

The Third Global TB/HIV Working Group meeting was held on 4–6 June 2003 in Montreux, Switzerland. Information and experiences were shared in a forum environment, partnerships between people from the TB and HIV communities were strengthened and networks expanded.

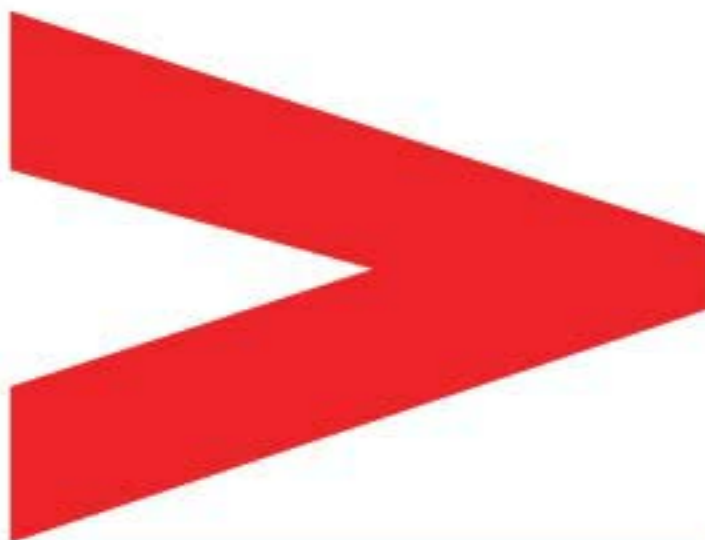
The Working Group has met annually since 2001 and advises WHO and the STOP TB Partnership on TB/HIV issues and aims to reduce the burden of TB in populations with high HIV prevalence.

# “Two diseases – one patient”

“Two diseases, one patient, one community” was the message that emerged from the Third Meeting of the Global TB/HIV Working Group, emphasizing the need for closer collaboration between HIV/AIDS programmes, TB programmes, and general health services. Such collaboration is essential to ensure the equitable provision of comprehensive, person-centred prevention and care services for HIV and TB for the benefit of communities.



Stephen Lewis, Kofi Annan's Special Envoy on HIV/AIDS for Africa, echoed this theme. In an inspirational speech, he committed himself to raising awareness of the urgent need for a joint response to the dual epidemics of TB and HIV and pledged to ensure that the links between TB and HIV are highlighted in United Nations speeches. His speech was welcomed by the more than 140 delegates who travelled to Montreux to attend the meeting.



WORLD HEALTH ORGANIZATION



REPORT OF THE THIRD WORKING GROUP MEETING, MONTREUX

## Major killer

Stephen Lewis lamented the fact that, although TB is one of the leading causes of death of people living with HIV/AIDS (PLWHA), the relationship between HIV and TB is rarely addressed by the AIDS community, and there is scant mention of TB at UN Theme Groups or international AIDS conference plenaries. United Nations leaders do not talk about TB if they are speaking on HIV and say nothing of AIDS if they are speaking about TB – yet TB affects 50% of PLWHA in Africa, and HIV is primarily responsible for the global resurgence of TB. Mr Lewis described the apocalyptic situation of TB and HIV in Africa as criminal neglect, with millions of lives being lost unnecessarily despite the existence of life-saving treatment and effective prevention strategies.

### *“No two diseases could be more inextricably linked”*

The deadly symbiosis that is TB/HIV requires a massive joint effort at all levels to avert disaster. Stephen Lewis gave examples of opportunities to tackle the dual epidemic, including strengthening the health infrastructure and developing human resource capacity to deliver better and more accessible care and prevention. Linked with this is the need to increase access to affordable treatment by putting pressure on governments and the pharmaceutical industry to reduce the restrictions on generic drug production in public health emergency situations and to develop new drugs and vaccines that are useful in the developing world. The role of men's "predatory" attitude to women in HIV transmission highlights the need to address gender inequality. Another crucial opportu-

nity for collaboration lies in applying the lessons from the WHO DOTS strategy for TB control to the provision of antiretroviral treatment (ART) for HIV.

**All those newly diagnosed with HIV infection must be screened for TB and all persons diagnosed with TB must be offered HIV testing and counselling. These basic steps must become standard global practice.** Only with these basic minimum standards can we hope to begin tackling the dual epidemic, averting new TB and HIV infections and saving the lives of those already infected. We must seize this opportunity to link HIV and TB programmes, ignite activists and respond effectively.

