

From Mekong to Bali

Report of the meeting
organized by the World Health
Organization in collaboration
with the TB/HIV Working Group
of the Stop TB Partnership

Stop TB Partnership



From Mekong to Bali: The scale-up of TB/HIV collaborative activities in Asia-Pacific: 8–9 August, 2009, Bali, Indonesia



Participants at the "From Mekong to Bali" meeting, 2009

Summary

Catalysing collaborative tuberculosis and human immunodeficiency virus (TB/HIV) activities in the Asia and Pacific region is a priority. This region has more than half the global burden of TB and 12% of the global burden of HIV. The meeting "From Mekong to Bali: The scale-up of TB/HIV collaborative activities in Asia-Pacific" was organized by the World Health Organization in collaboration with the TB/HIV Working Group of the Stop TB Partnership.

A total of 127 people from 18 countries took part in the meeting with representation from all countries with high TB and HIV burdens. Participants shared experiences and best practices to inform plans to accelerate the implementation of nationwide scale-up of collaborative TB/HIV activities. The meeting followed from the first regional TB/HIV meeting held in the Mekong subregion in Ho Chi Minh City, Viet Nam in October 2004.

National TB and HIV programme managers were joined by a broad range of HIV/AIDS and TB stakeholders active in the Asia and Pacific region, members of the TB/HIV Working Group, and representatives of bilateral, multilateral, nongovernmental and faith-based organizations.

This report summarizes key outcomes, conclusions and recommendations of the meeting.

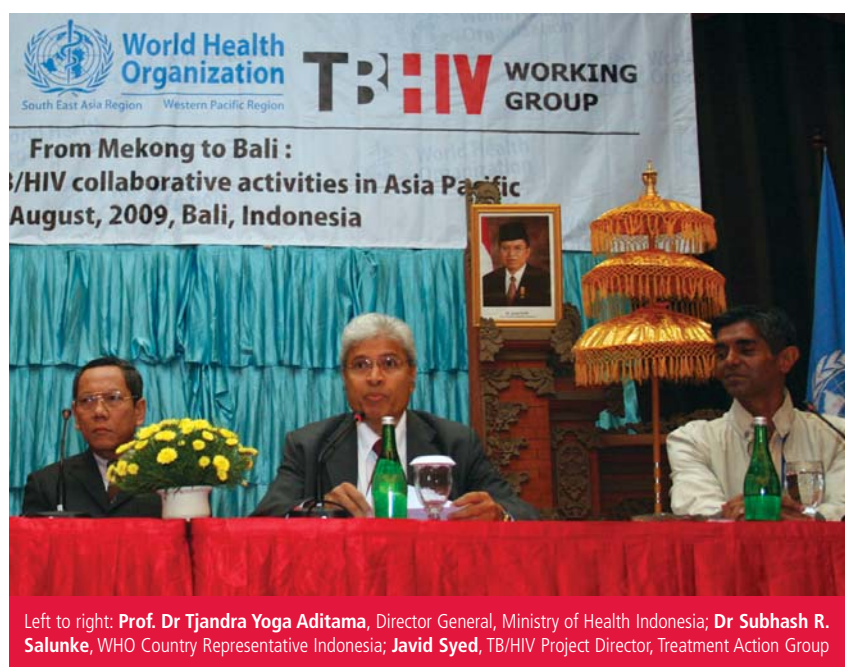
¹ Bangladesh, Bhutan, Cambodia, China, Fiji, India, Indonesia, Lao People's Democratic Republic, Malaysia, Maldives, Mongolia, Myanmar, Papua New Guinea, Philippines, Sri Lanka, Thailand, Timor-Leste and Viet Nam.

Scale-up of HIV testing and provision of ART and CPT—possible and greatly needed

Only 20% of people living with human immunodeficiency virus (HIV) know their HIV status. Lack of access to HIV testing and counselling is the biggest barrier to access to comprehensive HIV prevention care and treatment. Provider-initiated counselling and testing guidelines from the World Health Organization (WHO) call for all tuberculosis (TB) patients to be offered HIV testing.

Country	Proportion of TB patients with known HIV status in 2007 (%)
Thailand*	69
Japan	64
Malaysia	60
Australia	41
Cambodia	39
Viet Nam	15
Lao PDR	11
Sri Lanka	6
India	5
China	3
Myanmar	2
Papua New Guinea*	1
Indonesia	0.10
Philippines	0.03

* Countries with adult HIV prevalence of >1% (UNAIDS).
Source: WHO Global TB Control Report, 2009.



Programme data from Indonesia show that most HIV-positive TB patients are young males, who do not know their HIV status when diagnosed for TB. Although the overall scale-up of HIV testing among TB patients in Asia-Pacific was still low in 2007, there had been a multifold year-on-year increase. In 2004, only 0.3% of all TB patients were tested for HIV, a figure that rose to 6% by 2007. In 2008, Cambodia tested 57% and Thailand 79% of all TB patients. India tested over 126 000 TB patients the same year, a fourfold increase in four years.

