

2007 HIV/AIDS Implementers' Meeting, June 16-19, 2007, Kigali, Rwanda
'Scaling Up Through Partnerships'

Conference highlights on TB/HIV

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Collaborative TB/HIV issues, activities and services featured prominently in the meeting with one plenary, 2 dedicated TB/HIV abstract-driven sessions and several TB/HIV presentations in other sessions.

Plenary on experience in setting up joint TB/HIV services in Kenya

Dr J M Chakaya from the National TB Control Programme (NTP) in Kenya gave a talk entitled '**TB/HIV: Integration of services and stopping the newest epidemic**'. Kenya has a national HIV prevalence of 7% and almost 120 000 TB cases registered in 2006 although there is some suggestion that the rise in TB caseload is levelling off. An estimated 60% of TB patients are also HIV-positive. In 3rd quarter 2005 the NTP incorporated HIV indicators into TB reporting and from then to 4th quarter of 2006 the proportion of TB patients counselled and tested increased from 49% to over 65%, coverage of cotrimoxazole preventive therapy increased from 60% to 85% and that of antiretroviral therapy (ART) for co-infected TB patients remained stable at 25-29% (Figure 1). This was due to the fact that there were 320 ART sites compared to 1,801 TB clinics in the country! In spite of this impediment of ART access among TB patients, they represent 30% of all individuals on ART (125,000) at the moment.

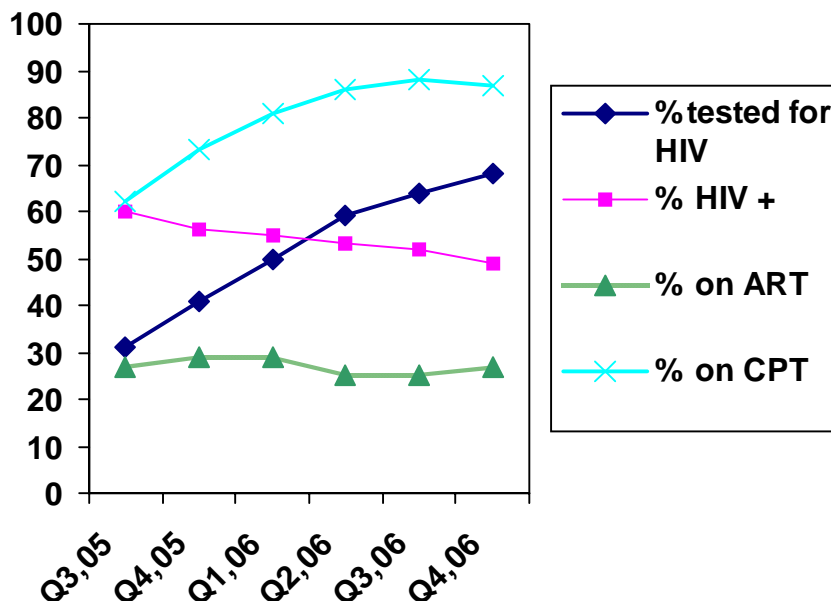


Figure 1: HIV Testing and Provision of HIV Interventions to TB Patients - Kenya

Kenya has made impressive, rapid progress in implementing collaborative TB/HIV services as a result of the following key factors:

- Setting national targets facilitated implementation and mobilization of political commitment.
- Development of policy and operational guidelines, training manual and protocols created conducive health policy environment.

- TB/HIV coordinating bodies at all levels of health care engaged stakeholders and accelerated implementation.
- HIV testing facilities were expanded and TB clinicians and nurses were allowed to test TB patients for HIV. Testing and counselling was also extended to individuals who presented with symptoms and signs suggestive of TB, the so called TB suspects.
- Training and supportive supervision of health care workers contributed to fast scaling up of joint TB/HIV services of satisfactory quality.
- Recording and reporting formats for TB were amended to accommodate HIV and HIV related indicators. This enabled monitoring of programme implementation and its overall performance towards the set targets.
- Regular and sufficient supply of rapid HIV test kits, drugs and other essential commodities was important for fast scaling up.

Dr Chakaya's enthusiasm for rolling out the package of collaborative TB/HIV services, including decreasing the burden of TB among people living with HIV was palpable and one could not help feeling the urge to 'get up and just do it' in one's own setting!

WHO/UNAIDS guidelines for Provider-Initiated Testing and Counselling for HIV

Dr K M De Cock of World Health Organization presented the State of the Art on Provider Initiated Testing and Counselling for HIV. He argued convincingly for the urgent and massive global scale up in persons who know their HIV status. The new guidance promotes the offer of HIV counselling and testing for HIV to all individuals who attend health services for any complaint in settings with a generalised HIV epidemic, further increasing the momentum for ensuring access to HIV testing for all TB patients and TB suspect. The guidelines can be downloaded from: <http://www.who.int/hiv/topics/vct/PITCguidelines.pdf> .