## TB/HIV and “3 by 5”

TB programmes can help to achieve the “3 by 5” goal – 3 million HIV-positive people in the developing world on ART by 2005. In Africa alone, more than half a million PLWHA are diagnosed with TB each year, almost all of whom are eligible for ART.



“Collaboration is key,” said Dr Mario Raviglione, who has replaced Dr J.W. Lee as Director of the WHO Stop TB department. Dr Raviglione explained that the “new WHO” under Dr Lee is committed to the “3 by 5” objective. “TB and HIV programmes must work together to accelerate an effective joint

response to the epidemic of HIV-associated TB in all affected countries. We do not mean the launching of yet another vertical programme – rather, the TB/HIV Working Group can be a bridge between the TB and HIV communities. We are dealing with two diseases, one patient, one community.”

## Bad company

**“TB and HIV hang out together. TB and HIV are bad company.”**

**Catherine Hankins** from UNAIDS stressed that we must turn the joint threat of TB and HIV into a joint opportunity. It is not just a matter of TB and HIV programmes helping each other – they *need* each other if they are to respond effectively to the joint epidemic. We must focus on and develop areas of potential synergy, such as models of care delivery, monitoring of adherence and resistance to treatment, community mobilization, and information, education and communication (IEC).

When TB and HIV communities learn to work more closely together, we will ensure that we improve the health of the communities that we serve. Together we *can* make a difference.

**Good company** – The directors of WHO's HIV and TB departments show their commitment to collaborative TB/HIV activities.



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## Facts, Vision, and Action – setting the agenda

Dr Gijs Elzinga, chairman of the Global TB/HIV Working Group, introduced the agenda of the meeting with the headings Facts, Vision, and Action.

**Facts** – The grim reality of the global burden of TB/HIV was outlined. Although the epicentre of the dual epidemic is in sub-Saharan Africa, the issues are global, with concern extended to the potential for disaster in the Russian Federation and eastern Europe, India and south-east Asia.

**Vision** – Our mission is to develop and implement global strategies for both TB and HIV, to rapidly scale up access to appropriate care and prevention through patient-focused, collaborative action between TB and HIV/AIDS programmes and general health services. Such action must make the most effective use possible of all existing tools and mechanisms for continuous programme improvement.

**Action** – Key areas for concerted action were highlighted, with promotion of TB/HIV collaboration at all levels being emphasized in particular. We need to develop a global TB/HIV policy document to establish global standards of care and prevention. We must stimulate and prioritize the TB/HIV research agenda. Delivery of comprehensive care and prevention must be accelerated by rapidly scaling up the lessons learned from ProTEST pilot projects and other collaborative TB/HIV projects – we must provide countries with technical assistance and stimulate resource mobilization.

Dr Elzinga opened his call to action by thanking members and partners of the Working Group for their invaluable contributions to advancing this important initiative.

## TB in the era of HIV – What can epidemiology tell us?

Experts from WHO's TB and HIV departments joined forces to describe the epidemiology of dual infection. We have the opportunity to learn from the important differences in HIV epidemics around the world, both between countries and, as surveillance improves, within countries. There is some evidence that HIV is stabilizing in parts of Africa, albeit at very high levels. In Africa, the disproportionate impact of HIV on young women and urban populations is likely to have significant implications for control of TB. Elsewhere, there has been rapid growth in some eastern European countries but little epidemic growth in the Americas; in Asia there has been overall growth, but declines have been reported in Cambodia and Thailand. In countries such as China and India, where the epidemic is focused in discrete populations, we still have the opportunity to make an impact on transmission through concerted prevention efforts.

**“Dealing with HIV and TB in isolation is likely to bring limited benefits. Dealing with them jointly may bring important synergies.”**

Data from Kenya have been used to model the likely impact of HIV and ART on TB. In general, the rise in TB incidence follows the rise in HIV prevalence after about six years. While ART may lead to a dramatic reduction in AIDS deaths, it is unlikely to have a significant impact on overall transmission of TB in the population. In the model, the most effective way to rapidly reduce TB morbidity and mortality is to improve case detection and cure rates.

