IV

Directions suggested by epidemiological modelling

6.1

The impact of available interventions

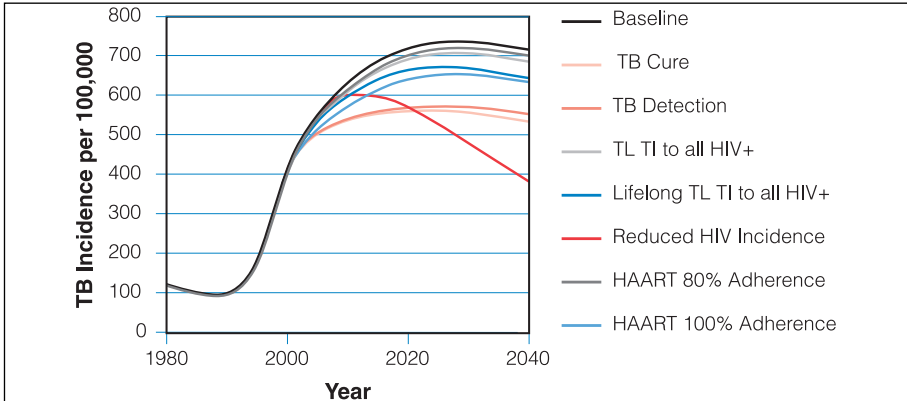
Christine Currie (Faculty of Mathematics, University of Southampton, UK) presented an epidemiological model of TB and HIV, and discussed its possible application. There are two sub-models: one for people who are HIV negative or at an early stage of the HIV disease, and one for people who are HIV-positive or are at a later stage of the disease. The model can be used to explore the impact of a range of different interventions against TB and HIV. Data from the current situation in Kenya was used to illustrate how it can be used in practice. The interventions so far modelled are:

- Improving TB cure and case detection rates;
- Treating latent TB infections (either for 6 months or for life), assuming an effectiveness of 70%.
- Providing triple anti-retroviral therapy (ART), assuming either no dropout or a 20% annual dropout
- Reducing HIV incidence through available interventions such as the provision of condoms, peer education programmes and so on.

Data from Kenya were used to illustrate the way in which the model can be used to predict the effect of each of the interventions on the prevalence of TB. The figure shows the impact of a 10% improvement in each intervention from current levels. Reducing HIV incidence by 10% produces, according to the model, a dramatic reduction of TB incidence but only in the long-term, ten or more years after introducing the intervention. The usual TB intervention, improving case detection and cure by 10%, produces a much more rapid reduction within a few years.

Part of the reason why detecting and curing TB cases is more effective than ART at reducing TB transmission in the short run, is that TB interventions target everyone with TB while the HIV interventions target only those TB patients who are also infected with HIV. In high HIV burden countries, TB cases and deaths are likely to continue to increase in the short run although the extent of this increase can be reduced by further improvements in case detection and cure. In the long run reducing HIV incidence will be essential to ensure a sustainable reduction in the burden of TB. Models such as this can of course be used to investigate the cost-effectiveness of different interventions. This makes it easier to compare and contrast different kinds of intervention and work on this is in progress.

Impact of Interventions on TB Incidence



Kenya - Constant HIV

The black line shows the projected course of the TB epidemic in Kenya if current control measures are maintained, no new measures are introduced and the HIV prevalence stabilizes at its current level. The remaining lines show the impact of a 10% increase in cure rates and case detection, treating latent tuberculosis infections or providing HAART to 10% of the population, or reducing HIV incidence by 10% from its projected levels.

6.2

Implications of an analysis of the TB and HIV epidemics

Dr Brian Williams (Stop TB, WHO) stressed the importance of taking a dynamic view of epidemics and for a broader perspective on the nature of TB/HIV interactions. In many East and southern African countries it seems clear that even reasonably good DOTS programmes are in themselves not sufficient to bring the rising epidemic of TB under control. Various other interventions which, if combined with DOTS, may significantly reduce the future burden of TB include:

- the provision of TB preventive therapy for those with HIV;
- TB mass treatment in situations where the incidence of TB is very high. This is currently being investigated on some gold mines in South Africa.
- Widespread provision of free ART as is currently being done in Brazil;
- Providing ART for particular high risk groups of people such as commercial sex workers;
- Promoting behaviour change to bring about reductions in HIV incidence (as in Uganda).