Countries show great variability in the proportion of TB patients tested (table 1). Some test more than 50% of all TB patients but others fewer than 5% of them. The high rates demonstrate that general scale-up to test all TB patients is possible throughout the Asia-Pacific region. One issue of concern, however, is the high mortality of HIV-positive TB patients during TB treatment. Cohort outcome analysis of HIV-positive TB patients in Asia-Pacific countries shows between 20% and 50% mortality during TB treatment, most of which occurs in the first two months of treatment.

This high mortality is thought to be due to late identification of HIV-related TB. Data from Thailand suggest that over 80% of HIV-related TB patients have CD4 cell counts¹ of fewer than 250 cells/mm³ and 60% fewer than 100 cells/mm³ at the time of diagnosis. Data from India show that death is strongly associated with the absence of antiretroviral therapy (ART) during TB treatment.

In Asia-Pacific, only one fifth of HIV-related TB patients go on to ART and only around two fifths receive co-trimoxazole preventative therapy (CPT). To minimize mortality, meeting participants recommended that programmes should promote high coverage of HIV testing, and for those who are found HIV positive, ART and CPT should be provided quite early during TB treatment.

Most TB/HIV patients are young males, and do not know their HIV status when diagnosed for TB. Of those tested, 80% have CD4 counts below 250 cells/mm³—less than a fifth receive ART and nearly a quarter die

¹ The CD4 cell is a type of infection-fighting white blood cell that carries the CD4 receptor on its surface. HIV infects and kills CD4 cells, which leads to a weakened immune system. The CD4 count is one of the most useful indicators of the health of the immune system and the progression of HIV/AIDS.

The three I's: A long way to go

THE THREE I's

INTENSIFIED TB case-finding with TB treatment of those in HIV care

ISONIAZID preventive therapy (IPT) provision for those without TB

INFECTION control in health care and congregate settings

Intensified case-finding: Screening of people living with HIV for TB—happening but no documentation

Intensified TB case-finding was reported in most countries as being available to people living with HIV, though only 16 countries reported data on this in 2007.

Data from Papua New Guinea show that 67% of newly detected cases among people living with HIV were tested for TB in 2008. The 90% local target for this indicator was exceeded in Thailand the same year (93%), and this testing resulted in 14% of those screened diagnosed with TB.

India has shown that intensified TB case-finding among people presenting for voluntary counselling and HIV testing also identifies HIV-negative TB suspects. It reported a sevenfold increase in referrals for TB screening from integrated counselling and testing centres between 2005 and 2008. In 2008, of the 189 530 patients referred from these to the TB programme for further TB symptom investigation, 66% were HIV negative.

In most countries the monitoring and evaluation of intensified case-finding has not been incorporated into the HIV reporting and recording systems, and so the data

presented to WHO underreport country activities.

Operational research on a new algorithm for screening for TB among people living with HIV—supported by a multi-country study of the Centers for Disease Control and Prevention in Cambodia, Thailand and Viet Nam—confirms other research that shows that cough or any single symptom is insufficiently sensitive for TB screening in people living with HIV. Any one of the following three symptoms is needed: cough in the last 24 hours, fever or drenching night sweats during the last three weeks. This was found to be more than 90% sensitive for identifying TB.

According to the algorithm, among those with none of the symptoms around a third of all those assessed would receive no further investigation before initiating ART/isoniazid preventive therapy (IPT). Among these, 3% would have TB.

For the symptomatic patients, this algorithm attempts to prioritize and minimize further investigations—including smear microscopy, chest X-rays, and culture and CD4 counts—and optimize their yields. However, culture is required for reliable diagnosis in 45% of screened cases. Compared to screening only those with chronic cough, this algorithm reduces false negatives by at least 83%.

This research will inform the proposed scale-up of IPT provision to people living with HIV in Cambodia.

The added benefits of screening for both TB and HIV

In concentrated HIV epidemics, the screening for TB of attendees at HIV counselling and testing sites also identifies large numbers of HIV-negative TB patients.

In settings with high rates of HIV, the testing for HIV of all TB suspects also identifies large numbers of HIV-positive people who turn out not to have TB.

IPT: Plan for national scale-up

Isoniazid preventive therapy (IPT) is the "I" that is not being implemented as part of a national package of TB/HIV activities. However, data are being reported from pilot projects in an increasing number of countries. In 2007, six countries in Asia-Pacific reported some data from pilot projects, but no country reported national IPT scale-up by end-2008. Cambodia and Thailand reported plans to go to scale with IPT provision in 2010.

In many countries, concerns among medical personnel and other experts include the difficulty of ruling out active TB in HIV-positive patients, the threat of magnifying isoniazid resistance, the difficulty and cost of managing adherence to IPT and the longer-term efficacy of IPT. These concerns are being used as arguments not to implement IPT.