Data from studies in Kenya, South Africa, and the United Republic of Tanzania raise more questions about the impact of HIV on the transmission of TB. Although the risk of developing active TB disease through new infection or reactivation of latent TB infection is much greater in HIV-positive people, the duration of disease is much shorter than in HIV-negative individuals. Counter-intuitively, HIV-positive people with TB may individually pose a lower risk of infection because of their relatively short duration of disease. Although these preliminary findings may raise more questions than they answer, as more data are collected we will develop a greater understanding of the complex interaction between these two diseases.

The overall conclusion of this session, reflecting that of the meeting, is that the combination of improved TB case detection and cure, increased testing for HIV, and wider provision of ART will bring substantial benefits.



## Progress in TB/HIV – country experiences

### The lie of the land

#### Malawi – situational analysis

An in-depth review of the epidemiological situation and of existing TB and HIV activities was presented by **Rehab Chimzizi** from Malawi's Ministry of Health. "This is exactly the kind of situational analysis that is needed from most countries with a high TB/HIV burden," said one participant.

Malawi is one of the few high-burden countries to have had a model ProTEST project and early high-level commitment from TB and AIDS leaders for joint action. Despite this commitment, there are only 70 voluntary counselling and testing (VCT) sites in Malawi. Less than 2% of the total population and less than 10% of TB patients were tested for HIV in 2002 – yet more than three-quarters of the 27 000 TB patients diagnosed in Malawi each year are co-infected with HIV. Today, few of the country's estimated 850 000 PLWHA are receiving ART, and in 2002 only about 1000 were receiving ART in the hospital system.

Malawi's public and faith-based hospitals and health care sector are ready to scale up collaborative TB/HIV activities. A blueprint for expanding activities during 2003 has been prepared, and it was expected that, by 1 July, all hospitals would be able to offer VCT to TB patients.

From the results of their analysis, the Malawi team has determined that national scaling up of TB/HIV activities requires: full-time counsellors with regular support from a counsellor supervisor or mentor, dedicated counselling rooms, standardized registers, and regular quality assurance. HIV testing services need an uninterrupted supply of rapid whole-blood HIV test kits, standardized guidelines for testing, standardized training for counsellors performing rapid tests, a mandate to report regularly on HIV test results, separate registers and reporting for results from blood donors and patients, and a standardized system of quality control.

### The ProTEST Song

#### Malawi, South Africa, Zambia – more than 14 000 potential HIV infections averted

More than 140 000 people accessed VCT for HIV through the successful ProTEST pilot projects. These results, presented at the Durban ProTEST lessons learned workshop in

February 2003, were summarized for the Working Group.

Started in 1998 and covering 6 districts in 3 countries – Malawi, South Africa, and Zambia – the ProTEST (from **P**romoting **H**IV **T**ESTing) projects have demonstrated that TB/HIV collaboration clearly improves health services through capacity building and access to a wider range of preventive and care services for people living with HIV/AIDS and TB. Preliminary analysis from the Malawi site suggests that collaborative activities can also reduce sexual risk behaviour. Other studies indicate that, for every 10 000 people accessing VCT, over 1000 HIV infections will be averted, suggesting that the ProTEST projects themselves may have averted more than 14 000 HIV infections.

Limited human resources were recognized as the greatest constraint to TB/HIV collaboration. Greater involvement of NGOs and communities in providing prevention, care, and support services and training of lay people as counsellors were seen as useful solutions to this problem.

The crucial components of successful collaborative TB/HIV activities were identified. The development of a TB/HIV coordinating body at national level and a joint situational analysis are critical starting points. These must be followed by provision of accessible, quality-controlled VCT services (based on same-day rapid HIV test kits) as the entry point to a comprehensive package of appropriate care and prevention services for people living with TB and/or HIV/AIDS. The basic care package should include cotrimoxazole preventive therapy (CPT) for HIV-positive TB patients, TB screening of all HIV-positive people identified at VCT, with isoniazid preventive therapy (IPT) for those with no active TB.



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## Experience beyond ProTEST

Collaborative TB/HIV experience from Rwanda corroborated the ProTEST experience but achieved greater overall success in enrolling HIV-positive people on IPT and CPT and maintaining compliance.

