

Global TB/HIV Working Group
Report of the 6th TB/HIV Core Group Meeting
Geneva, 21-22 June, 2004
Host: World Health Organization, HQ – Stop TB Department, THD

The meeting was started with introductions of new members of the Core Group (CG). The new members were Dr L. Chauhan (MoH/ India), Dr R. Dlodlo (IUATLD / Zimbabwe) and Dr R. Mpazanje (MoH/Malawi). Progress on main recommendations from the previous CG meeting were reported and discussed. Presentations on strategic and other key issues of importance were made by some WHO staff and CG members and discussed. The main conclusions and recommendations of the meeting were:

1. Assessment of progress and the future: The CG noted that significant progress has been made in coordinating the effective response to the TB/HIV epidemic. The main ones include:

- Executive Board (EB) Resolution calling for collaboration between HIV and TB control programmes to implement collaborative TB/HIV activities including delivery of antiretroviral treatment (ART) for HIV infected TB patients;
- Joint UNAIDS/WHO policy on HIV testing recommended systematically offering HIV testing to all TB patients as part of their routine management and;
- STAG-TB recommended that NTPs ensure ART access to HIV infected TB patients.

However, a lot has yet to be done. Therefore, the CG recommends efforts should be intensified to boost the engagement of the HIV community and accelerate country level implementation of activities. It also advised Working Group members to brief country delegations for WHA 2005 of the importance of joint TB/HIV activities and in particular the need for NTP programmes to take responsibility to ensure HIV infected TB patients receive ARV. The normative work of the Secretariat (developing policy and guidelines, technical support, partnership building and advocacy) should continue with particular focus on best ways that address the human resource problems.

2. HIV testing and counselling for TB patients: The recent Joint UNAIDS/WHO policy statement on HIV testing has responded to the earlier request of the CG. The CG recognises that ensuring nationwide access of quality HIV testing for TB patients in high HIV settings will be difficult. Addressing the associated stigma may also be a challenge. In this regard, the CG shared the concern reflected by Dr Chauhan that this associated stigma may hamper the scale-up of HIV testing for TB patients particularly within the context of India. It was also noted that the need to scale up HIV testing from <1% to 100% entails risk of decreasing quality of services. Moreover, it recognises the importance of short and simple Standard Operating Procedures (SOPs) to provide HIV testing for TB patients. The CG has also emphasized the importance of "co-localisation" of both TB and HIV testing and counselling services at the same place to reduce losses due to transport and referral linkages. The CG recommend the documentation of existing experiences (e.g. of CDC and FHI as in Cote d'Ivoire and Rwanda). It also advises to design innovative approaches to address the human resource implications (e.g. involving PLWHA as counsellors). Research is urgently needed to address the operational aspects for nationwide scale up of HIV testing and the corresponding stigma issues and possible negative impact on the performance of NTPs. The CG noted quality of disclosure of HIV status as a key factor in the process and advised for simple training that particularly addresses disclosure of HIV status.

3. Antiretroviral treatment for HIV infected TB patients: In the wake of the EB resolution and STAG's recommendations, efforts should be intensified to ensure the delivery of antiretroviral drugs for HIV infected TB patients. As ART is a component of the TB/HIV care package that also includes, amongst others, isoniazid and cotrimoxazole preventive therapies, it does not need a separate new brand name. The CG recommends that operational researches should be urgently done to identify optimal clinical pathways and different ART delivery models. The CG also advised on the need to increase the visibility of TB/HIV within "3by5" through advocacy. It has appreciated the kind offer of Dr C. Gilks to include TB/HIV component in the planned induction course of the "3by5" Country Managers. The Secretariat was advised to follow-up on this.

4. Country support: The CG noted that collaborative TB/HIV activities are expanding in many parts of the world and advised the Secretariat to do global mapping and documentation of the activities. It also recognised that success stories and best practices in implementing collaborative TB/HIV activities should be demonstrated both in low/middle and high HIV settings. Therefore, it recommends the technical support should be intensified to all categories of countries.

5. Advocacy and community mobilization: The CG recognises that advocacy for TB/HIV at global, national and local levels is essential for accelerating implementation of TB/HIV activities. It suggested that the TB/HIV advocacy should function within the TB and HIV/AIDS domains to garner support from both communities. It further advised the advocacy should be country focused so as to best understand the appropriate mechanisms to boost it. The CG recommends support groups and people living with HIV should be involved and patient activism enhanced. The cost requirements for collaborative TB/HIV activities need to be finalised at the earliest time and used to set advocacy messages. The CG requested that the work plan of the newly formed *Advocacy and Communication Working Group* of the Stop TB Partnership to be presented in the next core group meeting.

6. Other issues:

6.1. Selection of vice-chair: The importance of having a vice-chair (VC) for the core group was agreed and the chair was requested to work with the Secretariat on the selection procedure. The CG suggested that the VC should be more from the HIV side. Core Group members should provide suggestions on the selection procedure and nominees for the post.

6.2. TB Infection Control: The CG noted that TB infection control in high HIV settings is important as more immuno-compromised patients are attending health care settings. Health care workers and other staff need to be protected. It recommends that a sub-group (to be led by B. Miller) should be established to guide on what should be done. The Secretariat was advised to coordinate the revision of the TB Infection Control Guidelines to include TB/HIV components through liaising with TBS, CDC and other stakeholders.

6.3. Isoniazid preventive therapy: Clarification is needed on IPT guidelines. The secretariat was advised to assemble a small panel of members to address these issues and make recommendations, using the latest evidence on the utility of chest X-rays in excluding active tuberculosis.

6.4. Research agenda: The secretariat is encouraged to go ahead with the proposed TB/HIV research prioritization meeting. Core Group and the Secretariat should solicit for resources to support the TB/HIV research priorities that are identified. As a matter of priority, a proposal to study drug interactions between Rifampicin and antiretroviral drugs needs to be prepared (Responsible: M. Vitoria).

6.5. Training: It was advised the training strategy should be in line with existing training strategies in TB and HIV/AIDS. The CG emphasised adding TB/HIV components to existing TB and HIV courses.

6.6. Agenda for 4th Working Group Meeting: The core group endorsed the dates and meeting place (September 20-21, 2004; Addis Ababa, Ethiopia) for the upcoming Working Group meeting. The Core Group supported the proposition by the Secretariat to sponsor country participants based on their ability to share experiences or opinions through poster presentations. The CG discussed the draft agenda and provided useful comments including the inclusion of more HIV speakers (including people living with HIV) and coverage of contentious issues.

6.7. Next Core Group Meeting: The core group will have a maximum of 2 hours side meeting on September 19, 2004 in conjunction with the 4th Working Group Meeting in Addis Ababa. The next core group meeting should be in the first quarter of 2005. The CG recommends the secretariat to decide venue and dates.