

*IAS Forum Joint Session on HIV/TB*

# HIV and TB at the Crossroads: Integrating the operational agenda

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**TB:HIV**

# Logic of the presentation

## Goal: to reduce burden of TB/HIV

- HIV drives the TB epidemic in high HIV settings (DOTS alone is insufficient) and HIV transmission will continue for foreseeable future
- TB is the most serious OI
- In Africa, estimated case detection for TB is only 50% (2003) thus DOTS expansion first priority
- WHO's 3 by 5 initiative has stimulated unstoppable urge for treatment but implementation is difficult
- Consensus reached (from both HIV and TB communities) on joint TB/HIV measures to address the needs of HIV+ TB patients and support ART expansion

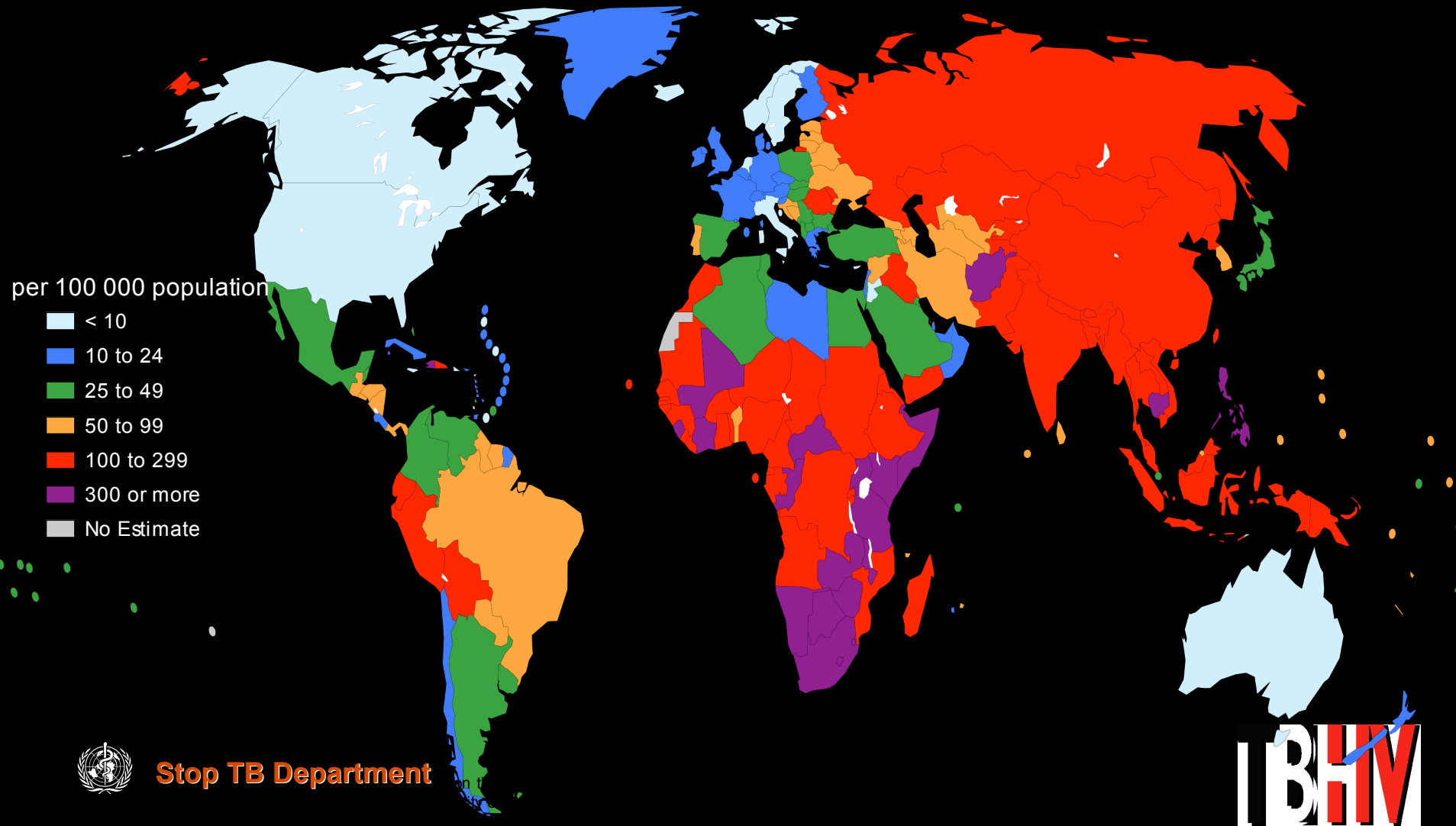


# Logic continued

- However, the evidence base for these measures is thin and urgently needs expanding
- Countries are demanding immediate scale up of what works – opportunities are being missed
- Constraints include turf, weak health systems, weak surveillance and monitoring and low operational research capacity
- Success in rapidly reducing the burden of these 2 diseases depends on evaluation of TB/HIV joint activities and on defining the best approaches