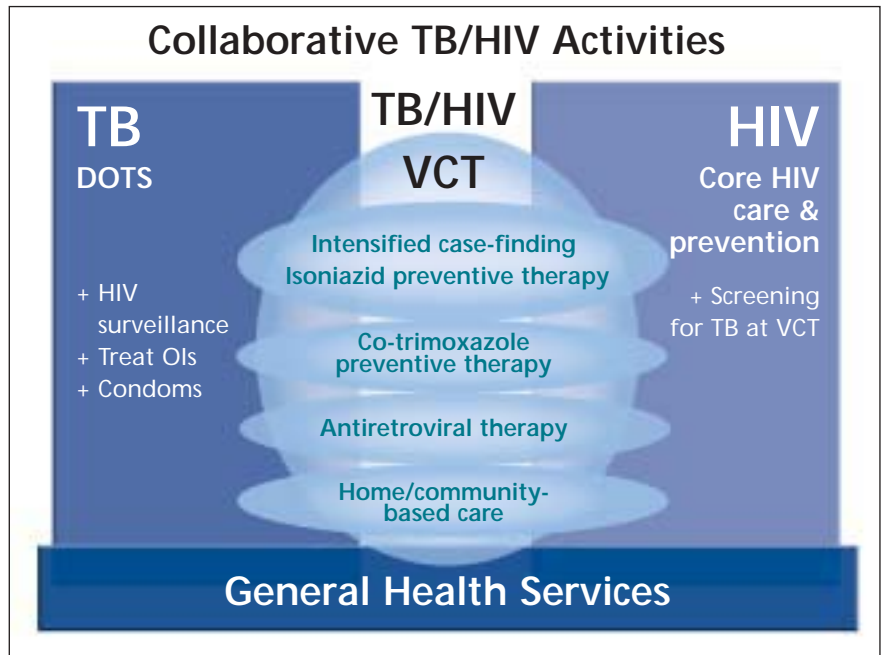
## Responding to TB/HIV in high-burden countries

### Experience of Kenya, Malawi, South Africa, Uganda, and United Republic of Tanzania

Countries in sub-Saharan Africa bear the brunt of the HIV-fuelled TB epidemic. Experiences of implementing collaborative TB/HIV activities in Africa were presented. From these presentations it was concluded that



TB and HIV/AIDS prevention and care services can work effectively together and that promoting VCT as the entry point to comprehensive TB/HIV prevention and care activities is feasible. Although only 7% of the African population has access to VCT today, experience from these projects demonstrates that huge increases in



the number of people accessing VCT can be achieved through collaborative TB/HIV activities. The challenge now is to expand these activities to all districts in all countries with a heavy burden of HIV-related TB.

The need for clear policy guidance to accelerate country-level implementation by defining which collaborative TB/HIV activities should be undertaken in what circumstances was at the top of the agenda. This guidance should also address human resources and cost-effectiveness issues. The involvement of TB programmes in increasing access to ART was discussed and supported – although it is important to ensure that such involvement does not adversely affect TB control.

The absence of early advocacy and policy dialogue, to sensitize target populations at all levels before the start of collaborative TB/HIV activities, was viewed as a missed opportunity for the rapid scaling up of activities. Other factors that contribute to the slow progress of collaborative TB/HIV activities in high-burden countries include the lack of standardized monitoring and evaluation tools, and limited human resource capacities. Greater involvement of the private sector and the community was seen as a possible solution to staffing shortages.

In a separate session, meeting participants from high-burden countries underscored the importance of a regional response to the TB/HIV problem. The components of such a response should include regional capacity building through training of a pool of local consultants, mobilization of resources, and support for regional strategy and policy development.

## Responding to TB/HIV in low- and middle-burden countries

### Experiences from Brazil, Cambodia, India, Thailand

The challenges facing low- and middle-burden countries differ from those in high-burden countries. For the first time, the Working Group meeting held separate sessions for presentation and discussion of experience in such countries, including Brazil, Cambodia, India, and Thailand. Several positive messages emerged – the establishment of good collaboration between TB and HIV programmes in Cambodia, India, and Thailand, the availability of screening for TB among VCT clients in several countries, a consistent emphasis on ensuring access to DOTS for HIV-positive TB cases, widespread access to preventive therapy in Thailand and to ART in Brazil,

successful implementation of routine HIV surveillance among TB patients in Cambodia, and the success of patient support groups and day-care centres in increasing access to services and compliance with preventive therapy in Thailand.

