

tive staff throughout the health sectors of most countries affected by the dual TB/HIV epidemic needs urgent intervention. Salaries and incentives need particular attention. Key stakeholders – for example, the WHO Evidence and Information for Policy (EIP) cluster and the Rockefeller Foundation – are already working to address the issue of human resource capacity constraints, and the WG must collaborate with them to contribute and implement their recommendations for TB/HIV. Solutions should include ensuring that existing staff members are competent to carry out their tasks, and must address clinical, counselling and laboratory staff needs that need to be developed, as well as the advantages of expanding the traditional workforce to include community health workers, lay counsellors and PLWHA. These efforts should be linked with strong advocacy activities at all levels. Communities need to be involved to establish what they can contribute in terms of human resources to support scale-up. Ministries of health need to ensure that acceptable services are in place to prevent transmission of HIV and TB to health-care workers. Health-care workers should be encouraged to consider their own HIV status.

## Costing TB/HIV activities: who is going to foot the bill?

WHO has estimated the cost for implementing collaborative TB/HIV activities in the 34 priority countries of the “3 by 5” initiative at US\$ 250 million per year. Governments and funding agencies need to be lobbied to identify the necessary funds.

## Act up and involve the community

The meeting benefited from much greater involvement of HIV activist and community groups, but even more effort is needed to truly engage communities in the fight against TB and HIV. Zackie Achmat, who heads Treatment Action Campaign in South Africa, spoke about the role of advocacy and activism for effective TB/HIV response. He acknowledged that much information is already available for patients and community groups to act on and help ameliorate the TB/HIV epidemic, but TB communities still do not know enough about HIV, and vice versa. Informed community groups and patient populations are critical to effective implementation of collaborative TB/HIV activities.

Governments must be held accountable to their TB and HIV/AIDS commitments made at the Millennium Summit, the UNGASS, the Abuja Summit and the World Health

Assembly, and in the Amsterdam Declaration. Access to TB and HIV prevention, diagnosis and treatment services must be seen as an essential human right. Governments should be pressured to take responsibility for delivering the best TB and HIV/AIDS services available under existing circumstances. Joint delivery of TB and HIV prevention and treatment services including ART must become the standard of care and be centred on the patient.

The involvement of activists and community groups should particularly be sought to accelerate the implementation of collaborative TB/HIV activities in countries with high TB and HIV. This country-level activity should embrace building the pressure on country programmes to enhance their accountability with regard to addressing the TB/HIV epidemic.

## PLWHA activists in the TB/HIV front in Uganda

The National Forum of PLWHA Networks in Uganda shared their experiences of an emerging TB/HIV advocacy movement from Uganda. They recognize that TB is not yet on the advocacy agenda of PLWHA and HIV is not yet fully on the agenda of the TB community, and they aim to address these gaps. Uganda has yet to develop a national policy or plan to support the implementation of collaborative TB/HIV activities and they are fighting for this. They have made a presentation to the national HIV/AIDS Partnership to educate them on the need for TB/HIV collaboration and to seek its technical, financial and moral support for collaborative activities. This PLWHA-led activity is also geared towards influencing pe-



*“Our work should be measured by how many people we put on antiretroviral therapy through our TB programmes and by how many people we put on TB drugs and IPT through our HIV/AIDS programmes in each country”.*

**Zackie Achmat, Treatment Action Campaign of South Africa**

ripheral service providers and organizations (e.g. NGOs) to deliver joint TB and HIV services.

## **African Union calls for scaling-up TB/HIV activities**

The WG meeting was an excellent opportunity for high-level advocacy to garner political support for collaborative TB/HIV activities both locally and internationally. Dr Jack Chow, Assistant Director-General of WHO, and Dr Julie Gerberding, Director of CDC, met with H. E. Meles Zenawi, Prime Minister of Ethiopia, to highlight the importance of TB/HIV in Ethiopia. With the appointment of a national TB/HIV coordinator, the availability of a substantial amount of resources and the initiation of activities in seven pilot sites, Ethiopia is ready to take on its scale-up of activities. These high-level dignitaries also spoke with a delegation from the African Union. The Union has recognized that HIV-related TB is a serious problem facing the continent and called for all Member States to embrace and scale up implementation of collaborative TB/HIV activities. Press conferences were conducted in Addis Ababa and Nairobi during the meeting, with wide international and national media coverage.

## **Experience from the field**

Beyond the plenary presentations, country-level experiences in implementing collaborative TB/HIV activities were shared in an interactive forum with poster displays and moderated discussions. Presentations were made by Cambodia, the Democratic Republic of the Congo, Ethiopia, India, Kenya, Malawi, Mozambique, Nigeria, the Russian Federation, South Africa, Sudan, Thailand, the United Republic of Tanzania, Uganda, Ukraine and Zambia. They included activities run by ministries of health, partner organizations and technical agencies, NGOs and community-based organizations. Country-level implementation is accelerating but still falls short of national coverage of all the collaborative TB/HIV activities defined in the interim policy. There are no longer valid excuses for countries with a high burden of HIV-related TB not to plan to implement collaborative TB/HIV activities, particularly with clear policy recommendations and greatly increased opportunities for scaling-up through the international funding opportunities.

## **TB/HIV data are scarce in Europe**

Eastern European nations are experiencing particularly high levels of TB and MDR-TB, and a fast-rising HIV epidemic. Such a combination is potentially disastrous for both TB control and HIV care, but there is a scarcity of data that systematically document the impact of HIV on TB in the region. TB and HIV surveillance systems and the health information system must be strengthened to inform appropriate policy and programme interventions.

## **Need to explore the link between HIV and MDR-TB**

The worrying situation in eastern Europe offers the spectre of an HIV-fuelled epidemic of MDR-TB, which is also possible in other settings such as South Africa, where it could occur in a more localized way. Clearer definition of the extent of this lethal combination is urgently needed.

## **Nutritional support is important for TB/HIV care**

In Cambodia, the World Food Programme provides nutritional support for TB patients. This has contributed to the improvement of TB care. Nutritional support was emphasized as a component of TB/HIV care that could improve the adherence and livelihood of HIV-infected TB patients.

## **Lack of national TB/HIV policies impedes activities**

Weak or non-existent national policies and operational guidelines to support programme implementation in many countries impede the accelerated implementation of collaborative TB/HIV activities, particularly by NGOs and community-based organizations. Countries are urged to develop the necessary delivery, support and monitoring systems that will ensure quality delivery of services by all service providers.

## **Community involvement in TB/HIV care is crucial**

Strengthening the role of community involvement in TB/HIV care was considered as a stepping stone to a sustainable TB/HIV care-delivery system. The role of family members, relatives, caregivers and other community supporters, including PLWHA, to deliver TB/HIV care should be explored.