The meeting recommended that a coherent communication strategy be developed. This would outline evidence refuting these concerns and would be made available to all decision-makers, professional bodies, experts and beneficiaries. Participants also emphasized the need for improved diagnostics with the development of a point-of-care test, and for increased investment in TB/HIV research.

Participants underlined the requirement to link IPT provision with intensified TB case-finding algorithms. Clinicians should no longer dismiss HIV patients with a diagnosis of "cannot exclude TB, but will not treat TB". Clinicians should be encouraged either to treat people living with HIV for TB, or—after performing tests to exclude TB—provide IPT. Participants stressed the urgent need to implement and optimize IPT provision at country level rather than waiting for further research results. Cost-benefit analysis needs to be part of the implementation process.

Infection control—overwhelmingly neglected?

Of the three I's, infection control, like IPT, is not a general practice in Asia-Pacific. Much has been done for infection control for blood-borne diseases (HIV) and respiratory infections (SARS and flu preparedness), and in response to multidrug-resistant TB. However, a coordinated and integrated approach to TB infection control is still missing. Integrated policies and guidelines for all levels of health services now need to be developed.

Integrating TB infection control scale-up efforts with general infection control efforts (hand washing and other respiratory disease infection control practices) is essential to sustainability. This requires attention to airborne, and not just droplet, transmission precautions.

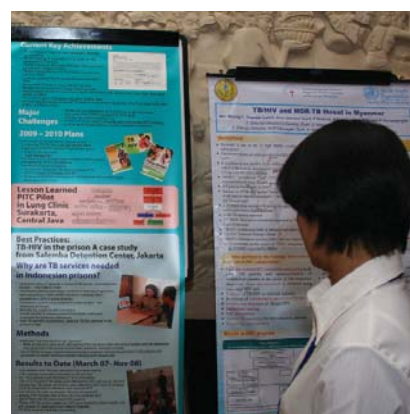
Infection control is a cross-cutting area and at this time of human resource challenges, health care workers need to be kept safe from acquiring TB in the workplace. People coming to access health care in facilities also need to have their safety assured by effective TB infection control measures.

Introducing appropriate measures is a slow process and, although infection control measures have been included in national plans in Bhutan, India, Indonesia, Myanmar, Nepal and Thailand, most countries have not begun implementation. Thailand has, however, established an infection control body that covers TB, while China, the Philippines and Thailand have developed specific TB infection control policies and guidelines.

Despite limited human resources and capacity to implement TB infection control, an increased focus

on capacity building to enable national programmes to respond has seen infection control training conducted in Mongolia and planned for China and Thailand.

No advocacy is conducted, and so most people have no awareness about infection control or why it is essential. Infection control is excluded from most grant proposals, such as those of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), and from monitoring and evaluation processes. It is still unclear who should take the lead in implementation—the TB programme, HIV programme, national infection control bodies or individual hospitals and health care facilities?



Participants view posters from countries showing scale-up



Infection control in India: A waiting area outside an outpatient department

All countries in Asia-Pacific need to develop integrated infection control guidelines at all levels. They also need to carry out much more advocacy for partnership development and to mobilize greater resources.

Technical assistance is needed to help countries implement infection control measures and to develop information, education and communication materials. These materials will be targeted at communities, patients and health care workers to provide a safer working environment.

Integrated case management of services: The fourth "I"?

TB and HIV programmes benefit from close coordination and integration at the point of service delivery. Patients with both diseases benefit from a single source of HIV care including CPT, ART and directly observed treatment, short-course (DOTS). This integration requires further decentralization of HIV services. A comparison of service delivery points for HIV testing with those for TB diagnosis and TB treatment with ART provision in 11 countries in South-East Asia shows this need clearly (table 2).

Ideally, TB treatment, HIV testing and ART provision should be managed in an integrated fashion. In seven out of 10 countries with data, fewer than 5% of health institutions offering TB treatment can offer antiretroviral therapy.

There are more than two TB diagnostic sites for every HIV testing site in seven out of the 11 countries.

Integrated training, monitoring, evaluation and supervision at peripheral health centres should form part of programme efficiencies, and the "Integrated Management of Adult Illness" (IMAI) training package for health staff is an option to move towards this goal of integration. HIV programmes need to decide what level of decentralization is appropriate for HIV registration, diagnosis, treatment and care in low levels of HIV transmission or concentrated epidemic situations.

Still, it is clear that in most countries, further decentralization of HIV counselling, care and treatment centres is necessary to facilitate access to TB/HIV services. Likewise, the local provision of TB diagnostic services at every HIV service delivery point is essential for integrated case management.

Monitoring and evaluation: Coordination and documentation urgently needed

TB/HIV indicator monitoring

TB registers have been revised in most countries in line with the WHO-recommended reporting and recording revisions of 2007. Twenty-nine countries in Asia-Pacific have reported data on HIV testing among TB patients. However, the revision of the generic WHO HIV reporting and recording system to include three TB/HIV indicators relating to the first two of the three I's (intensified TB case-finding with TB treatment of those in HIV care, and IPT provision for those without TB), has been slow. Only the latest revision shows how these data can be systematically collected and reported nationally.