The current strategy for implementation of TB/HIV activities is consistent – a focus on geographical areas where HIV prevalence is high. Challenges include expanding a joint package of TB/HIV interventions to more district hospitals, increasing access to ART, improving the understanding of TB by PLWHA, developing HIV/AIDS care, reconciling the differing perspectives of AIDS and TB staff, and increasing community and private sector involvement.

Steps required to strengthen existing responses to TB/HIV at country level included assessing the magnitude of the TB/HIV burden, developing a national TB/HIV framework and related guidelines, organizing joint TB/HIV meetings for national programme managers and joint training for mid-level managers, coordinating external funding in support of an agreed national TB/HIV framework, and improving technical support at country level.



## Specific policy issues

### Antiretroviral therapy for TB patients

#### Practice and prospect – dream or reality?

People who are co-infected with HIV and TB are, by definition, eligible for ART in addition to their anti-TB drugs. TB patients presenting to health services are therefore, if HIV-positive, an ideal population to consider for ART. For many HIV-infected people, developing TB will be the first indication of an underlying HIV infection. It is thus crucial that all TB patients have access to HIV testing and counselling in order also to have access to ART (if appropriate). Unfortunately, a number of complications and interactions can arise with concurrent use of ART and anti-TB drugs: details of how and when ART should be started in HIV-positive TB patients need to be clarified. At present, recommendations vary around the world, and WHO is currently reviewing and updating guidance on the management of ART in the context of TB.

Delaying initiation of ART for 4–8 weeks after the start of anti-TB therapy offers the advantages of easier identification of the cause of side-effects, reduced paradoxical reactions, and enhanced adherence. However, the risk of HIV-related mortality is highest in the first few weeks of TB treatment and, in the absence of firm guidelines, any decision on treatment should be individualized, based on response to anti-TB therapy, side-effects, and readiness for ART.

Experience in Brazil showed that reduced incidence of TB among PLWHA coincided with the provision of ART. The advantages and disadvantages of directly observed ART were discussed. The advantages include improvements in adherence and in clinical and laboratory monitoring; the increasing complexity of AIDS treatment was seen as a disadvantage and the lack of infrastructure a limitation to delivery. During the discussions, the feasibility of directly observed lifelong ART was questioned, especially in countries with fewer resources than Brazil.

The new WHO administration is emphasizing its commitment to provide 3 million PLWHA in the developing world with ART by 2005 – the so called “3 by 5” goal, which was strongly endorsed at the meeting despite its ambitious scale. It was recognized that TB programmes can contribute significantly to achievement of this target by identifying those who would benefit from ART. The experience of TB programmes in monitoring long-term treatment and compliance is invaluable to HIV/AIDS programmes. There is also the possibility that, with additional resources and careful monitoring of the impact on TB control, TB programmes could take on the role of starting and monitoring ART where the appropriate infrastructure does not exist within HIV/AIDS programmes.

Valuable lessons can be learned from the Stop TB Partnership Global Drug Facility, which may facilitate the procurement and reliable supply of ART to country programmes. Resources for ART are increasingly available through the Global Fund to Fight AIDS, Tuberculosis and Malaria and other new funding streams, but the “3 by 5” plan still needs an immense mobilization of effort,

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particularly in human resource capacity, enhanced community participation, and broad partnerships with the private and other sectors to ensure accessibility and affordability of ART for all who need it.

## Monitoring and evaluation

A guide to monitoring and evaluation for collaborative TB/HIV activities is being developed and the draft outline was presented. The guide will be piloted in several countries towards the end of 2003.

## The right to know

Everyone should know their HIV status: knowledge of HIV status ensures access to appropriate and comprehensive prevention, care, and support services. If we are to have any hope of achieving the "3 by 5" target for ART we must radically scale up HIV testing and counselling to reach all communities at risk. Scaling up of VCT must include preparation of communities, as well as the health services, to address issues of stigmatization and discrimination that may arise: peer educators and community mobilizers are successful in attracting people to VCT services. Limited human resource capacity will be the greatest constraint to the rapid scaling up of access to VCT.