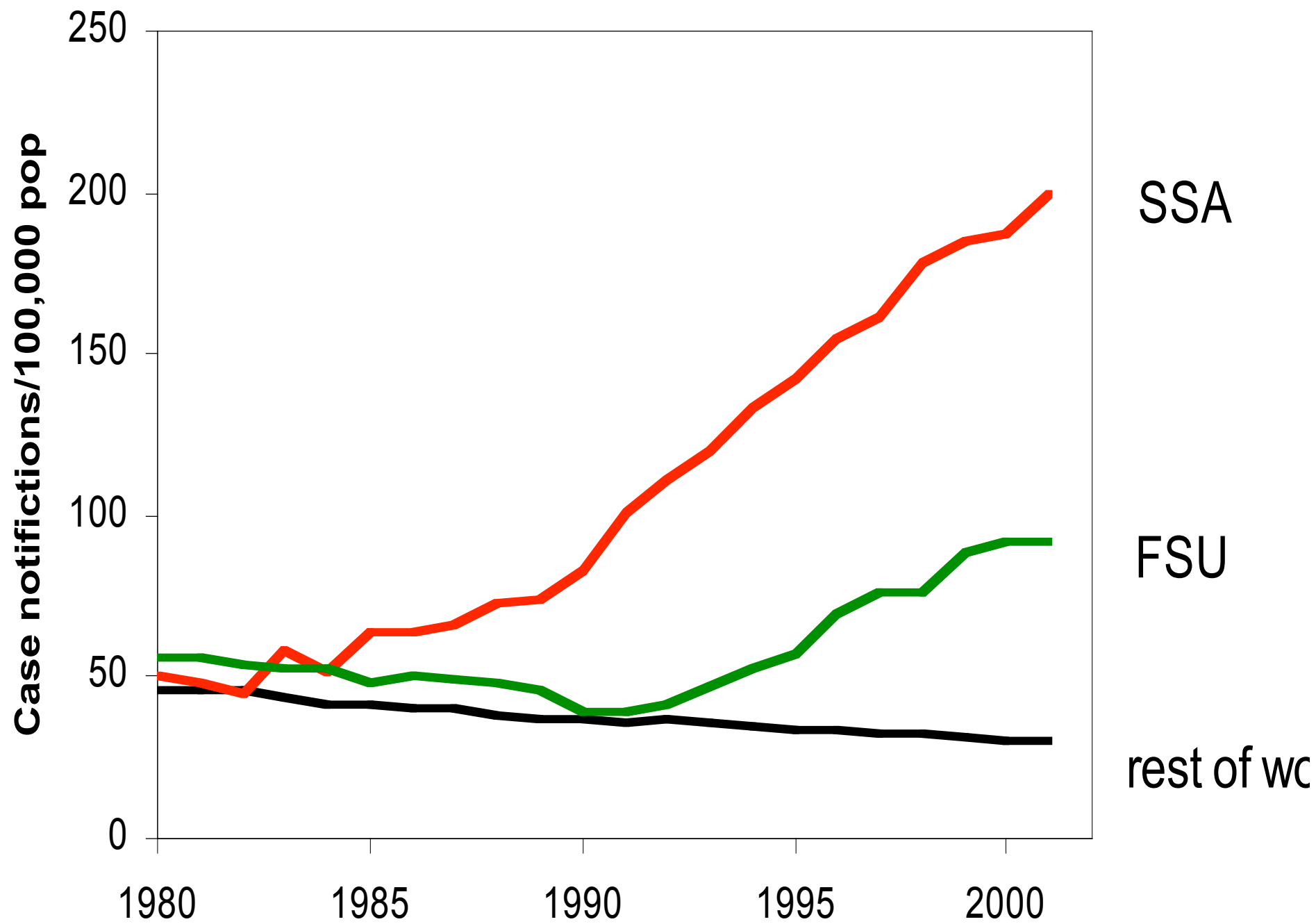


# Highest TB rates per capita are in Africa linked to HIV/AIDS