Missed opportunities: high numbers of patients with active TB found in HIV care clinics and medical wards

The break out meeting of June 16, 2007 examined issues on 'TB/HIV: Steps to successful integration'. Experiences from 4 countries were shared along with an international overview that compared global progress in implementation of collaborative TB/HIV activities with those in the 15 PEPFAR 'focus' countries.

Dr R Grand'Pierre from Haiti reported 2,395 (26%) cases of active TB among 9,199 people living with HIV and on the other hand, when 3,768 TB patients were counselled and tested for HIV, 1,213 (32%) were found to be HIV-positive.

In Uganda, sputum smears were collected from 1,869 inpatients on the medical ward of a national referral hospital and 587 (32%) were found to be smear-positive (of whom 65% were also HIV positive) indicating serious delays in making a TB diagnosis due to various barriers faced by patients. The speaker, **Dr R Wanyenze**, summarised the challenges in developing a model for TB/HIV care as follows: diagnosis of sputum smear-negative and extra-pulmonary TB, effective transfer of co-infected patients to HIV care and ART sites at completion of TB treatment, supporting couples and reaching out to do contact tracing in all families.

Dr H Muttai, who presented a view on joint TB/HIV services at a district hospital level from Kenya, reported an increase in the mean CD4 cell count measurements of 78 cells/mm³ in co-infected TB patients who had completed their TB treatment only and 139 cells/mm³ in those co-infected patients who had been started on ART during their TB treatment. The TB treatment outcome analysis at this hospital where 100% coverage of cotrimoxazole preventive therapy among co-infected TB patients had been reached, showed that 64%, 14%, 11% and 11% of co-infected TB patients

completed TB treatment, defaulted, were transferred out and died, respectively. The hospital team needed to find out why so many patients defaulted (did they die?) and wished to transfer out. From **Dr A Reid's** presentation we learned that globally only 7% of TB patients are tested for HIV and less than 0.5% of people living with HIV were screened for TB during 2005. In general, the 15 PEPFAR focus countries were more successful in implementing the range of collaborative TB/HIV activities compared with the other high TB/HIV burden countries, e.g. 12% of TB patients were tested for HIV in 2005 in the PEPFAR countries compared to only 5% in the other countries. However, even in the PEPFAR countries far too few people were accessing collaborative TB/HIV activities and many opportunities were being missed to offer comprehensive care to TB patients and people living with HIV.

TB infection control in health care settings, especially HIV care and ART sites, is a top priority

In an evening break-out workshop on TB/HIV, three papers were presented. **Dr G Venderbriel** described the status of collaborative services at the two model sites in Rwanda with 75% of TB patients being tested for HIV in 2006, 42% were HIV positive, 46% and 31% received cotrimoxazole and antiretroviral therapy respectively. **Dr A Mwinga** from Zambia discussed the steps that should be taken to improve TB diagnosis in people living with HIV and **Dr H Getahun** summarised the major points made in the recently published booklet on 'TB infection control in the era of expanding HIV care and treatment', which can be downloaded at: http://www.who.int/tb/publications/who_tb_99_269/en/index.html . Lively discussion followed and several clarifications were made, for example, regarding the facts that development of drug-resistant TB is better to be prevented and it can be done by meticulous TB patient management that adheres to the national and international TB control policy and guidelines and that strong and effective DOTS programmes remain a must. Development of drug-resistant TB is in no way associated with the need for the NTP to plan and work together with the National AIDS Control Programmes to address the issues pertaining to the TB/HIV co-infection.

Another related presentation was given in the session on **Caring for the Carers**. **Ethel Dauya** presented the initial results of a survey from the Biomedical Research and Training Institute, Zimbabwe entitled 'Health Workers Access to HIV/TB Prevention, Testing, Treatment and Care Services: a Pilot Study in Zimbabwe. The study showed high rates of self-testing for HIV and willingness to undergo regular TB screening, 63% of staff reported having had an HIV test (28% had self-tested). 70% identified TB as the greatest health threat in the workplace, compared to 22% HIV. 65% were very interested in knowing their HIV test and 95% were very interested in regular TB screening.