Dr Williams reviewed the epidemiological data on TB, HIV and co-infections with both. In many countries TB surveillance is reasonably good while HIV surveillance remains relatively weak and needs to be strengthened. In order to respond to the dual epidemics of TB and HIV it is important to know the extent to which HIV is now responsible for driving up the rate of TB in particular countries. Perhaps more

importantly, we must also be able to anticipate the effect that HIV might soon have on TB in countries such as India.

There is often a wide variation in HIV prevalence between adjacent territories. Thus, mainland Tanzania has an HIV prevalence rate some 20 times that of Zanzibar. We do not understand the reasons for such large variations. The major differences often found between adjoining districts need particular study; this is being done, for example in Kenya and Tanzania.

It is instructive to rank countries both by the number of HIV-attributable TB cases and by the proportion of HIV-attributable TB cases (per 100,000 population), as shown in the Table, as these give rather different views of the situation. All the higher ranking countries (in terms of number) have, with the exception of South Africa, an average annual gross national income of less than US\$500. South Africa has the highest number of cases (77,800). The only non-African country amongst the ten nations with the highest number of HIV related cases of TB is India. Ranking countries by the number of HIV attributable TB cases per 100,000 population puts Botswana at the top of the list (724/100,000) and South Africa then falls to seventh place (333/100,000). Of the twenty countries with the highest case rate, all are in Africa except for Thailand which ranks 20th. TB is an increasing problem in sub-Saharan

RANK	COUNTRY ^a	NUMBER	COUNTRY ^b	RATE
1	S. Africa	77.8	Botswana	724
2	Ethiopia	59.2	Zimbabwe	501
3	Nigeria	49.9	Lesotho	492
4	Kenya	43.9	Swaziland	478
5	India	41.4	Zambia	409
6	Zimbabwe	29.2	Namibia	385
7	Tanzania	25.2	S. Africa	333
8	DR Congo	22.6	Djibouti	325
9	Mozam.	21.5	Malawi	323
10	Zambia	18.9	Kenya	295
11	Uganda	17.3	CAR	290
12	Malawi	16.1	Mozam.	258
13	C. d'Ivoire	15.0	Burundi	228
14	Cameroon	10.1	Rwanda	211
15	Cambodia	7.7	Ethiopia	209
16	Rwanda	7.6	C. d'Ivoire	197
17	B. Faso	6.5	Uganda	173
18	Burundi	6.4	Tanzania	155
19	Ghana	6.0	Cameroon	147
20	Thailand	5.6	B. Faso	132
21	Botswana	5.5	Congo	128
22	CAR	4.9	Cambodia	126
23	Myanmar	4.9	Togo	113
24	Lesotho	4.8	DR Congo	105
25	Haiti	3.7	Nigeria	96
26	Angola	3.1	Haiti	94
27	Namibia	3.1	Gabon	82
28	China	2.9	Ghana	64
29	Togo	2.4	S. Leone	56
30	USA	2.3	Angola	56

Countries ranked by:

a) Number: the number of TB cases annually attributable to HIV (thousands) and

b) Rate: the number of TB cases attributable to HIV per 100,000 population.

Above red line: 80% of total number; above blue line: 90% of total number.

Africa, largely because of the epidemic of HIV, and in Eastern Europe, largely because of the collapse of health services, but the highest rates of increase are in central Asia. And in the USA, for example, where TB is relatively uncommon, the proportion of TB cases attributable to HIV is, nevertheless, among the highest in the world. In countries such as the USA both TB and HIV may be concentrated in certain sub-groups of the population. The point is simply that there are many ways to view the burden of AIDS related TB and we need to consider carefully how best to do this when deciding on where to focus our efforts.