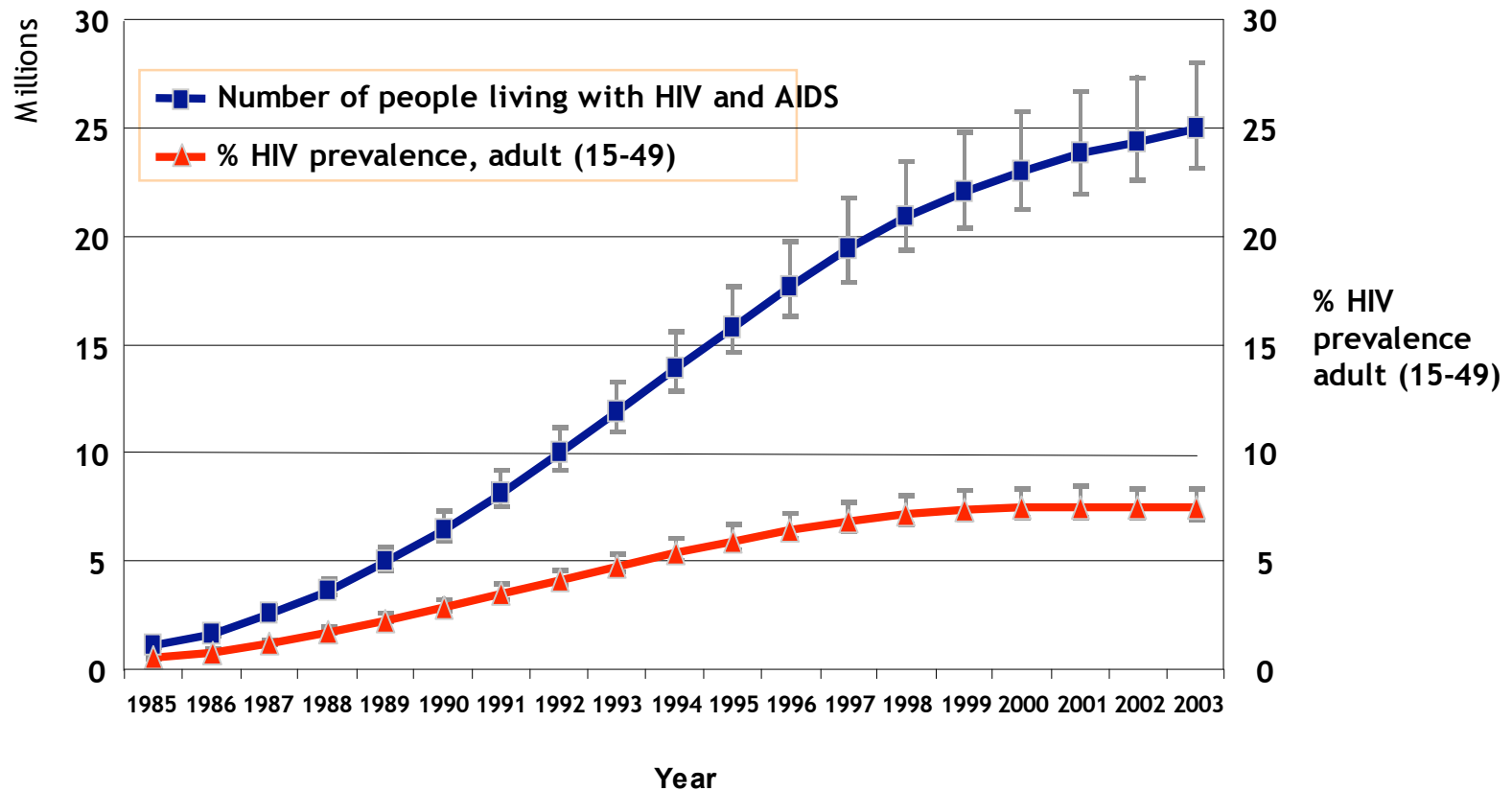


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# Epidemic in sub-Saharan Africa 1985–2003