Although reporting of this indicator also shows year-on-year improvement, fewer than one third of countries are reporting any data. All managers at the meeting identified the need to improve reporting and recording as well as TB/HIV cohort data analysis urgently.

Data cross-checking

Participants at the meeting emphasized cross-checking of data to validate data coming from TB and HIV care registers. Cambodia reported that over 90% of people in need of ART had received treatment by end-2008. In the same year, according to Cambodia's TB registers, around 80% of HIV-related TB cases did not receive ART during TB treatment.

Data from very small samples—where cross-checking HIV-positive people on ART registers with those on TB registers was carried out—show that the proportion of HIV-

Table 2
The fundamental challenge in TB/HIV – Service delivery mismatch

Country	Number of Health Institutions				% with TB Tx and ART (assuming overlap; Ideal: 100%)	Ratio TB Dx: VCT (Ideal 1)
	TB Rx	TB Dx	HIV Testing	ART		
Bangladesh	954	954	23	2	0.2%	41.48
Bhutan	30	30	7	1	3.3%	4.29
DPR Korea	285	285	34	0		8.38
India	300000	12500	4889	211	<0.01%	2.74
Indonesia	8000	4855	482	148	1.9%	10.07
Maldives	203	35	22	1	0.5%	1.59
Myanmar	329	324	199	53	16.1%	1.62
Nepal	4129	429	136	23	0.6%	3.15
Sri Lanka	26	26	26	5	19.2%	1
Timor-Leste	74	18	9	2	2.7%	2
Thailand	847	1023	1014	1014	83.5%	1.01

TB Rx = Tuberculosis treatment; TB Dx = Tuberculosis diagnosis.

Source: TB and HIV programme managers meeting, Malé, Maldives, December 2008.

related TB cases on ART is higher than indicated through routine recording. Programmes need to cross-check HIV-positive people on ART registers with those on TB registers and update registers to minimize underreporting. This would also update data for subsequent TB/HIV treatment outcome analysis, which is essential to monitor and manage programme performance and quality.

Patient follow-up

Part of the HIV care decentralization has been the increasing implementation of provider-initiated HIV counselling and testing at peripheral health centres, often focusing on TB patients. However, this is still not linked to registration of patients in HIV care at the same sites. Unless referral to much more centralized HIV care facilities that provide ART is successful, those HIV-positive TB patients who are identified at peripheral health centres and treated for TB may slip through the care net once they leave the TB registers on completion of TB treatment.

The absence of registration means that, all too frequently, no one knows what happens to these people in terms of their HIV care or long-term outcomes. HIV-positive TB patients should be registered for both TB and HIV care in respective care registers from the time of diagnosis. Although registration for HIV care of HIV-positive TB patients is one of the TB/HIV indicators, it is one that most countries do not report. With increasing numbers of HIV-related TB cases identified, countries need to pay more attention to this aspect of care.

Monitoring of infection control

Although most countries report having infection control policies, none reports on other TB infection control indicators. This needs to be addressed as part of the regional response to infection control.



Group at the Bali meeting discussing key issues and mapping out action plans

Resource mobilization

The majority of external resources for TB and HIV programmes in Asia-Pacific come from the Global Fund and the United States President's Emergency Plan for AIDS Relief (PEPFAR).

The Global Fund has allocated US\$ 1.3 billion for Asia-Pacific and provides 57% of external funding for TB programmes. PEPFAR supports HIV programmes in Cambodia, China, India, Indonesia, Lao PDR, Papua New Guinea, Thailand and Viet Nam, where its support for TB programmes is made primarily through technical assistance rather than grants. The exception is Viet Nam, where an annual US\$ 4 million will be spent by 2010.

PEPFAR-supported technical assistance can leverage additional funding from the Global Fund and the United States Agency for International Development (USAID). The USAID Regional Development Mission Asia is already supporting a variety of TB activities with US\$ 17.25 million in funding over the three years 2008–2010.

The financial support is concentrated on the nine high-burden countries in the region (Bangladesh, Burma, Cambodia, China, India, Indonesia, Philippines, Thailand, and Viet Nam). Countries in the region with bilateral USAID missions can also access Tuberculosis Coalition for Technical Assistance (TBCAP) funds of approximately US\$ 100 million a year. TBCAP is a coalition of technical partners focusing on DOTS, private–public mixes, TB/HIV collaborative activities and human capacity development.

Since last year, the Global Fund board has supported the requirement to include collaborative TB/HIV activities in both TB and HIV proposals, and PEPFAR is making TB screening a requirement of Track 1.0 funding agreements (these concern HIV funding for priority countries). Between 2005 and 2008 PEPFAR spending on TB/HIV increased from US\$ 19.2 million to US\$ 147.7 million. The funding available for TB/HIV appears to be growing and country TB and HIV programmes must access these funds to supplement domestic funding for TB/HIV scale-up. Domestic funding will also need to rise to ensure the goal of universal and sustainable access to TB/HIV services.

