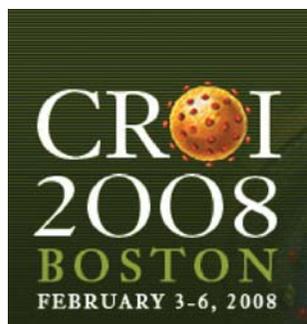


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TB/HIV at CROI 2008



The Stop TB and HIV/AIDS Departments of the World Health Organization (WHO) in collaboration with the Consortium to Respond Effectively to the AIDS TB Epidemic (CREATE) hosted an HIV/TB meeting as an affiliated event to the 15th Conference on Retroviruses and Opportunistic Infections (CROI 2008) on behalf of the TB/HIV Working Group of the Stop TB Partnership. The meeting held on February 3, 2008 in Boston, USA was attended by more than 50 leading HIV researchers, policy makers and representatives from funding agencies. Participants reviewed ongoing research efforts, promoted interchange of scientific ideas on unmet research needs and discussed priorities around the prevention of TB (isoniazid preventive therapy) and enhanced TB case finding (TB screening) among people living with HIV (PLHIV).

Read the meeting report and see the presentations at:
» www.stoptb.org/wg/tb_hiv/

World Bank, UN agencies work with African countries to scale up TB/HIV activities

Sixty-eight participants from ten countries met in Nairobi, Kenya in December 2007 to discuss scale up of TB/HIV activities. The World Bank in collaboration with WHO and UNAIDS conducted the workshop in an effort to address key challenges to implementation of TB/HIV activities in Burkina Faso, DR Congo, Malawi, Mozambique, Ghana, Sierra Leone, Lesotho, Uganda, Tanzania and Kenya. Participants came from governments, service providers and civil society. International and national experiences were shared and countries were tasked with producing a list of challenges and possible solutions which could be addressed over the next six months.

Priority areas were improving national joint coordination and joint strategic planning between programs. Infection control was also highlighted as a priority need and countries requested technical assistance to understand how

to implement measures particularly in facilities where collaborative activities are already being implemented. Participants also requested guidelines for implementation of infection control be developed and made available as soon as possible. Difficulties in screening people with HIV and the absence of consensus guidelines were cited as reasons for failure to implement IPT (isoniazid preventive therapy) for PLHIV (people living with HIV). Much more needs to be done to practically overcome barriers to scaling up those activities that reduce the burden of TB in PLHIV.

Another key area which was being neglected was national advocacy and social mobilization for TB/HIV. Participants agreed that advocacy must be included in technical assistance and funding proposals in order to engage communities and NGOs in scale up activities.

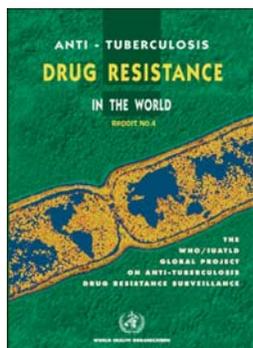
MORE

» About the Stop TB Partnership
www.stoptb.org



Highest rates of drug-resistant tuberculosis ever recorded: Link with HIV limited but emerging

How do we engage all health providers in TB/HIV collaborative activities?



WHO recently released its Anti-Tuberculosis Drug Resistance in the World fourth report which shows the highest rates ever recorded of tuberculosis resistant to standard drug treatments. The data was collected between 2002-2006, from 83 countries out of which only 7 countries reported data disaggregated by HIV status. WHO now estimates there are nearly half a million new cases of multi-drug resistant TB (MDR-TB), about 5% of the nine million new TB cases annually. Estimates also indicate that in Eastern Europe and Central Asia one in five people with TB have MDR-TB.

Only six countries in sub-Saharan Africa, the region with a huge HIV associated TB problem, were able to provide drug resistance data for the fourth report. Most countries in the region could not conduct surveys due to lack of equipment and trained personnel needed to identify drug-resistant TB. While the report finds generally low levels of resistance in the countries surveyed, recent experiences in South Africa show that high HIV levels and the occurrence of MDR-TB and extensively drug resistant (XDR) TB can result in extremely high mortality particularly among those who are also co-infected with HIV.

