

nities raise many challenges in achieving an effective and productive partnership. Experience from a TB/HIV project in Khayelitsha, South Africa, demonstrated some of these differences. TB services are geared towards chronic-care services with simple and standardized technical procedures, while HIV/AIDS services are clinically oriented and tend to be more individual-patient-oriented. Likewise, experience from Thailand highlighted the differences between the well staffed but poorly funded TB programme and the younger, more dynamic and well-funded HIV programme. Although collaboration exists on paper, the differences between the programmes are one of the main barriers to HIV-infected TB patients accessing ART.

The WG concluded that the differences between TB and HIV programmes need to be addressed at all levels, building on strengths and eliminating weaknesses, in order to ensure effective collaboration between the programmes and joint delivery of comprehensive services to coinfecting patients. Where possible, providing this care in a “one-stop shop” should be the aim of the collaboration between TB and HIV programmes. Integration of the programmes is not necessary for this purpose.

## Why is more money still not buying us better health?

In recent years, there has been an unprecedented increase in the resources available to tackle TB and HIV through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the US President’s Emer-

gency Plan for AIDS Relief, the World Bank and other sources. However, with money itself being less of an obstacle, other bottlenecks hamper effective implementation at country level. The recruitment freeze and ceiling placed on salaries in the public services, as recommended by donor and international financial agencies, makes it difficult to attract and retain competent health professionals in the public sector. This limits health service capacity to absorb new funds and translate them into health improvement in the population.

The WG identified the following donor and country (government) factors as key barriers for the money supply (see box).

International funding initiatives, such as the GFATM, should be considered only as an emergency interim response to the escalating global TB/HIV crisis. Longer-term, more sustainable funding strategies should be developed, including longer commitment by donors, but it is essential that governments find ways to allocate adequate funding for health in the future. Conditional debt cancellation for health, education and social security, and international trade balance should assist long-term commitments by governments.

The GFATM is likely to remove the TB/HIV category as a separate entity for future proposals. Instead, countries will be expected to explicitly address TB within all HIV proposals, and vice versa. The WG expressed concern that this may give the message to countries that TB/HIV activities are no longer a priority. It was recommended that the GFATM makes very clear on its website and in all guidance for the 5th round proposals that all TB proposals should contain activities to address HIV, and vice versa.



### Donor factors

- Imposition of detailed, lengthy processes and conditions hampers smooth and timely disbursement and utilization of resources.
- Lack of harmonization with national policies and systems and bypassing well established in-country coordination mechanisms undermine the stewardship and leadership roles of national bodies.
- Tendency for very selective funding without due focus on strengthening the health system and improving the health workforce crises.

### Country factors

- Lengthy bureaucratic procedures and restrictive financial management mechanisms.
- Limited financial management capacity at all levels, particularly at district level.
- Concerns about sustainability and exit strategies in the context of lifelong treatments and time-bound funding.

## Two diseases – one patient

Treatment for both HIV and TB provides a lifeline to millions of coinfecting people worldwide. Lucy Chesire, a Kenyan activist who has lived with HIV/AIDS for almost 10 years, shared her traumatic personal experience with TB and pleaded with the participants to accelerate patient-centred action in order to reduce the suffering and deaths of HIV-infected TB patients. TB and HIV programmes need to look beyond their rigid boundaries and take on expanded roles in order to deliver better prevention, treatment and support services for their clients.

The DOTS strategy alone is not sufficient to control TB in high HIV prevalence settings where, for example, smear-negative and extrapulmonary TB are much more common. The WHO *Expanded DOTS framework for effective TB control* lays out additional elements that are needed under different circumstances to bring about TB control, including collaborative TB/HIV activities, addressing drug-resistant TB and expanded involvement of the private sector. This framework has been insufficiently communicated and implemented by policy-makers and health workers. The flexibility and inclusiveness of the DOTS strategy to provide patient-centred care should be better communicated. Beyond this, the existing guidelines on

*“Of all the years I lived with HIV, the worst time of agony, suffering, hopelessness and social ostracism has been when I was diagnosed with TB. The climax of all this was when I had to take about 20 antiretroviral (ARV) and TB drugs a day on an empty stomach. Today, thanks to my diagnosis of TB ... I am on ART and alive. Although TB has induced an insurmountable suffering on me, it is ironic that I am indebted to it, because it has created the door for my ARVs”.*

**Lucy Chesire, a Kenyan activist who has been living with HIV/AIDS since 1994, speaking at the opening of the meeting.**

the diagnosis and management of smear-negative and extrapulmonary cases of TB should be reviewed. New ways of accelerating accurate diagnosis and treatment are urgently needed in the HIV era.

Data presented from Cambodia showed that previously undiagnosed TB was detected in 15–25% of people living with HIV/AIDS (PLWHA) who were screened for TB. HIV programmes must prioritize intensified TB case-finding for PLWHA and treat latent TB infection in those who have no evidence of active TB disease.

## TB – the technological vacuum

The diagnosis of TB depends largely on a smear microscopy test that is more than 100 years old, yet within 20 years of its discovery a simple test can accurately diagnose HIV in minutes from a single drop of blood. The long duration and high pill-count of current TB drug regimens coupled with the spectre of in-

creasing drug resistance to existing drugs requires urgent development of new drugs, in addition to new, rapid and more reliable diagnostics for TB.

Very strong advocacy at the highest levels is required to stimulate emergency responses from governments and the international community to encourage the development of new drugs and diagnostics for TB that can be used in field settings. In the meantime, we must ensure the maximal use of existing tools by improving laboratory capacity and standards of diagnostic protocols and drug regimens.

## “3 by 5” by DOTS?

The “3 by 5” initiative, which plans to put three million PLWHA on ART by the end of 2005, is an ideal opportunity to stimulate improved access to ART for HIV-infected TB patients, thus reducing morbidity and mortality. However, HIV programmes face a major challenge in transforming HIV/AIDS from a killer into a chronic disease through public provision of ART to all those in need. Such a transformation will require a strengthened HIV programme supported by strong political commitment that is able to detect a high proportion of PLWHA eligible for therapy, guarantee reliable diagnosis and drug supplies, ensure adherence to standardized treatment regimens, and be able to accurately monitor, record and report response to treatment on an individual and national basis. Clearly, the DOTS strategy can provide many lessons for ART and the “3 by 5” initiative, and TB control programmes can provide valuable assistance to HIV/AIDS programmes in setting up and manag-