Meeting the needs of the most at risk

The populations most at risk of TB and HIV often have the poorest access to or uptake of TB and HIV prevention, treatment and care services. Drug users, prisoners and migrants have particular difficulties in accessing the multitude of services they need. Working adults, women and young people would also have much better uptake if services were better tailored to their needs and a multisectoral approach was used.

People who use drugs

Drug users should be treated like any other person with a medical need and the right to services. In fact, people who use drugs are receiving increasing attention as part of the regional HIV response, but as yet the capacity of drug user networks and services to address TB is limited. Broad dissemination and implementation of the joint WHO/UNODC/UNAIDS guidelines for addressing TB/HIV in injecting drug users is important to fill this gap. Contrary to the belief of many clinicians, drugs users' adherence to TB treatment, IPT and ART is equivalent to that of non-drug users. Perhaps this is because "nobody knows better how to take drugs than a drug user".



Joint planning for drug users needs coordination

A comprehensive policy response for TB/HIV in drug users based on a human rights approach is needed. It is important to de-stigmatize and decriminalize the behaviours associated with increased risk (whether drug use, sex work or the behaviour of men who have sex with men). Failure to respond to the health needs of injecting drug users (IDU) and other risk groups will have a much increased public health impact.

A public-NGO partnership for TB screening and DOTS treatment from India has been forged between the Revised National Tuberculosis Control Programme (RNTCP) and the Avahan HIV prevention programme for high-risk groups, including sex workers.

Avahan is a large NGO working with 290 000 people from high-risk groups in six high HIV prevalence states together with Family Health International. Peer educators and outreach workers, as well as sexually transmitted infection clinic staff, have been trained by the partnership in TB symptom screening, and they referred TB suspects for smear microscopy and further examination.

RNTCP provided technical support, accepted referrals for TB diagnosis and treatment as well as monitoring of partner activities, while Avahan provided staff and training, supported reporting and initiated referrals of TB suspects. Within a year, just over 10 000 TB suspects were identified, of whom 1500 were diagnosed with TB. Of these, 75% started TB treatment.

This partnership is serving as a model of further roll-out of TB/HIV collaboration between the RNTCP and NGOs in India.

Women and families

The UN Secretary-General's Special Envoy for HIV/AIDS in Asia-Pacific, Dr. Nafis Sadik, discussed the special needs of women and families in relation to TB/HIV. Women's vulnerability to TB and HIV is complex and varies by setting. Social, economic and cultural factors can exacerbate this vulnerability and create barriers to women accessing TB/HIV services. Delayed diagnosis and access to treatment can greatly increase the TB/HIV impact on women and their families.

Stigma can be particularly harmful for women. There are fears that HIV or TB will prevent them from marrying, or will lead to rejection by their husbands as well as social exclusion for themselves and their children. Gender issues are seldom discussed in the context of TB control and few programmes know if treatment outcomes are equal between men and women.

While integrating the delivery of TB and HIV services, health planners also need to make sure these services meet the specific needs of women, according to the Special Envoy. The benefits of integrating TB and HIV services with sexual and reproductive health care services need to be explored. Can home-based family counselling and testing for TB and HIV extend reach and increase uptake?

The Special Envoy called for determined leadership in favour of women's health, education and empowerment to enable women to emerge from poverty, to stay healthy, to raise their families and to guarantee the continued social and economic development of the region.

Developing a multisectoral response to TB/HIV

Important additions to the public sector response to TB and HIV are partnerships with other players to broaden engagement to as many

service providers and stakeholders as possible. Examples of local partnerships with the private sector, labour unions, private practitioners, academic institutes, civil society (including faith-based organizations) and NGOs, the police, defence forces and tourism bodies were presented at the meeting as models for effective partnerships.

In all cases, participants regarded the development of multisectoral coordinating bodies as an important factor in success. Partnerships serve various purposes: in some countries faith-based organizations are important for health services delivery, in other settings NGOs have been used to fill specific technical gaps. For example, Médecins Sans Frontières has provided technical assistance with multidrug-resistant TB treatment in Myanmar. Novel partnerships can be used to increase coverage and reach—for example using the police, frequently in contact with many marginalized and at-risk populations—to support health interventions.

Engagement of networks for people living with HIV has been successful even in countries where civil society engagement is generally discouraged. Participants identified constraints as lack of capacity of national programmes to establish and maintain partnerships; limited partner capacity in terms of knowledge, ability to act and funding; restrictions on civil society activism and engagement; and competition with government health programmes for human and financial resources.