The report found that the proportion of MDR-TB was significantly higher among PLHIV compared with people who are HIV

negative in the Ukraine and Latvia. In Ukraine, 31.6% of PLHIV TB patients had MDR-TB compared to 23.8% in HIV negative TB patients. PLHIV TB patients are 1.5 - 2 times more likely to have MDR-TB compared with HIV negative patients.

Both of these countries are situated in the former Soviet Union where diagnostic networks for TB and HIV are relatively well developed. This link between HIV and MDR-TB is a major concern because tools to diagnose resistance are still unavailable in most parts of the world, particularly sub-Saharan Africa where HIV prevalence rates are highest. This means that PLHIV will not receive appropriate therapy quickly enough to prevent death.

The report also found other evidence which suggests that the association between HIV and MDR-TB may be more closely related to environmental factors such as transmission in congregate settings rather than biological factors. This requires further investigation but it highlights the need for improved infection control in congregate settings i.e. health care facilities and prisons.

The report also found that there is need for a better understanding of the epidemiological relationship between drug resistance and HIV and calls for more research.

TB drug resistance requires urgent action today. Existing treatments and diagnostics must be made available to more people and we must have laboratory networks which are able to provide rapid diagnosis of drug resistance for all TB patients including those co-infected with HIV. Investment in research and development for new diagnostics, new drugs effective against resistant strains and an effective TB vaccine must be increased significantly if we are to respond effectively and stop MDR-TB in its tracks.

Read the full report:
» www.who.int/topics/tuberculosis/en/

Patients with symptoms of TB and HIV seek and receive care from a wide variety of health care providers, ranging from private practitioners to traditional healers, depending upon availability, acceptability, costs and many other factors. Almost every health care provider in any setting can contribute to TB/HIV collaborative activities by undertaking one or more of the several essential tasks of suspecting, referring, diagnosing, managing and notifying cases.

A consultative workshop held in Geneva from February 27-28, 2008 brought together a panel of experts from a variety of health care services to discuss a protocol which guides the engagement of all health care providers in TB/HIV collaborative activities.

The protocol aims to provide practical steps to National TB and AIDS Programmes (and/or different implementing agencies), to initiate, expand and systematically document the engagement of private and public providers for collaborative TB/HIV activities. It is also aimed at encouraging organizations and associations to include collaborative TB/HIV activities, through collaboration with national, regional and local health authorities. Following the consultation, the protocol is now being finalized, and countries and partners will be encouraged to use it to harness the contribution of different providers. The evidence and experience gathered by using the protocol will also contribute to a policy on the engagement of all care providers in the fight against TB/HIV.

People receiving TB treatment no more likely to die than others who start ARVs

New research presented at CROI showed that, in general, people receiving treatment for pulmonary TB are no more likely to die if they start antiretroviral treatment than their counterparts without TB. The study carried out in South Africa found the only exception to this finding were malnourished people with TB who start ART less than 30 days after starting TB treatment.

Researchers carried out the study due to conflicting data from resource-limited settings regarding the impact of active tuberculosis on the risk of death in HIV-positive patients starting antiretroviral therapy.

Investigators from the University of North Carolina School of Public Health and the Themba Lethu Clinic in Johannesburg performed a retrospective study to see if patients with active tuberculosis when they started anti-HIV treatment had an increased risk of death or loss to follow-up (for reasons other than transferring care to another HIV treatment centre) than tuberculosis-free patients.

The study ran between April 2004 and August 2007. Of the 7519 clinic patients who started antiretroviral therapy during this period, 1202 (16%) had active tuberculosis and were included in the investigators' analysis. Of these patients, 284 received tuberculosis treatment for 30 days or less before anti-HIV treatment was started.

Overall there was no difference in the risk of death or loss to follow-up for patients with or without active tuberculosis in the twelve months after anti-HIV therapy was initiated.

Results suggest that individuals receiving tuberculosis treatment are not at increased risk of death after [antiretroviral therapy] initiation however, individuals with additional risk factors, such as low body mass index and low CD4 counts may have substantially increased risks.

