

## **Scaling up the implementation of collaborative TB/HIV activities: update on current status and future perspective.**

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**Background:** The TB/HIV Working Group (WG) of the Stop TB Partnership works to reduce the global burden of HIV-related TB through effective collaboration between TB and HIV programmes and communities, and establishing policies, targets, and monitoring and evaluation systems for evidence-based collaborative TB/HIV activities. The WG developed the *Interim Policy on Collaborative TB/HIV Activities* in January 2004, which gives guidance on activities that address the interface of the TB and HIV/AIDS epidemics and that should be carried out as part of the health sector response. The WG also facilitates the sharing of experience and disseminates lessons learnt in order to accelerate the implementation of these collaborative TB/HIV activities. The Working Group has a priority list of countries with the brunt of the problem in order to intensify its priority efforts of accelerating the implementation of collaborative TB/HIV activities. The TB/HIV priority list currently contains 63 countries including all countries with an adult HIV prevalence  $\geq 1\%$ , and five additional countries (Brazil, China, India, Indonesia and Viet Nam), which together make up 98% of the global burden of HIV associated TB\*. However, the WG emphasizes continued vigilance of the TB/HIV situation in those countries with low HIV prevalence and promotes the implementation of HIV surveillance in TB patients and carrying out interventions to decrease the burden of tuberculosis in people living with HIV, giving priority to groups at high risk for HIV and TB such as injecting drug users and sex workers.

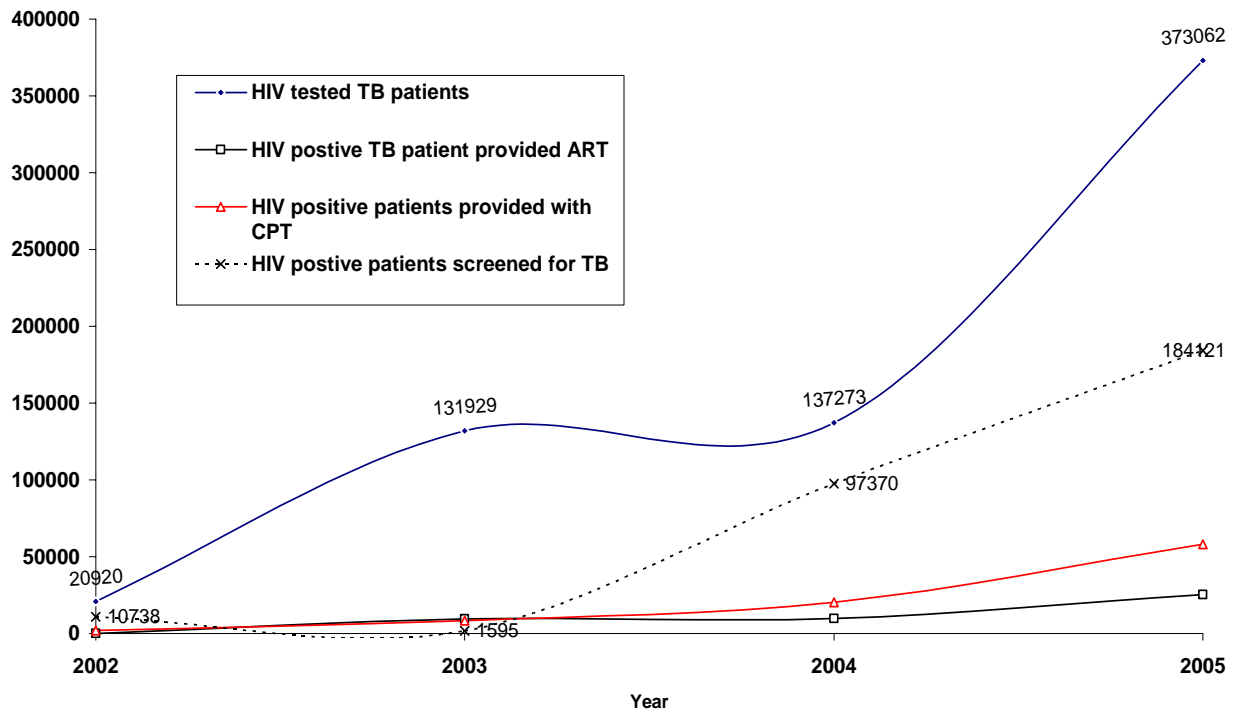
**Progress and status of the implementation of collaborative TB/HIV activities.** WHO started monitoring the implementation of collaborative TB/HIV activities in 2004 through a retrospective qualitative assessment undertaken to determine the extent of implementation of the 12 collaborative TB/HIV activities described in the *Interim Policy* among the 22 high TB burden countries. This was followed in 2005 by the introduction of key TB/HIV elements in the WHO standard data collection form that was sent to 199 countries. All countries reported on the extent to which TB patients were tested for HIV, assessed for ART and provided with ART in 2003. A detailed supplemental questionnaire was also sent to 41 and 63 priority countries with the highest incidence rates of TB with HIV co-infection in 2005 and 2006 respectively.