Workplace programmes

The Thailand Business Coalition on AIDS has developed partnerships among hospitals, NGOs and companies for prevention and treatment of TB and HIV in the workplace. The partnership developed a National Code of Practice on TB and HIV at the

ministerial level—the ASO-TB standard certification. It also engaged in media campaigns and trained workers on TB and HIV. Company TB focal points were established and trained to support staff and liaise with local hospitals in providing HIV testing, as well as TB and HIV treatment for employees.

This national initiative is giving to 2 million workers knowledge and understanding about TB and HIV, involves 10 000 companies, and aims to have 7000 companies accredited with ASO-TB certification. It has a target of 80% of infectious TB cases at the workplace treated and cured.



Success with partnership

Health sector partnerships usually require joint training and the agreement of a minimum package of care, plus codes of practice and incentives appropriate to the partners. These elements include performance indicators, awards and public recognition. Among the facilitating factors are transparency (to build trust and manage the dynamics between partners); training; developing mutual respect; and reviews of any regulations that hamper partnerships.

Community involvement to stop TB/HIV

According to one speaker at the meeting, the empowerment of communities in their response to TB and TB/HIV is crucial, particularly as many community groups still show little involvement. Too many TB and HIV stakeholders continue to view community involvement as an add-on (normally last minute and with no budget allocation) to the decision-making process rather than as a key element in the national response. Although the number of nongovernmental and community-based organizations involved in TB/HIV activities has steadily risen in the past few years, significant constraints remain. In short, community groups need to take urgent action in Asia-Pacific.

Participants recognized that activism by key players in the fight against HIV—communities, NGOs, people living with HIV and TB patients—is not visible in the TB community. They saw that community HIV activists in Asia-Pacific are an untapped resource and important allies in TB/HIV.

Only a few TB community activists monitor national implementation of collaborative TB/HIV activities. However, it is important to look at the lessons learnt from HIV activists' efforts in applying what can effectively nurture a similar movement for TB. HIV activists have a seminal role to play in addressing the crisis of TB and TB/HIV, and so it is vital to increase their knowledge of TB science and policy literacy.

A rights-based approach for TB: Still a dream

HIV activism succeeded, the meeting was informed, because well-organized affected and at-risk communities recognized and demanded their right to comprehensive HIV prevention,

treatment, care and support, regardless of the country they lived in. TB survivors have not yet demanded this right.

People living with HIV have yet to fully recognize the threat that TB poses to their health and rarely demand the TB services that they need. They need to know the following: that they should ask for IPT to prevent latent TB from progressing to active TB; facts about the proper investigation of smear-negative TB; and that TB is preventable and curable. They also need to demand protection from TB infection when they attend health facilities, which requires infection control measures to be in place.

Some participants felt that activists need to call for the adoption and implementation of the three I's; engage with policy bodies (such as national TB/HIV coordinating committees and Global Fund country coordinating mechanisms to mobilize resources); and understand the current situation in TB and TB/HIV research (to ensure that community priorities are addressed and data are translated into policy and services on the ground).

The principle of greater involvement of people living with HIV should also be used for TB/HIV. Such people must be involved not only in advocacy and implementation but also in the design and the monitoring and evaluation of TB/HIV activities.

Treatment literacy for TB and HIV

The meeting heard that informed community members can take an active role in improving the response to TB/HIV. Activists who are literate in the scientific (and policy and programme) aspects of TB and TB/HIV coinfection are better able to advocate for universal access to effective TB diagnosis, care and treatment for people living with HIV. Increasing people's knowledge and understanding of TB/HIV will ensure that people

know when they should be tested, or how infection control should be addressed in health-care facilities. Community involvement in TB is much more than being DOTS observers.

When empowered with information on TB/HIV, communities can assume—and indeed have assumed—a more active role in the response to this co-epidemic. As governments around the world continue to make bold commitments to scaling up the 12 collaborative TB/HIV activities,² recommended by WHO, particularly the three I's, they must also make meaningful commitments to working with communities—not merely as beneficiaries but as planners, implementers, monitors and advocates.

Still the clash of two cultures

Discussions also raised issues of the cultural clash between HIV and TB responses. Historically, TB has used a medical approach to control TB that did not offer a major role for the community. One meeting participant noted that TB stakeholders are now moving towards working more effectively with civil society, community groups and people living with HIV.

Limited community capacity

One of the key problems of community involvement is an underlying lack of patient empowerment primarily due to lack of their capacity to respond. Still-limited resources are donor driven and most do not percolate to community groups. If the potential for people living with HIV to respond to TB/HIV is to be realized, they need to be supported to do so.

Capacity is also needed at programme level as there are TB managers who want to engage further with civil society and would like to include advocacy activities in programmes, but are not sure of the best approach. Capacity building for this group is essential,

and international and national technical assistance providers need to fill this gap.

Effective monitoring and evaluation frameworks from donors for community-based capacity building for advocacy are key components in helping TB and HIV programmes to include advocacy and social mobilization budget lines in their proposals. Also needed are clear standardized monitoring and evaluation frameworks for advocacy communication and social mobilization activities and for quantifying the impact of performance-based funding mechanisms.