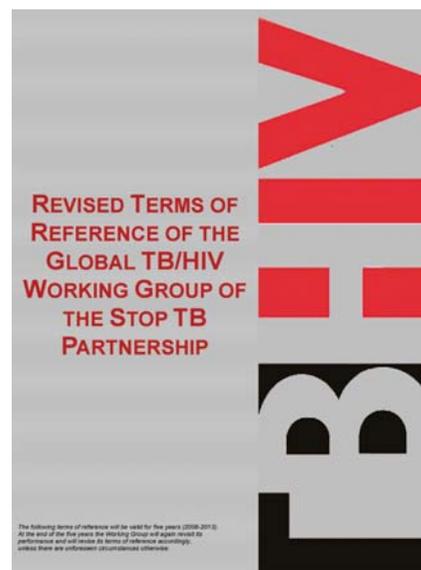
* Information reported by **Michael Carter, AIDSMAP**

Reference

Westreich D et al. *The influence of TB on early mortality in the Themba Lethu clinical cohort, Johannesburg, South Africa*. Fifteenth Conference on Retroviruses and Opportunistic Infections, Boston. Abstract 145, 2008.

Revised Terms of Reference for the TB/HIV Working Group

The TB/HIV Working Group of the Stop TB Partnership was established in 2001 with the aim of coordinating the global response to the HIV associated TB epidemic. The HIV pandemic presents a massive challenge to the global control of TB at all levels. The overall progress of implementation of collaborative TB/HIV activities particularly in those countries that carry the brunt of the problem has been low. In light of recent global changes and needs, the TB/HIV Working Group reviewed its strategy and operational framework in order to address these gaps, and ensure the delivery of collaborative TB/HIV activities for patients in need of the



services. The TB/HIV Core Group invited Working Group members to comment on the revised ToR for the TB/HIV Working Group. These were reviewed and approved by the Core Group at their meeting in October 2007. Thank you to all Working Group members who sent in their input. The new revised ToR is now valid for five years (2008-2013). At the end of this period the Working Group will again revisit its performance and will revise the ToR accordingly.

The new ToR is now available on the TB/HIV website at:

» www.stoptb.org/wg/tb_hiv/assets/documents/TB%20HIV%20WG%20ToR%20Final%202008.pdf

NEW RESOURCES



I Am Stopping TB is more than slogan it is the start of a two-year campaign that belongs to people everywhere who are doing their part to Stop TB. This year's World TB Day (March 24, 2008) is about celebrating the lives and stories of people affected by TB: women, men and children who have taken TB treatment; nurses; doctors; researchers; community workers--anyone who has contributed towards the global fight against TB.

Download materials that will help you make your own World TB materials such as posters, web postings and video; and plan World TB Day activities.

» www.stoptb.org/events/world_tb_day/2008/

A new resource on TB/HIV will be available on the TB/HIV website from March 17, 2008. It is a powerpoint presentation which outlines what is TB, what is HIV/AIDS, and how can we respond effectively to TB/HIV. It presents the latest statistics and data from the Global TB Report 2008 including global and regional overviews and country examples of TB/HIV collaborative activities implementation.

» www.stoptb.org/wg/tb_hiv/

OVERCOMING BARRIERS TO IMPLEMENTATION OF COLLABORATIVE TB/HIV SERVICES IN UGANDA



In 2006 The International Union Against Tuberculosis and Lung Disease (The Union) collaborated with the Uganda National TB and Leprosy Program and the AIDS Control Program to launch multi-phased operational research (OR) programs in order to identify operational barriers to the implementation of collaborative TB/HIV activities.

The Uganda national collaborative TB/HIV policy consists of coordination and planning of joint services, TB diagnosis and treatment for PLHIV (people living with HIV) and HIV screening and care for TB patients. In spite of the existence of this policy, there were low levels of implementation. It was estimated that in mid 2006 only 30% of TB patients were routinely offered counseling and testing for HIV. As a result the first phase of operational research was a qualitative study conducted in five rural/peri-urban districts: Apac, Oyam, Kumi, Bukedea and Mukono between August and December 2006. A total of four hospitals and four health center were selected for the study. Research assistants were trained and conducted 26 focus group discussions, 34 key informant and 28 in-depth

interviews using local languages. Barriers were elicited by assessing knowledge, attitudes, practices and beliefs in relation to collaborative TB/HIV activities. One hundred and twenty five patients (TB, HIV and TB/HIV), 65 health providers and district health officials, and 70 community members were interviewed. Barriers were identified at the health system, health provider and patient levels.