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\* **Africa Region:** Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Congo, DR Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Mali, Malawi, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sierra Leone, South Africa, Somalia, Swaziland, Togo, UR Tanzania, Uganda, Zambia and Zimbabwe. **East Mediterranean region:** Djibouti and Sudan. **American region:** Bahamas, Barbados, Belize, Brazil, Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Jamaica, Suriname, Panama and Trinidad & Tobago. **South East Asia Region:** India, Indonesia, Myanmar and Thailand. **Western Pacific region:** Cambodia, China and Viet Nam. **European region:** Ukraine, Russian Federation and Estonia.

In 2003, among the 199 countries that completed the WHO data collection form, 49% have a national policy of offering HIV testing to TB patients and 46 countries (23%) routinely assessed HIV positive TB patients for their eligibility for ART. However, only 3% of the 4.4 million notified TB cases were reported to have been tested for HIV and only 1349 TB patients were reported to have started ART in 2003. This has increased to nearly 10,000 in 2004 and 25000 by 2005 (Figure 1 ). The number of countries that reported routine offer of HIV testing to TB patients increased from 7 in 2003 to 92 in 2005. This shows that most countries have only recently begun implementing collaborative TB/HIV activities. There has been rapid exceptional progress in some countries. For example in Kenya, in the first quarter of 2006, 50 % of TB patients were tested for HIV, 30% of the HIV positive TB patients were put on ART and 85% on co-trimoxazole preventive treatment (CPT). Likewise 77% of TB patients were tested for HIV in Rwanda during the second quarter of 2006 and a third of the HIV positives were put on ART.

**Figure 1. Global progress of selected collaborative TB/HIV activities (2002-2005)**



However, despite these rapid recent progress the overall coverage of implementation of collaborative TB/HIV activities is unacceptably low. Globally only 14% of the estimated HIV positive TB patients were identified by HIV testing in 2005. This figure is 13% in the Africa region despite carrying 80% of the estimated burden of HIV related TB. On the other hand the American region detected more than two third of the estimated HIV positive TB cases in 2005. Once the HIV testing is done and cases are identified, the provision of CPT and ART is very high in the Africa Region. For example in 2005 in those African countries that provided report, between 82-92% of HIV positive TB patients were put on CPT and a third on ART.

The coverage of those activities that need to be carried out by the HIV side such as screening of HIV positives for TB and provision of Isoniazid Preventive Therapy (IPT) are very low. For example in 2005 only 0.4% of people living with HIV were screened for TB and only about 25,000 were started on IPT. This calls for an urgent attention as TB is now the commonest presenting illness among People living with HIV (PLHIV) who are on ART.

It is also imperative to note that the current progress of the implementation of collaborative TB/HIV activities is far short of with what has been laid out in the Global Plan to Stop TB (2006-2015). The Global Plan proposed that 1.6 million TB patients would be tested for HIV in 2006 and 220,000 should be started on ART. However, in 2005 the coverage was only 14% and 11% of what has been planned for 2006 respectively. Likewise, the number of PLHIV screened for TB in 2005 was only 1.7% of the 11 million targeted for 2006 and the number started on IPT in 2005 was 2.2% of the 1.2 million targeted for 2006.

**Challenges for accelerated implementation:** The Working Group recognizes the following as key challenges for the accelerated implementation of collaborative TB/HIV activities.