Williams gave a number of recommendations based on lessons learned from such countries as Thailand, Cambodia, Senegal, and Brazil. In high burden countries it is essential to extend and strengthen the current TB interventions, providing additional resources where necessary, to deal effectively with the combined epidemic of TB and HIV. In countries where HIV and TB have not yet reached the levels seen in some sub-Saharan African countries increased efforts will be needed to control HIV and to ensure that it does not reach the levels seen in the high burden countries. In the countries of Eastern Europe and the former Soviet Union it is important to ensure good control among high-risk groups where both infections are spreading rapidly. India and China should both continue to expand DOTS and improve HIV monitoring. Epidemiological modelling shows that if DOTS expansion is slow there will be no reduction in TB, but a with fast DOTS expansion good reductions can be achieved. These conclusions depend strongly on the future course of the HIV epidemic and in neither country is there sufficient data over time to make reliable long term forecasts.

6.3**Discussion**

It was agreed that the presentations demonstrated the need for global and strategic thinking and for regular monitoring of both the TB and the HIV epidemics. National rates may be misleading given that there are very substantial intra-country variations in both TB and HIV, and ranking countries simply according to their national figures could in some cases be misleading. Given the size of some of the states in India, for example, it will be important to collect and analyse data on a substantially finer geographical scale.

Clearly, the impact of ART on TB and other opportunistic infections will depend critically on when, during the course of the HIV infection, the treatment is started. Currently people in Brazil are offered ART if their CD4+ cell count falls below 500/ml but it is likely that in many African countries people are unlikely to be given ART unless their CD4+ cell count falls below about 200 /ml or they present with an opportunistic infection such as TB. Careful consideration needs to be given to the relationship between the timing of ART and the impact on TB transmission.

Prevention of recurrent TB infection is important. In HIV-positive individuals the annual incidence of TB may be as high as 10% in some settings and the annual recurrence rate can be in the region of 5%, depending of course on the background rates of TB transmission and the treatment regimens used. The use of TB-preventive therapy in people who are HIV positive could make a substantial contribution to reducing TB transmission.

Constraints and recommendations to overcome them

Six break-out groups discussed the constraints to be overcome in joint TB/HIV activities. Each group's recommendations were debated and developed further in a plenary session.

A summary of key recommendations was then agreed.

7.1

Planning and establishing an organizational framework at country level (Groups 1 and 2)

Action to address the epidemic of TB/HIV coinfection has been held back by a lack of awareness, political commitment and resources (especially human resources); and also by poor DOTS coverage and stigma. The vertical nature of TB and HIV programmes has added to the problems. However, recent favourable developments (including funding from GFATM, the development of the TB/HIV Strategic Framework, and experience gained from pilot projects) have presented new opportunities to act. The following recommendations are therefore made to Working Group (WG) partners, including countries.

- Nationally, a committee for joint TB/HIV activities should be established. It should be an authoritative technical group. (Its remit may also include advocacy; if it does not, other arrangements, e.g. a forum, must be made for this important function.)
- This body should be under the Ministry of Health and it should work through existing MoH structures. The MoH must identify mechanisms for joint funding and joint planning of TB and HIV/AIDS activities.
- Collaboration should be promoted at all levels; focal points or co-ordinators should be identified to facilitate this collaboration.
- Each programme can learn lessons from the other. For example, TB programmes have experience of managing drug supplies; AIDS programmes have established good networks with other relevant organizations. Sharing of infrastructure may also be possible.
- Communities and NGOs should be included in the planning process.
- Operational research should be included in the plans.
- Planning must include adequate training including drawing up simple guidelines (using helpful wall charts etc.) for use by front-line health workers.
- Activities should be introduced using a step-wise approach, notwithstanding the unrealistic demands of some donor agencies for major expansion within a short time-scale.
- Constraints must be identified and addressed in the design of the framework; in particular **human resource issues** and **management skills** require attention.