HEALTH SYSTEM BARRIERS

Some of the most commonly reported health system barriers were frequent stock outs of HIV supplies, especially cotrimoxazole, rapid HIV testing kits and antiretroviral (ARVs) drugs. The stock outs disrupted service delivery, created patient frustration and demoralized staff in both HIV and TB services. Patients revealed that despite being referred for HIV diagnostic and care services, they had to return repeatedly to the health facilities to find out whether supplies had been received. In some facilities, patients eligible for ARVs could not access them due to inadequate stocks to sustain all eligible patients.

Providers attributed the stock outs to:

- Inaccurate health facility orders for supplies and their delayed submission

- Limited provider knowledge on quantification of supplies
- Delivery of insufficient quantities of ordered supplies by the National Medical Stores
- High patient service demand

Due to the shortages experienced at the health facilities, patients resorted to buying drugs, like cotrimoxazole and occasionally ARVs. This meant substantial additional expenses to patients who sometimes had to pay for chest X-rays and CD 4 cell count measurements. In most of the facilities, patients were not initiated on antiretroviral treatment (ART) without CD 4 cell count results, even though tests were sometimes unavailable.

Another logistical issue was that TB and HIV services were offered on separate days and operated independent TB and HIV clinics which affected implementation of collaborative TB/HIV activities. In order for patients to access "complete" TB/HIV services they needed to come to the facility on different days.

PROVIDER FACTORS

Providers attributed the low level of implementation of collaborative TB/HIV services to inadequate dissemination of

national collaborative TB/HIV policy and guidelines, lack of district leadership and financial support for implementation of these activities, inadequate provider knowledge, and patient factors. Gaps in knowledge varied between clinics: in TB facilities providers lacked sufficient knowledge and skills on HIV counseling and testing, and did not know how and when to start people living with HIV (PLHIV) who also had TB on ARVs. In HIV clinics, providers lacked knowledge on diagnosing TB, especially smear negative and extra-pulmonary tuberculosis, and providing TB treatment. A number of PLHIV TB patients were told inaccurately to stop taking their ARVs while on TB treatment.

Other provider barriers reported included understaffing, poor staff motivation, and high workload.

PATIENT FACTORS

Due to high levels of stigma and discrimination in the communities researched the uptake for HIV counseling and testing was low. Other patients said that they were uncertain whether they could cope with a diagnosis of having both TB and HIV disease and preferred to complete TB treatment before getting HIV tested. More females were willing to test for HIV. In some instances

OVERCOMING BARRIERS TO IMPLEMENTATION OF COLLABORATIVE TB/HIV SERVICES IN UGANDA



Patient being interviewed in a hospital as part of the study

male partners refused to give permission to their spouses to test for HIV. In other instances, males were afraid or ashamed to test for HIV and resorted to using their female partner's HIV status as an alternative for their HIV status.

Awareness of the association between TB and HIV affected the uptake of HIV testing among TB patients. Patient and community knowledge on the importance and key components of collaborative TB/HIV services was generally limited, despite awareness of the association between TB and HIV. Such awareness has created dual stigma within the communities, thus further preventing them from seeking HIV services. Patients also considered that poor infrastructure at the facilities compromised their privacy and was a barrier to utilization of HIV testing services.

This study highlights some of the challenges and barriers experienced by services providers and patients, and reveals the importance of operational research to assess the barriers that may affect implementation and scaling up of collaborative TB/HIV services. Recommendations as a result of this research includes training providers in joint TB/HIV activities; regular supervision; provision of sufficient and regular supplies of drugs and test kits; integration of TB and

HIV services, and community education about collaborative TB/HIV services, stigma and discrimination and treatment literacy for patients.

Collaborative TB/HIV activities are increasing but further operation research is essential to find solutions to implementation barriers.

This study was made possible by the generous support of the American people through the United States Agency for International Development (USAID) under Cooperative Agreement GHS-A-00-03-00045-00.

Information provided by:

Rose Okot-Chono, John Frank Mugisha, Paula Fujiwara, and Riitta Dlodlo of the International Union Against Tuberculosis and Lung Disease (The Union), and Makerere University.

Editorial note:

we are keen to publish any follow up to this research which measures the inputs recommended and the subsequent implementation levels of TB/HIV collaborative activities. Watch this space!