## Adults set to benefit from better standards of care

IMAI – or Integrated Management of Adolescent and Adult Illness – hopes to

do for adults and adolescents what the highly successful Integrated Management of Childhood Illness did for children. It aims to integrate acute and chronic care of common adult diseases with prevention, at the primary health care and community level. Training modules and algorithms for each condition are designed for primary health care staff working in resource-poor settings. The focus is on nurses, peer (lay) educators, and support staff, in close collaboration with community volunteers and organizations. The combination of IMAI modules for acute, chronic, and palliative care, with specific TB and HIV care modules should ensure the highest standards of care and prevention for people living with HIV/AIDS and or TB, accessible at the primary health care and community levels.

## Quantifying dual infection

### Guidelines for HIV surveillance in TB patients revised

Participants welcomed the draft update of WHO's 1994 publication *Guidelines for HIV surveillance among tuberculosis patients*. The revision takes account of changes in the understanding of the diverse epidemiology of HIV and of improvements in surveillance technology. The new guidelines will provide a comprehensive outline of the key

issues related to HIV surveillance among TB patients and offers a variety of surveillance methodologies that can be used in different settings. Two outstanding issues require clarification: the role of salivary HIV test kits in testing sputum samples for surveillance, and the ethics of anonymous, unlinked HIV testing need to be established before publication and broad dissemination of the guidelines.

## Chapter and verse – preventing TB recurrence

Recurrence of TB is more common in HIV-positive patients; moreover, the shorter the duration of rifampicin in the treatment regimen, the greater the risk. Recurrence is likely to be under-estimated because of under-reporting and confusion in notification. By improving notifications, Malawi has identified a much higher level of recurrence (3% of total cases in 1998, rising to 11% in 2002). The problem consumes resources, requires a more complex treatment regimen, increases TB in the community, increases morbidity and mortality, and erodes faith in treatment among patients, health staff, and the community.

Four options for reducing recurrence were discussed: 1. Use rifampicin and isoniazid throughout the continuation



## Think Globally - Act Locally

### HIV and TB – one community, one patient

Participants at the third meeting of the TB/HIV Working Group in Montreux were struck by the extent of common ground between TB and HIV communities, embodied in the opening theme “Two diseases – one patient”. For the first time, the goal of working together as one community seemed truly achievable, with broad representation and contribution from both the HIV and the TB communities. Programme collaboration is essential if we aim to deliver effective, comprehensive care and prevention at the community level. Care must be patient-focused. People with TB and/or HIV often have a range of conditions and should not need to attend health services separately for each of them. Working together will take time, but senior HIV officials, such as Elizabeth Madraa, head of Uganda’s national AIDS programme, expressed great optimism that joint action can work. Evidence for the effectiveness of joint TB/HIV action is mounting. As participants heard, it has modified risky sexual behaviour in Malawi, achieved a sixfold increase in the number of people getting HIV test results in projects in southern Africa, impressively accelerated the development of joint strategies in Asia, and integrated TB and HIV care in Chiang Rai, Thailand. One key lesson emerges: it is joint action that works – not TB or HIV programmes working in isolation.

### Joint action can bring “3 by 5” nearer

Even more exciting for the future, it emerged that TB/HIV collaboration can help in reaching the “3 by 5” target – 3 million PLWHA on antiretroviral treatment by 2005. Already, more than 300 000 people with HIV are diagnosed with TB each year in Africa alone, and an estimated 400 000 more cases are not yet identified or notified by national programmes. If all these patients were offered HIV testing and counselling they would, without doubt, constitute the largest single group eligible for ART. Furthermore, the experience that TB programmes have

gained in the provision of care makes them natural partners for AIDS programmes that have now added care to their prevention responsibilities.

### What now for joint TB/HIV action?

Demand was high for TB/HIV policy guidance, and WHO and partners presented the work in progress. Participants strongly endorsed the five key components:

- Strengthen DOTS and HIV care and prevention
- Establish a national-level TB/HIV coordination committee
- Establish HIV surveillance among TB patients
- Offer HIV testing and counselling to all patients with TB
- Screen for TB all people attending for HIV services.