7.2

Advocacy and Information, Education & Communication (Group 3)

Advocacy and IEC both have a vital part to play in addressing TB/HIV. However, relatively few activities have yet been conducted and it is hard at this stage to make concrete recommendations. More needs to be done to establish what actually works.

Advocacy and IEC activities must articulate the problems and specify the targets in a simple manner. Memorable slogans must be found!

Advocacy is needed to win political commitment. An important argument is that *TB treatment for PLWHA is the most affordable and cost-effective available intervention for cutting AIDS mortality rates*. This message must be promoted to:

- UN theme groups
- GFATM
- HIV programmes, especially in-country; these must explicitly identify TB/HIV as a priority
- Stop TB programmes
- ...and multi-sectorally.

IEC must include:

- patients and their families - stressing that adherence to treatment is good 'both for you and for yours' and encouraging agreement to VCT
- health workers - whose attitude towards HIV testing and towards TB treatment needs to be improved
- communities - the message that seeking care improves chance of survival must be promoted and stigma must be overcome
- policy makers.

7.3

Surveillance, monitoring and evaluation (Group 4)

It was noted that collection of data had been stressed throughout the draft guidelines for collaborative TB/HIV activities. Data are required for effective programmes, and quality information can help win political commitment. The WG made the following recommendations.

- Indicators must be agreed to help set objectives and goals. WHO's work to identify suitable indicators must be completed as soon as possible and shared with partners.
- Surveillance should be systematic and regular. Data collected must be interpreted and the findings disseminated. It is important that service providers receive feedback.
- Surveillance should determine the prevalence of HIV among all TB patients: smear-positive TB, smear-negative TB, extrapulmonary TB, new cases, and cases receiving retreatment.
- Surveillance must also include determination of TB prevalence among HIV-infected people. In the long term there should be a national anonymous HIV reporting system that includes all HIV indicator diseases.

- Surveillance should be collaborative. National AIDS and national TB programmes should undertake surveillance activities jointly.
- Confidentiality must be ensured.
- Quality assurance is an issue that must be addressed.
- The possible relation between HIV and MDR-TB should be investigated in analysis of surveillance data.

Evaluation requires measurable targets. A comprehensive set of indicators should be agreed upon. It is important to distinguish aspirational and operational targets. Targets should be 'level specific' – e.g. district, national or international.

7.4

Provision and improvement of clinical care (Group 5)

7.4.1

Diagnosis (both of TB and of HIV) must be strengthened in general health services, and at TB, HIV and VCT treatment sites. This will require the following.

- Strengthening the health system, particularly at district level. District health management should play a more central role. Collaboration between medical and other sectors should be improved.
- Acting in the community to increase awareness of signs/symptoms and encourage seeking treatment. Stigma against both conditions should be addressed. Traditional healers and pharmacy outlets should be included in community action plans.
- Removing barriers for access to healthcare facilities - cost and distance. The perception that there is no effective treatment available (especially for HIV) should be addressed.
- Improving human resources (HR) has been identified as a key constraint, and donor demands will prove unrealistic without an increase in HR capacity. The following actions were recommended as part of comprehensive national manpower planning:
 - increase effective staff numbers
 - improve training (in-service and pre-service)
 - provide training in counselling for all staff
 - cross-training of staff from the two programmes
 - training for polyvalent staff
 - find incentives to improve motivation and the retention of staff
- Improving specific practices. The turnaround time for TB diagnostic tests should be improved; for example by improving transport of specimens to laboratories and rapidly communicating results back to clinicians. The procurement of HIV tests should be improved to ensure quality.
- Developing and providing specific tools and commodities including joint guidelines (wall charts etc.), and appropriate diagnostic criteria.

7.4.2

Referral between TB and HIV services must be strengthened:

- clarify the roles of sites and of individual staff, as to where to refer etc.
- consider providing both services at the same location
- use proper referral forms
- involve district managers in the referral process.

7.4.3

Antiretroviral treatment offers many opportunities. The WG urged partners to work towards its rapid introduction. Successful introduction of ART would be greatly facilitated by several elements - some of which, in fact, essential:

- a functional primary health system
- infrastructure (including laboratories) of acceptable standard
- TB drugs and basic (non-ARV) drugs for HIV patients must be reliably available
- counselling services
- agreement on clear treatment eligibility criteria.