- **Limited HIV testing and counselling services:** HIV testing is a critical gateway to quality care for HIV infected TB patients. The uptake of HIV testing among TB patients is quite high especially when rapid testing is used and same day results are obtained from the same health worker. Expanding HIV testing facilities and allowing front line TB clinicians and nurses to test not only TB patients but those presenting with signs and symptoms of TB ("TB suspects") helped to achieve multi-fold increase in the number of TB patients tested for HIV. However, despite encouraging recent trends, the overall coverage of HIV testing and counselling in many countries with the burden of HIV related TB is low. Ineffective and inconsistent supply of HIV test kits, drugs and other important commodities are also impediments for accelerated implementation.
- **Shortage of trained manpower:** The lack of sufficient trained staff including in quantity, competence and distribution is consistently cited as the main constraint facing both HIV and TB control. This problem is of serious magnitude in those countries that bear the brunt of the HIV related TB. Accelerated implementation of collaborative TB/HIV activities entails intensive, continuous training and supportive supervision of health workers. This is a cross cutting health system problem that requires effective and collective response.
- **Lack of collaboration and coordination:** TB control services are geared towards controlling the transmission of tuberculosis largely with simple and standardized public health-oriented technical procedures building on sound evidence. HIV/ AIDS services, on the other hand, are largely individual patient-oriented and expanding fast building upon an evolving evidence base. Such conceptual, application and cultural differences between the two control programs and communities leads to failure to recognize the importance and relevance of TB to HIV care, prevention and treatment and vice versa. This in turn leads to lack of collaboration and coordination between the two communities at all levels and lack and difficulty of integration of TB and HIV services at service delivery point. ART services are centralized while TB services are highly decentralized to the periphery and managed by low cadre of health workers in many countries.

- **Lack of conducive national policy environment:** Creating conducive policy environment with the development of appropriate policy and operational guidelines, training manuals and protocols in line to international guidelines has been crucial in those countries that documented rapid progress in implementation. Although there is increasing recognition of the problem among many national authorities, there is no yet joint ownership in many countries. For e.g. concerns about INH prophylaxis giving rise to drug resistance, by key decision makers and service providers undermines its value in improving the quality of living of PLHIV. Setting national targets on TB/HIV assisted the accelerated implementation of collaborative activities and helped to mobilize political commitment from the TB and HIV control programs in those countries with rapid progress that is not yet taken into consideration by many of the countries.
- **Weak diagnostic capacity and technology vacuum:** TB diagnosis among PLHIV is characterized with difficulty due to both lack of new technologies and poor utilization of existing tools. The Working Group has recently been instrumental in changing the global policy environment to improve the diagnosis of TB and promote the use of existing tools to improve the diagnosis of TB among PLHIV. However, this needs massive investment for both expansion of the infrastructure and training for laboratory strengthening. Laboratory services are in general the weakest link with poor quality assurance system, insufficient human resources and centralized culture facilities and neglected in many countries with the TB/HIV burden.
- **Weak or non-existent infection control measures:** TB infection control is one key but neglected collaborative TB/HIV activity. The emergence of XDR-TB and the associated high mortality rate particularly among HIV infected patients brought the issue of infection control in health care settings high on the agenda. The newly established Infection Control sub-Group is now incorporated into the TB/HIV Working Group, which is currently recruiting members and drafting a terms of reference, which will be circulated for a wider consultation. Stepping up the necessary efforts to carry out this important but neglected area of work is a huge challenge for the Working Group.
- **Weak monitoring and evaluation:** Monitoring and evaluation of collaborative TB/HIV activities in general are weak, which may also contribute to low coverage due to poor documentation. It is reported that in some countries, activities are happening, but there is no system to capture it and inform the programmes in ways that will improve performance. Now the internationally recommended TB recording and reporting formats are revised including HIV variables. Those countries that used these revised formats improved documentation of the implementation of their activities. However, these formats are not implemented widely by TB control programmes and TB variables are not included in HIV registers of many of the countries.
- **Huge unmet research need:** The prevention, diagnosis and treatment of TB among PLHIV is characterized with multiple unanswered priority research questions that still need to be addressed both in the basic science and operational aspects. A critical area that need particular attention is the dearth of clinical trials that study ART delivery among TB patients. Most of the current studies that intend to study this important area are either stopped or crinkling for several operational reasons. There is limited level of resources and interest for TB/HIV research in both HIV and TB researcher communities.

**Opportunities and the way forward:** Despite the aforementioned challenges there are emerging opportunities that will be crucial for accelerating the implementation of collaborative TB/HIV activities. The WG has been actively engaged in increasing the visibility of TB/HIV among critical stakeholders in the HIV community with the aim to ensure TB prevention, diagnosis and treatment are core functions of HIV prevention, treatment and care services. Equally important efforts are needed to ensure HIV prevention, care and treatment services are integral part of TB control activities in those countries that are affected by the dual epidemic.