This is not a new vertical TB/HIV programme but joint national TB programme/national AIDS programme action. Financial barriers are falling fast, with new funding sources, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, but national TB and HIV programme leaders demanded an immediate increase in human resources and capacity. All partners are urged to address this problem. WHO AFRO, particularly, was charged with alerting NEPAD (New Partnership for African Development) and other African partnership organizations to wake up to joint TB and HIV issues. As the world begins to focus on “3 by 5”, let’s ensure that, at the very least, all TB patients in high-HIV areas can access an HIV test as the entry point to the most appropriate care and prevention. **Think globally – but act locally.**

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phase. 2. Extend the duration of the continuation phase in HIV-positive patients. 3. Give post-treatment isoniazid to HIV-positive patients who complete anti-TB treatment. 4. Treat HIV-positive TB patients with highly active ART (HAART). The evidence and experiences relating to each of these options was reviewed in the context of TB in areas of high HIV prevalence.

The session concluded that country TB programmes need to determine the true burden of recurrent TB in their particular settings. If the burden is high, it is important to assess which of the above four options is most cost-effective, most feasible, and least dangerous. In addition, further clinical studies and operational research are needed to determine the effectiveness of prolongation of regimens.

## Co-trimoxazole preventive therapy

Experience of CPT from Malawi and other countries was reviewed. CPT is "easy" to implement at low cost and popular with health workers: "At least we can offer something," is a common response from health workers asked about CPT. Although a number of practical questions remain about its mode of action, its efficacy, and its place in the face of ART expansion, CPT is still recommended as the only feasible, cheap, and widely available intervention for reducing morbidity and mortality among PLWHA in resource-poor settings.

## Research priorities

The need for more research was evident throughout the meeting, and received particular attention on the last day when participants were challenged to prioritize a list of 43 potential research topics identified in a draft "Research Priorities" document. The topics were divided into five categories – HIV diagnosis and prevention; prevention of TB infection and treatment of latent TB; TB case-finding; TB diagnosis and treatment; and programmatic issues. Participants worked in small groups (one group per category), scoring each of the research topics within their allocated category from 1 (poor) to 5 (excellent). Following Raj Gupta's presentation on the research prioritization process used in the MDR-TB Working Group, participants were urged to bear in mind the important distinction between "policy-relevant" topics and "interesting" topics.

The group work revealed clear differences in the priority attached to the various research topics. Only 10 topics scored the maximum 5. These were:

- how to increase the acceptability of HIV testing among TB patients;
- the feasibility, efficacy, and duration of effectiveness of CPT;
- the appropriate duration of IPT;
- the impact of widespread IPT on isoniazid resistance;
- how to rule out active TB;
- who should be given IPT;
- the value of empirical TB treatment for HIV-positive patients with suspected TB in addressing high early mortality in TB patients;
- evaluation of different systems of ART delivery, one of which would be ART-DOT;
- what ART regimens to use for TB patients on rifampicin-containing regimens; and
- the impact of ART on TB mortality.



The way forwards seems likely to be a process similar to that used by the MDR-TB Working Group. This was based on several principles: inclusion of as many people as possible in the prioritization process; one vote per institution (rather than per person); minimizing the time required; ensuring that the process has a clear end; and distinguishing between three types of research questions – primary topics (critical research activities to develop policy), secondary topics (key issues to refine policy and strengthen the evidence base), and other topics (basic science and smaller, but important, issues). Establishment of a database of all ongoing and planned research activities to show how the research agenda is being addressed, and what the gaps are, is also likely to be important.





## Policy development

### Interim policy on collaborative TB/HIV activities

An important discussion at the meeting focused on development of an interim policy on collaborative TB/HIV activities. The interim policy document, prepared in response to demand from countries, provides guidance on *what should be done* in what circumstances; it fills the gap between the existing TB/HIV strategic framework (*what could be done*) and the implementation guidelines (*how to do it*). The policy outlines activities that reduce the impact of HIV on TB, activities that reduce the impact of TB on HIV, and activities that strengthen the health sector response to both TB and HIV/AIDS.

Participants welcomed this timely and important interim policy document, which will help to accelerate the implementation of collaborative TB/HIV activities in countries. It provides guidance, based on the best available evidence, on minimizing the impact of TB/HIV through collaborative activities, and will evolve and improve as more evidence becomes available. The policy should be adaptable to country and regional needs and will need to be explicit about the responsibilities of each of the programmes in implementing collaborative TB/HIV activities.