Share experiences in TB/HIV implementation and research – Working Group members can send their contributions to the Forum (no more than 1000 words and no more than three authors) to tbhiv@who.int

Upcoming events

The Secretariat of the TB/HIV Working Group encourage members of the Working Group and other HIV and TB implementers and stakeholders to submit their abstracts on TB/HIV issues for these important meetings.

MARCH

FINAL DEADLINE FOR SUBMISSION OF ABSTRACTS FOR THE 39TH UNION WORLD CONFERENCE ON LUNG HEALTH, 16-20 OCTOBER 2008, PARIS, FRANCE

When: **March 10, 2008**

Theme: **Global threats to lung health: the importance of health system responses**

For more information:

www.worldlunghealth.org/Conf2008/abstract

APRIL

TB VACCINES FOR THE WORLD

AERAS Global TB Vaccine Foundation. CDC. GlaxoSmithKline Biologicals. Intercell Smart Vaccines.

When: **April 9-11, 2008**

For more information:

www.meetingsmanagement.com/tbv_2008/

TBV 2008, the follow-up to the successful TBV 2003 and TBV 2006 meetings, will focus attention on "Vaccine Issues" in relation to TB worldwide. TB vaccines form a developing area of activity, and TBV 2008 will allow researchers to come together to discuss the latest findings and trends associated with the research and development of TB vaccines: science, policy, strategy, delivery, and economics. The TBV 2008 Scientific Advisory Panel invites the submission of late abstracts for consideration for inclusion in the TBV 2008 poster program.

TRAINING WORKSHOP FOR PUBLIC-PRIVATE MIX (PPM)-TB CONSULTANTS

When: **April 14-19, 2008**

Where: **Sondalo Italy,**

For more information: rosella.centis@fsm.it

The WHO Collaborating Centre for Tuberculosis and Lung Diseases, S. Maugeri Foundation in Tradate Italy, in collaboration with the Stop TB Department, WHO, Geneva are organizing a training workshop on Public-Private Mix for TB control. This one week course will run from 14-19 April 2008, and is designed to provide TB experts with the knowledge and skills to plan, implement and monitor interventions to effectively engage diverse private and public sector health care providers in TB control.

The course is highly interactive and exercise based. It incorporates presentations, role plays, group work and also the experiences of participants themselves. Participants will be given hands-on training with the WHO Planning and Budgeting tool. The training course is based on the WHO document "Engaging all health care providers in TB Control: Guidance on implementing Public-Private Mix Approaches" which synthesizes evidence from interventions in countries.

UNAIDS PROGRAM COORDINATING BOARD MEETING

When: **April 24-25, 2008**

Where: **Thailand**

For more information:

www.unaids.org/en/AboutUNAIDS/Governance/default.asp

MAY

GENEVA FORUM: TOWARDS GLOBAL ACCESS TO HEALTH

Theme: **Strengthening Health Systems and the Global Health Workforce**

When: **25-28 May 2008**

Where: **International Conference Centre of Geneva, Switzerland**

For more information:

info.genevahealthforum@hcuge.ch or

www.genevahealthforum.org

Geneva Health Forum Secretariat

- **00 41 22 372 96 72 / 58**

15TH ISHEID (INTERNATIONAL SYMPOSIUM ON HIV & EMERGING INFECTIOUS DISEASES)

When: **May 28-30, 2008**

Where: **Toulon, France**

For more information: www.isheid.com

The deadline for abstract receipt is February 15th.

This conference is a combination of theory and practice with emphasis on practical data and interactive sessions leading to a dozen 'HOT TOPICS' translated into 'guidelines' which will subsequently be published in a peer reviewed journal.

JUNE

GLOBAL LEADERS FORUM ON TB/HIV

Hosted by the UN Special Envoy to Stop TB, Jorge Sampaio, on behalf of the UN Secretary General Ban Ki moon

When: **June 9, 2008**

(prior to this year's UNGASS)

Where: **New York, USA**

For more information: harropl@who.int

UNGASS (UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION) HIV/AIDS

When: **June 10-11, 2008**

Where: **United Nations, New York, USA**

For more information:

www.unaids.org/en/AboutUNAIDS/Goals/UNGASS/