Qualitative study investigating barriers and they reasons to the implementation of collaborative TB/HIV activities in Uganda

Dr R Okot-Chono of The Union in Uganda presented the findings of a qualitative knowledge, attitudes, practices and beliefs (KAPB) study that examined the barriers to the implementation of collaborative TB/HIV activities in five districts in Uganda at the level of the health system, health facility, health care providers, patients and communities. Twenty six focus group discussions, 28 in-depth interviews and 34 key informant interviews among 260 subjects were carried out. The major barriers identified included lack of dissemination and poor adherence to policy guidelines, frequent stock outs of key consumables, such as, rapid HIV test kits and cotrimoxazole (health system barriers); poor coordination of services that lead to parallel systems and necessitated multiple visits by co-infected patients (health facility barriers); and limited knowledge on the subject matter and feeling overburdened due to staff shortages and high demand for services (health care

provider barriers). In addition, patient and community related barriers that were identified included HIV-related stigma, fear of discrimination and negative attitudes towards people living with HIV, poverty (lack of money to attend, for example, TB service on a given day and HIV counselling and testing service on another) and gender-related matters, such as the need for female patients to seek authorisation by the husband or another male head of household for health-seeking behaviours.

A number of posters featured examples and lessons for scale up of TB/HIV activities. Community health workers in Rwanda are successfully using the national screening tool to identify undiagnosed TB among people living with HIV (Abstract 662). One high burden district in Kenya demonstrated 82.5% adherence to isoniazid preventive therapy (IPT). However, 2301/3094 eligible people living with HIV were excluded from IPT on the basis of existing TB or assessment of adherence. It was not clear from the poster what adherence assessment entailed. The utility of a standard TB screening tool was demonstrated in a poster from Rwanda with 6152/8121 newly diagnosed people living with HIV being screened for TB, 27% (1665) had a positive screen and of these 132 (8%) were diagnosed with TB. Similarly 5% of people living with HIV in Nigeria were diagnosed with TB on screening and this was reported to be as high as 12% in a poster from Nigeria. Uptake of HIV testing was high in a report from the Democratic Republic of Congo with 91% of TB patients accepting HIV testing. Of the 17% who were found to be positive 80% received cotrimoxazole prophylaxis but only 7% received antiretroviral therapy.

The global health and development architecture

There were a number of interesting sessions on health and development architecture one which dealt with the relations between the country coordinating mechanisms and National AIDS Councils with excellent presentations from Tanzania and Zambia detailing how they had altered the functioning of these two bodies to be more coordinated, integrated and in line with national planning.

Another session organized by the Global Fund outlined the new policy decisions they were implementing and others being planned. The Fund's **Helen Evans** reiterated their commitment to the Framework principles of achieving impact, improving harmonization and alignment with national programmes and other donors, and ensuring sustainability of activities. She emphasized the importance of health system strengthening for the three diseases and introduced three new policy areas that were now being put into place. Moving from project support to full programme support - countries can now submit entire national programme plans for consideration for funding lending support for the notion that 'no credible, costed national plan will go un-funded'. However, the Fund will be looking to key technical partners to develop standards for the essential components of a national plan against which submitted plans will be 'certified'. Secondly, grants will now be issued to 2 principal recipients, one government and one non-government (dual track financing), in an attempt to increase absorptive capacity and to strengthen civil society involvement. The Fund will also be introducing voluntary pooled procurement for drugs and supplies in an effort to ensure efficiency but it was not clear how this would link with existing mechanisms such as the Global Drug Facility.

Several new initiatives are under development and include the grant consolidation mechanism which aims to align the management and reporting of multiple year and multi-disease grants in any one country. They are also planning to moved to fixed dates for future rounds as well as a new mechanism to provide a further 6 years' funding for successful grants.

The session – **‘Making care truly comprehensive and providing a preventive care package for people living with HIV’** featured lessons on providing comprehensive care, mostly based on the holistic palliative care model, from Cote d’Ivoire, Rwanda, Tanzania, Zambia and South Africa. None of the speakers however mentioned TB prevention, diagnosis and treatment this omission was noted and was highlighted in the rapporteur session on the final day – do not forget about TB!! Interestingly, one presentation showed convincingly the impact that investment in HIV services can have on health systems strengthening.

The new UN Secretary General’s Special Envoy on HIV for Africa – Elizabeth Mataka attended the conference and on a number of occasions voiced her commitment to addressing TB as a major threat to people living with HIV in the region and to promoting greater collaboration between TB and HIV programmes in order to address the interlinked epidemics.

A satellite meeting organized by PEPFAR and the Secretariat of the TB/HIV Working Group at WHO was attended by implementers from 22 countries. The main topic of discussion was how PEPFAR funds can be used to support TB control activities. Lessons learnt to date were presented by Ethiopia, Kenya, Rwanda and Zambia. This was followed by group discussions on how to overcome the barriers to nationwide scale up of collaborative TB/HIV activities; laboratory strengthening, TB infection control and monitoring and evaluation for collaborative TB/HIV activities.

Many of the presentations given at the meeting were filmed or transcribed and can be viewed on Kaiser Networks at:

<http://www.kaisernetwork.org/healthcast/hivimplementers2007/>