Source: UNAIDS/WHO, 2004

2004 Report on the Global AIDS Epidemic (Fig 5)



# Current Global Status (2003)

- 8.8 million new TB cases
  - 7.6% of total cases HIV+ (674 000) = 12% of adult cases
- TB notifications and estimated incidence decreasing in 5 WHO regions, increasing in Africa
- Globally TB incidence would be falling but for HIV: Global estimated incidence grew 1% 2002-2003, prevalence and mortality rates falling
- In Africa, 210,000 deaths from TB + HIV = 15% of HIV deaths due to TB (*late breaker poster, Wednesday*)
- Only 3% of TB cases tested for HIV



# Context and ongoing processes

- New TB control strategy in preparation and to be launched October 2005
  - Expands and maintains DOTS
  - Involves all care providers
  - Addresses TB/HIV and MDR-TB
  - Strengthens laboratories
  - Urges research and development of new tools
- Research priorities defined in TB/HIV, February 2005. Report now out.
- PEPFAR, GFATM etc
- CREATE, NIH, ANRS etc





# TB/HIV Collaborative Activities

## Establish mechanisms for collaboration

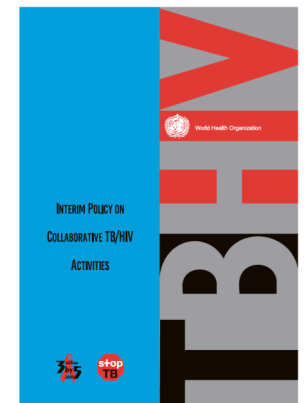
- Set up a coordinating body for TB/HIV activities
- Conduct surveillance of HIV prevalence among tuberculosis patients
- Carry out joint TB/HIV planning
- Conduct monitoring and evaluation

## Decrease the burden of TB in people with HIV/AIDS

- Establish intensified tuberculosis case-finding
- Introduce isoniazid preventive therapy
- Ensure tuberculosis infection control in health care and congregate settings

## Decrease the burden of HIV in tuberculosis patients

- Provide HIV testing and counselling
- Introduce HIV prevention methods
- Introduce co-trimoxazole preventive therapy
- Ensure HIV/AIDS care and support
- Introduce antiretroviral therapy



# Where are we now in TB/HIV?

- Global consensus around TB/HIV interim policy
- But slow country level implementation of joint TB/HIV activities
- Constraints
  - Low awareness of what needs to be done and how
  - TB and HIV programmes acting separately
  - Some technical approaches undefined eg TB/HIV for children, IDU
  - Operating in the context of weak health systems
    - Lack of human resources
    - Competing priorities: DOTS expansion, ARV scale up etc



# The Policy-maker's Questions

1. What is the best solution to the TB/HIV problem?
  - WHO TB/HIV collaborative activities are best consensus to date, based on evidence available
2. What are the best ways to implement activities to solve the TB/HIV problem in my health system?
3. How can I bring about the necessary changes in the health system to implement TB/HIV activities?

*Lavis J et al. Use of research to inform public policymaking. Lancet 2004;364:1615-21*



# 1. Assessment of the TB/HIV package

- What is the overall benefit of implementing the TB/HIV policy package?
  - Can it be implemented (process indicators)?
  - How much impact will it, or its components, have, if any (impact indicators)?
  - How much will it cost, relative to the other interventions we are, or could be doing?
- Build assessment into implementation
  - TB-side underway through annual survey
  - How to record and report "HIV-side" activities?
- More formal assessment would help, but costs



## 2. What are the best ways to implement TB/HIV activities?

- What governance, financial and delivery arrangements are the most conducive to the effectiveness of the package, in our setting?
  - Eg. Management by public sector, NGOs, both
  - Aid agency supported?
  - Community based care?