Once development is completed, the interim policy must be published rapidly and "marketed" effectively, especially to country-level policy-makers. Following its endorsement by the TB/HIV Working Group participants, the policy has been strongly endorsed by WHO's Stop TB oversight group, the Strategic and Technical Advisory Group for TB (STAG).

### Lessons from the STOP TB Partnership

The TB/HIV Working Group can learn from the STOP TB Partnership – a "global social movement" to eradicate TB, with 300 global partners and still growing. **Petra Heitkamp** of the Stop TB Partnership secretariat in WHO suggested the use of up-to-date information technology, such as Internet-based collaborative workspaces or an e-mail-based electronic discussion forum, to broaden the participation of Working Group participants in developing policy and sharing best practice. The importance of branding, advocacy, social mobilization, and IEC regarding TB/HIV was stressed. Possible new

approaches to strengthening global TB control were also outlined, including pairing of high-burden countries and partners; "up-front" guarantees of support for countries that commit to aggressive new methods to reach global case detection targets; special grants for innovators to develop new tools; franchising; and massive recruitment to build human resource capacity. We need to think laterally and "outside the box" to control TB/HIV.

### The marketplace

Some light relief was provided when the poster session became interactive, with participants being given the floor for one minute to "sell" their successful or innovative TB/HIV experiences. Dr Bernhard Schwartlander, director of WHO's HIV department, reiterated his department's commitment to TB/HIV collaboration and then opened the market by ringing a cowbell.



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## Major conclusions and recommendations

**Collaboration between TB and HIV communities has been growing worldwide.** Joint TB/HIV activities are planned in all WHO regions. National collaborative TB/HIV activities under way in many African countries, as well as in Cambodia, India, Thailand, and Viet Nam, must be nurtured by continued financial and technical support as necessary. Progress in Africa, where the problem is greatest, is slow, constrained mainly by limited human resources and absorption capacity. There is an urgent need to implement and strengthen collaborative TB/HIV activities in this region by forging strong partnerships between the health sector, communities, and the private sector.

**Collaborative TB/HIV activities are having a positive impact on sexual risk behaviour.** Preliminary results from Malawi showed that encouraging changes in sexual risk

behaviour are reported by those attending VCT provided through collaborative activities.

**No need for vertical TB/HIV programme.** The meeting called for increased collaboration between the HIV/AIDS and TB control programmes – but not for an independent vertical TB/HIV programme. In addition, both programmes need to strengthen their core activities.

**Country-level situational analyses are useful.** Countries starting joint TB/HIV work are advised to carry out a situational analysis at both national and district level before embarking on collaborative TB/HIV activities. Such analyses are useful in planning collaborative activities and facilitating their implementation.

**Collaboration can increase TB case detection.** Additional cases of undiagnosed TB can be identified by screening at the time of HIV diagnosis in the VCT setting and also at regular intervals thereafter (the Cambodia experience). The impact of increased case-finding on national TB control should be studied when collaborative activities are scaled up to national coverage.

**National TB control programmes need to consider new HIV testing approaches.** HIV testing is the entry

point for HIV care and prevention for TB patients. New approaches need to be developed to maximize accessibility and coverage for TB patients, such as routine diagnostic HIV testing for all consenting TB patients.

**Human resources capacity must be increased.** Lack of human resources is the main constraint to the provision of appropriate prevention, care, and support services for people living with TB and/or HIV/AIDS.

**Proactive advocacy is needed at all levels.** The message about the importance of TB/HIV and of addressing TB and HIV together needs to be targeted to appropriate regional and subregional intergovernmental organizations, such as, in Africa, the Organization of African Unity (OAU); the Economic Community of West African States (ECOWAS); New Partnership for African Development (NEPAD); and the Southern African Development Community (SADC).

**A TB/HIV resolution should be raised** at the World Health Assembly in 2004 to maximize national and international commitment to a joint approach to TB and HIV.

**Focus on operational research is needed.** The need for rapid solutions to the growing TB/HIV problem indicates that the main research focus should be operational.

TB and HIV programmes must work together to reach the “3 by 5” target and the TB case detection and cure targets by 2005.

A strong spirit of partnership emerged from the three-day meeting with a vision for expanding collaborative TB and HIV activities in all regions.





WORLD HEALTH ORGANIZATION

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GROUP MEETING, MONTREUX

Presentations from the  
meeting can be viewed on  
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