Further development of existing WHO guidelines is needed, especially to clarify when patients on TB therapy can begin to receive ARVs.

Where TB programmes are strong, ARV programmes may work particularly well, because of the experience the TB programme has gained in managing a chronic condition. However, ARV programmes should be considered elsewhere; they too could strengthen the health system!

7.5**Scaling up joint activities**
(Group 6)

- The WG urged WHO and partners to continue and expand their work to establish the evidence base for TB/HIV interventions through phased implementation of nationally defined core activities.
- Joint activities will vary but the following must always be considered for inclusion: syndromic management of sexually transmitted infections, voluntary counselling and testing for HIV, active case finding, isoniazid preventive treatment, cotrimoxazole preventive treatment, treatment of opportunistic infections, home-based care, prevention of mother to child transmission, anti-retroviral treatment.
- Nationally, the first step must be a situation analysis/baseline review of existing initiatives taking account of: stakeholders/role-players, workload, human resources, level of performance.
- There must be a consensus on indicators and targets.
- Community, private sector and NGO collaboration must be sought.

Prerequisites for scaling up include:

- sufficient advocacy
- political commitment
- existence of coordinating committees at all levels

- improved management skills for co-ordinators
- strategic and operational planning
- expanded capacity within the health system, both financial and human

Financial resources should be sought for the necessary:

- health system support and co-ordination
- drugs
- diagnostic services
- transport, logistics
- capacity building, especially human resources.

Recommendations to improve adequate human resources:

- determine optimum staffing levels (locally) and estimate number of new staff required
- measure staff attrition, due to illness, migration etc.
- improve salaries and offer incentives to reduce attrition
- make use of compulsory community service schemes and volunteers
- consider authorising lower level staff to perform different functions.

The WG stressed that a key issue in scaling up is the need to protect the core DOTS programme. Expansion of programmes and addition of new priorities/activities must not be allowed to weaken DOTS activities, which will remain central.

7.6

Summary of key recommendations

1. In recognition that control of TB in high HIV prevalence settings requires full implementation of the DOTS strategy and incorporation of additional joint TB/HIV activities, the WG urges WHO:
 - to submit a resolution to the WHA in 2003 that urges governments to implement an HIV/AIDS care strategy and country-level implementation of joint TB/HIV activities, as set out in the Global TB /HIV Strategic Framework
 - that the HIV/AIDS Department should finalise the development of its AIDS care strategy and, without delay, share details of the principles on which it is based
 - that the Stop TB Department should finalise its TB/HIV guidelines within three months, in collaboration with the HIV/AIDS Department, and regional offices should be requested to adapt the guidelines for their own use
 - to continue working to establish the evidence base for TB/HIV interventions, initially through phased implementation of nationally defined core activities and also via focused operational research
 - to act urgently to determine the feasibility of delivery of ART in resource poor settings, given that it appears to be the most effective intervention to prolong life in those receiving it and will also reduce the incidence of TB in those treated
 - to finalise the indicators and targets for joint TB/HIV activities
 - that all measures above should incorporate approaches that include the private sector, community-based organizations and industry.
2. The WG urges UNAIDS, with all its cosponsoring agencies, in collaboration with the WHO Stop TB and HIV/AIDS Departments, to develop a comprehensive advocacy and IEC strategy for TB/HIV, which can be adjusted to country-specific situations.