Where to now?

Programmes and partners need to leverage extensive HIV community involvement for TB, expand general community involvement for TB and use this to support TB/HIV activities. National TB and HIV programmes and partners must promote patient empowerment, encourage TB/HIV treatment literacy among communities, and include TB in the activities of nongovernmental and community-based organizations for the most-affected populations. Documentation and dissemination of best practices are also required so that these practices can be used in nationwide scale-up.

Technical partners should support the capacity of national programmes for TB and AIDS by developing national experts to support planning and partnerships, to advocate with donors to support community involvement, and to develop monitoring and evaluation frameworks for community involvement.

Organizations of people living with HIV can promote TB/HIV treatment literacy and include TB in all advocacy agendas.

² Interim policy on collaborative TB/HIV activities
http://www.who.int/tb/publications/tbhiv_interim_policy/en/index.html

Recommendations for scale-up of TB/HIV activities in Asia-Pacific

KEY RECOMMENDATIONS

HIV testing and treatment scale-up for TB patients

- ▶ All countries need to scale up the availability of HIV testing to all TB patients.
- ▶ Programmes should promote early and maximum uptake of CPT and ART for HIV-positive TB patients to reduce the mortality rate among HIV-positive TB patients.

The three I's

- ▶ Develop a coherent communication strategy on the three I's, especially in support of intensified case-finding (TB diagnostic algorithm) and IPT (addressing decision-makers, professional bodies, experts and beneficiaries). In particular this should counter the common concerns raised about implementing IPT for people living with HIV.
- ▶ Encourage clinicians to screen all people living with HIV regularly for TB and either start TB treatment if appropriate or, once active TB has been reasonably excluded, provide IPT.
- ▶ Scale up IPT urgently. Pilot studies should not delay the opportunity for all people living with HIV to benefit from this effective TB prevention intervention. Cost–benefit analysis needs to be part of implementation.

- ▶ Develop and implement integrated infection control guidelines at all levels to ensure that health-care facilities and other enclosed settings are safe from TB transmission through the implementation of effective TB infection control measures.
- ▶ Advocate for partnership development and resource mobilization for infection control.
- ▶ Coordinate technical assistance to countries to implement the three I's as part of nationwide scale-up of collaborative TB/HIV activities.
- ▶ Advocate for, and build the capacity of, communities, patients and health-care workers to create safer, TB-free, living and working environments.

TB diagnostics

- ▶ Improve the speed and quality of TB diagnostics with TB laboratory strengthening, including rapid TB culture, the development of a point-of-care test and strong advocacy for increased investment in TB/HIV research.

Programming

- ▶ Improve structural mechanisms to maximize collaboration between national HIV and TB programmes.
- ▶ Further decentralize HIV testing and counselling, as well as HIV care and treatment services, to facilitate access to integrated TB/HIV prevention, treatment and care.

Monitoring and evaluation

- ▶ Improve recording and reporting of collaborative activities and TB/HIV cohort data analysis urgently. In particular, improve reporting of TB screening, TB treatment and IPT provision in HIV care and treatment registers through incorporating the indicators in routine HIV recording and reporting systems
- ▶ Cross-check TB cases in ART registers against people living with HIV in TB registers. Update registers to minimize underreporting and facilitate TB/HIV treatment outcome analysis, which is essential to monitor and manage programme performance and quality.
- ▶ HIV-positive TB patients should be registered in both TB and HIV registers from the time of diagnosis. This requires HIV care registration at the time of diagnosis and may involve decentralization of HIV care registration.
- ▶ Monitor implementation of infection control practices.

Funding

- ▶ Country TB and HIV programmes should increase national and external funding sources to ensure adequate scale-up of TB/HIV activities.
- ▶ Ensure that countries are aware of the requirements of the Global Fund and PEPFAR regarding the inclusion of TB/HIV collaborative activities in all TB and HIV proposals.

Multisectoral response to TB/HIV

- ▶ Disseminate and implement the joint WHO/UNODC/UNAIDS guidelines for addressing TB/HIV in injecting drug users to improve the capacity of drug user networks and services to address TB as part of the harm reduction response.
- ▶ De-stigmatize and decriminalize the behaviours associated with increased risk of HIV and TB, whether drug use, sex work or the behaviour of men who have sex with men.
- ▶ Explore the benefits of integrating TB and HIV services with sexual and reproductive health care services, including Prevention of Mother to Child Transmission (PMTCT) services. Explore the benefits of home-based family counselling and testing for TB and HIV for extending reach and increased services uptake.

- ▶ Community groups should take urgent action to increase their capacity to address HIV-related TB, through greater TB science and policy literacy among HIV activists with the support of all Stop TB partners.

- ▶ Activists should advocate strongly for the adoption and implementation of the three I's; engage with policy bodies (such as national TB/HIV coordinating committees and Global Fund country coordinating mechanisms to mobilize resources); and understand the current situation in TB and TB/HIV research (to ensure that community priorities are addressed and data are translated into policy and services on the ground). All this requires the closer involvement of people living with HIV.