The Working Group is increasingly forging strategic partnership and collaboration with key HIV stakeholders such as PEPFAR, International AIDS Society and UNAIDS. The awareness of the importance of TB prevention, diagnosis and treatment for HIV services is increasing. This is particularly true as TB is now the commonest presenting illness among PLHIV on ART both in developed and resource constrained countries. TB has been very visible during major international AIDS Conferences including the XVI International AIDS Conference in August 2006 and Conference on Retroviruses and Opportunistic Infections in February 2007.

The Working Group is currently working with several partners to organize abstract and non-abstract driven TB/HIV session in the 2007 HIV implementers meeting that takes place in June 2007 in Kigali, Rwanda and with IAS on the 4<sup>th</sup> IAS Conference on HIV Pathogenesis, prevention and treatment that takes place in Sydney in July 2007. The Working Group is also undergoing changes within itself to increase the representation of more HIV stakeholders in its structures including its Core Group. The emergence of XDR TB and the associated high mortality rate among HIV positives is also a wake-up call for accelerated implementation of collaborative TB/HIV activities.

The increasing availability of resources through the GFATM and PEPFAR for TB/HIV will also be critical to accelerate implementation. For example the recent meeting the Working Group conducted in collaboration with OGAC and the Gates Foundation has yielded an extra 50 Million USD for TB/HIV in 2007. This makes the total money available for TB/HIV from PEPFAR for 2007 at 120 million. The global efforts against the two diseases are armed with strategic plans (the Global Plan to Stop TB 2006-2015 and Universal Access to HIV prevention, treatment and care), which recognize the TB and HIV links. Likewise, despite the differences in culture and philosophy, there are encouraging signs that the two communities are now starting to proactively reach out to each other.

Seizing these existing and promising opportunities and through promoting constructive dialogue and collaboration between the TB and HIV communities at all levels and forge the partnership and promoting accelerated implementation of the strategic plans and collaborative TB/HIV activities at country level will be the priorities of the WG. With this regard, the TB/HIV Working Group will prioritize the following key strategic directions:

- **Raising the priority of TB prevention, diagnosis and treatment services among HIV stakeholders:** The Working Group will work with country leaders, professional societies and with key HIV stakeholders such as IAS, OGAC and UNAIDS to press for TB prevention, diagnosis and treatment as a core function of HIV prevention, care and support services. The Working group will facilitate linkages between the implementers and funding agencies to ensure that initiatives to incorporate TB activities into HIV care are adequately resourced.

- **Promoting exchange of information and best practices on integrated HIV and TB services:** Rapid implementation of activities will be accomplished most readily if lessons learned in developing and implementing integrated TB and HIV care services are shared between countries and program managers. It is important to recognize that systems developed in one region may not apply in another and that a menu of successful programmatic structures will be necessary to accelerate implementation of collaborative TB/HIV activities. The Working group will facilitate exchange of best practices through face to face meetings, mentoring programs and through web based systems.
- **Enhance community mobilization for TB/HIV:** Community groups and affected communities are extremely important partners and under-utilised resources for the implementation of collaborative TB/HIV activities and the provision of quality care. Ensuring increased involvement of community groups and enhancing their capacity at all levels will be a priority. Particular emphasis will be given to mobilize grass root groups to generate demand for collaborative TB/HIV activities and mainstream TB in already established grass root HIV prevention, treatment and care services.
- **Response to drug resistant TB.** The Working Group recognizes that urgent action is needed to respond to the extensively drug resistant TB (XDR-TB). The working group will coordinate efforts with all relevant stakeholders in the HIV and TB communities. Particular emphasis is needed to improve TB infection control in HIV services.
- **Increasing the use of technology for TB/HIV:** Improvement in diagnostic services is critical to the HIV/TB efforts. The working group will explore ways to coordinate TB diagnostic services and HIV laboratory services. The working group will explore and expand the use of new technologies for improved diagnosis, prevention and treatment of HIV related TB. It will explore ways to improve the management of the information exchange system between the TB and HIV communities.
- **Targeted advocacy for TB/HIV research:** The TB/HIV Working Group will develop a targeted research advocacy agenda for priority issues to meet the huge unmet research needs. It will also encourage and monitor the implementation of the priority TB/HIV research questions that were identified in 2005. The ongoing TB research movement needs to prioritize TB/HIV as one of its key areas.