3. The WG urges governments to develop clear organizational frameworks for expansion of joint TB/HIV activities and, in particular, to strengthen both NTPs and NACPs to carry out their respective core functions to:
 - ensure NTPs incorporate TB/HIV activities as part of national DOTS expansion plans
 - ensure NACs and NACPs introduce joint TB/HIV activities as part of national HIV/AIDS strategies.
4. The WG urges bilateral agencies, the World Bank, the GFATM and other financial partners to increase funding specifically for joint TB/HIV activities. Governments are also urged to increase their funding of TB/HIV activities and to ensure that these activities are included in requests made to these bodies.
5. The WG urges WHO and the World Bank to work with its partners to ensure that governments develop comprehensive manpower strategies to address the TB/HIV issue, and to work with the IMF to encourage more flexible policies for health staff recruitment and retention, with attention given to incentives. The WG further urges donors to make realistic demands on those countries with limited capacities.
6. The Stop TB partnership was requested to investigate the potential for the GDF to catalyse scaling up of the TB/HIV strategic framework through supply of TB/HIV related products.

Stop TB Partnership



Global TB/HIV Working Group

**2nd Global TB/HIV Working Group Meeting
Durban, South Africa
14-16 June 2002**

Chair: *Dr Gijs Elzinga*
Secretariat: *Dr Paul Nunn*
Rapporteur: *Dr Paul Chinnock*



Agenda

Main Theme

The main theme addressed in this meeting will be the support of countries as the working group shifts focus from global strategy development to implementation of joint TB and HIV activities at country level

Overall Objective

To expand and enhance joint activities at country level

Specific Objectives

1. To increase the amount of collaboration between the TB and HIV communities on TB/HIV activities
2. To determine progress with joint TB and HIV activities and identify opportunities and constraints at international and national levels
3. To agree on next steps for implementation and support, particularly at country level
4. To clarify ways of working of the Global TB/HIV Working Group, its components and its partners

Expected outcomes

1. An update on progress on joint TB and HIV activities at country, regional and global levels; endorsement of the “Guidelines for phased implementation of joint TB and HIV activities”; and an analysis of existing constraints to progress and how to overcome them.
2. Definition of practical steps that can be taken by the members of the Working Group, especially National TB and National HIV/AIDS Control Programmes, to advance joint TB and HIV activities, focusing particularly on:
 - the support required to win financial support in countries,
 - and the steps required to include anti-retroviral treatment in joint TB and HIV activities.
3. Agreement on the next steps required to ensure political support for joint TB and HIV activities, and to ensure the technical and managerial support needed.
4. A clear understanding on the part of all the partners of how the Working Group operates and agreement on mechanisms to ensure future co-ordination and progress.

Rapporteurs: *Dr Francis Adatu-Engwau and Dr E. Talbot*

13:00 - 14:00	Registration	
14:00 - 14:10	Welcome and Introductions:	<i>Dr A. B. Kaboré</i>
	Opening Address	<i>Dr J.W. Lee</i>
14:10 - 14:20	The Stop TB Partnership	<i>Dr F. Omaswa</i>
14:20 - 14:30	The objectives of the meeting	<i>Dr G. Elzinga</i>
14:30 - 14:40	Showing of the ProTEST Video	
14:40 - 15:00	Progress with recommendations of 1st Working Group meeting	<i>Dr P. Nunn</i>
15:00 - 15:10	Strategic vision of HIV/AIDS Control	
15:10 - 15:20	Discussion	
15:20 - 15:30	Regional and national progress in TB/HIV interventions	
	I. High HIV, high TB settings	
15:30 - 15:40	AFRO: TB/HIV strategy development	<i>Dr E. Nyarko/Dr M. Moeti</i>
15:40 - 15:50	Summary of ProTEST results	<i>Dr P. Onyebujoh</i>
15:50 - 16:00	Progress of formal evaluation	<i>Dr P. Godfrey-Faussett</i> <i>Dr L. Kumaranayake</i>
16:00 - 16:10	Supporting countries in phased implementation of collaborative activities	<i>Dr W. Nkhoma</i>
16:10 - 16:20	Discussion	
16:20 - 16:40	<i>Coffee</i>	
	HIV/AIDS: Global and National Perspectives:	
16:40 - 16:50	Key elements for a Public Health Response to HIV/AIDS	<i>Dr M. Ghidinelli</i>
16:50 - 17:00	TB as a core element in comprehensive HIV/AIDS care	<i>Dr C. Gilks</i>
17:00 - 17:10	Position of TB in HIV/AIDS Control: Nigeria	<i>Dr P.I. Alade</i>
17:10 - 17:20	Position of TB in HIV/AIDS Control: Uganda	<i>Dr J. Musunguzi</i>
17:20 - 17:35	Discussion and close	
17:35 - 18:00	Rapporteurs: Drafting Group meeting	