- ▶ Governments need to make meaningful commitments to working with communities—not merely as beneficiaries but as planners, implementers, monitors and advocates for programmes.

- ▶ Document and disseminate best practices in community engagement in TB/HIV so that these practices can be used in nationwide scale-up.

- ▶ Develop clear standardized monitoring and evaluation frameworks to monitor advocacy communication and social mobilization activities and to quantify impact for performance-based funding mechanisms.

Follow-up

- ▶ Regional stakeholders such as WHO and UNAIDS should regularly monitor progress against these recommendations.
- ▶ A follow-up meeting should be organized in 2011.

Overall coordination lead:

Christian Gunneberg.

Meeting coordination team

Antonio Carlos Gerbase; Teodora Wi; Peter Johannes Van Maaren; Gaik Gui Ong; Meda Manuel; Reuben Granich; Laksami Suebsaeng; Nani Nair; Haileyesus Getahun; Colleen Adele Daniels; Massimo Ghidinelli; Meda Manuel; Firdosi Rustom Metha; Subhash K. Hira; Sara Whitehead; Jacques Jeugmans; Iyanthi Abeyewickremei; Bob Verbruggen; Chandrakant Revankar; Alasdair Reid; Fabio Mesquita; Rosalie Edma; Patricia R. Lang; Nenita Gochuico; Manjit Singh Trehan.

Report writing team

Colleen Daniels, Christian Gunneberg and Alasdair Reid with comments from the meeting coordination team.

Chairs and rapporteurs

E. Cooreman; C. Daniels; A.S.K.B. de Alwis; P.K. Dewan; M.T. Eang; Z. Fujie; M. Ghidinelli; C. Gunneberg; Y. Kasetjaroen; W. Maung; C.V. Mean; F. Mesquita; F. Ndenzako; K. Osuga; A. Reid; L. Suebsaeng; A. Surya; J. Syed; S. Thanpresertsuk; J. Tonsing; R.G. Vianzon; S. Whitehead; T.E. Wi; R.P.H. Yadav.

Meeting participants

R.J. Abrenica; T.Y. Aditama; N. Afriana; P. Aia; G. Ali; A. Anartati; P. Anuzaya; R. Avoi; A. Baroka; J.G. Belimac; A. Bergenstrom; M. Bloem; P. Bollen; D. Bolorchimeg; S. Bounmala; S. Chander; S. Cheng; P. Clevenbergh; E. Cooreman; C. Daniels; J. Danyuttapolchai; E. Daoni; A. Das; A.S.K.B. de Alwis; P.K. Dewan; H.T. Dien; K. Dorji; K.K. Eam; M.T. Eang; N. Edirisinghe; N. Fernandes; Z. Fujie; M. Fujita; A.M.C.G. Garfin; J.A. Ghani; M. Ghidinelli; C. Gunneberg; D. Gupta; C. Gusmao; L. Haitao; A.H. Hasan; Mr Henminlun; S. Hira; N. Islam; A. Isler; P. Kaima; M. Kal; Y. Kasetjaroen; A. Khera; A. Kimbro; J. Koroivueta; V. Kumaraswami; J. Lodomirski; N.C. Lang; M. Lay; L. Liang; X. Lin; D.T.T. Linh; E. Liu; E. Lukitosari; R.M. Mainabaubau; S.B. Mainawalala; B.N. Mandal; W.W. Mar; W. Maung; C.V. Mean; N. Medland; S. Mehta; L. Menghaney; F. Mesquita; A. Mirzoyan; D. Munkjargal; S. Murray; F. Nadhiya; S. Nadia; N. Nair; H. Nakatani; S. Nateniyom; F. Ndenzako; S.B. Ngadiman; J. Ngamvithayapong-Yanai; K. Osuga; R. Oula; M. Pardesi; B. Phichit; C. Phimpachanh; R. Phuntsho; A. Pramualratana; R. Rahman; S. Rahman; F. Raikanikoda; B. Raluek; A. Reid; C. Revankar; C. Rinzin; X. Ruigang; N. Sadik; S.R. Salunke; K.O. San; S. Sarkar; T.V. Son; P. Southalack; S. Sovannarith; B. Struminger; L. Suebsaeng; J. Sugiharto; A. Surya; J. Syed; P. Sylavanh; J.A. Taluker; L.H. Thai; S. Thanpresertsuk; J. Tonsing; M.S. Trehan; A. Tseesed; C. Utaipiboon; L. Vanthy; R.G. Vianzon; U. Vibol; M.A.D.A. Vitoria; J. Voskens; X. Wang; S. Warusavithana; S. Whitehead; T.E. Wi; D. Wutti; K. Xayabounthavong; R.P.H. Yadav; H. Young-Leslie; S.K.K. Zaw; J. Zhenquan.

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For more copies please send requests to: tbdocs@who.int