### 3. What are the changes necessary in the health system to implement TB/HIV activities?

- What informational, educational and financial (incentive) approaches are needed to change behaviours to implement the package?
  - Eg. How to best promote productive collaboration between NTPs and NACPs?
  - Define most effective training approaches

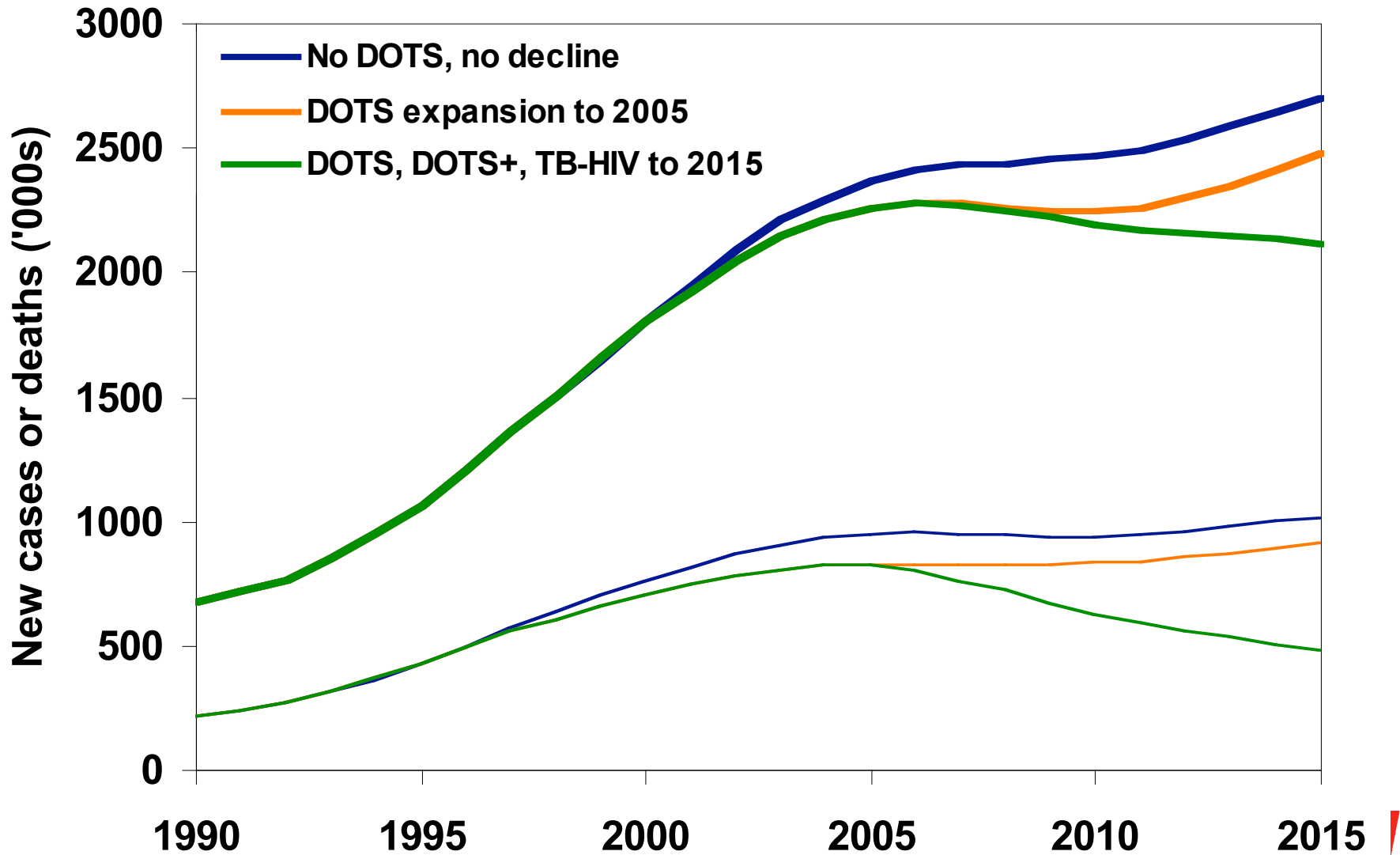
# Conclusions

- From this crossroads we must choose the route where TB and HIV control travel together
- Current TB/HIV policy is a reasonable base
- Now we need to show what works and what does not - research
- Integrating the agenda demands researchers and controllers work together in high HIV, high TB countries



# Africa (high HIV) & E Europe

impact depends on what we do from 2006 to 2015



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