**Day
2**

Saturday, 15 June 2002

Rapporteurs: *Dr Y. Mukadi and Dr R Ginwalla Lakhi*

Expansion of joint TB/HIV activities:

08:30 - 08:40 South Africa *Dr N. Simelela*
08:40 - 08:50 Kenya *Dr K. Chebet*
08:50 - 09:00 The role of NGOs in delivery of joint TB & HIV services
Dr R. Zachariah

09:00 - 09:15 Discussion

Regional and national progress in TB/HIV interventions

II. Low-mid HIV, high TB settings

09:15 - 09:30 WPRO/SEARO: TB/HIV strategy development:
Dr P. van Maaren
Dr M. Fujita/Dr Ying-Ru Lo

Anti-retroviral drugs and TB/HIV

09:30 - 09:40 Brazil: National level experience with anti-retroviral delivery
Dr M. Vitoria
09:40 - 09:50 WHO guidelines on anti-retro viral treatment
Dr C. Gilks
09:50 - 10:00 Constraints to implementation of joint TB/HIV activities, with
special focus on the delivery of anti-retroviral drugs in Africa
Dr A. Harries
10:00 - 10:30 Discussion - How should the Working Group co-ordinate with
and gain from initiatives to deliver anti-retroviral drugs
Coffee
10:30 - 10:45 Guidelines for phased implementation of collaborative TB and
HIV activities: current status *Dr Fabio Scano*
10:45 - 11:00
11:00 - 11:30 Discussion
11:30 - 14:30 Break Out Sessions

*TBD by Break-Out
groups*

Lunch

14:30 - 15:30 Presentations from break out groups
15:30 - 16:15 Discussion
16:15 - 16:30 Coffee

**Addressing operational constraints through policy and
priority-setting**

16:30 - 16:40 Financial and operational issues - integration of NTP and
NACP and the role of national AIDS Commissions (NAC)
Dr M. Loume

16:40 - 16:50	NAC: How to cope with competing and numerous priorities: where does TB/HIV fit? <i>Dr B. Mwale</i>
16:50 - 17:00	Multi-country AIDS projects and the position of TB/HIV <i>Dr K. Hansen</i>
17:00- 17:10	The UN Development goals and TB/HIV <i>Dr A. Kochi</i>
17:10 - 17:20	UNAIDS <i>Dr C. Sozi</i>
17:20 - 17:30	Leveraging financing for TB/HIV <i>Dr A. Bloom</i>
17:30 - 18:00	Discussion: Next steps to ensure policy makers address TB/HIV issues
18:00 - 18:30	Rapporteurs and Drafting Group meeting

**Day
3**

Sunday, 16 June 2002

Rapporteurs: *Dr A. Mwinga and Dr A. Matteelli*

08:30 - 08:40	Guidelines for phased implementation of collaborative TB and HIV activities: current status <i>Dr F. Scano</i>
08:40 - 08:50	Discussion to endorse or reject the guidelines
08:50 - 09:00	Objectives, governance, ways of working of the Working Group <i>Dr. F. Scano</i>
09:00 - 10:30	Discussion
10:30 - 10:50	<i>Coffee</i>

Directions suggested by epidemiological modelling

10:50 - 11:00	The impact of available interventions <i>Ms C. Currie</i>
11:00 - 11:10	An analysis of the TB and HIV epidemics: implications for the focus of the TB/HIV Working Group <i>Dr B. Williams</i>
11:10 - 12:30	Discussion

Conclusions, next steps Date of Next Meeting

TB:IV

Stop TB Partnership



Global TB/HIV Working Group

**2nd Global TB/HIV Working Group Meeting
Durban, South Africa**

14-16 June 2002

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