Global and regional implementation of the *Three I's for HIV/TB* and earlier initiation of ART

Frank Lule
World Health Organization, Brazzaville
Outline

• HIV/TB interventions and burden of HIV/TB

• Global and Regional Progress

• Enablers

• Tools for scale up

• Summary
WHO 2004 Interim Policy on Collaborative TB/HIV Activities

A. Establish NTP-NACP collaborative mechanisms
   - Set up coordinating bodies for effective TB/HIV activities at all levels
   - Conduct surveillance of HIV prevalence among TB cases
   - Carry out joint TB/HIV planning
   - Monitor and evaluate collaborative TB/HIV activities

B. Decrease burden of TB among PLHIV (the "Three I's")
   - Establish intensified TB case finding
   - Introduce INH preventive therapy
   - Ensure TB infection control in health care and congregate settings

C. Decrease burden of HIV among TB patients
   - Provide HIV testing and counselling
   - Introduce HIV prevention methods
   - Introduce co-trimoxazole preventive therapy
   - Ensure HIV/AIDS care and support
   - Introduce ARVs
Estimated HIV prevalence in new TB cases, 2009

0% estimated HIV+TB cases are in Africa
Implementation progress
Collaborative TB/HIV activities 2003-2009
Global

* Data as per October 2010
Collaborative TB/HIV activities 2003-2009

AFRO

<table>
<thead>
<tr>
<th>Year</th>
<th>Tested for HIV</th>
<th>HIV-positive</th>
<th>CPT</th>
<th>ART</th>
<th>Screened for TB</th>
<th>Diagnosed with TB</th>
<th>TB on ART register</th>
<th>IPT</th>
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<tr>
<td>2003</td>
<td>41,449</td>
<td>14,766</td>
<td>8,517</td>
<td>863</td>
<td>798</td>
<td>39</td>
<td>7,921</td>
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<td>2004</td>
<td>46,092</td>
<td>29,359</td>
<td>15,148</td>
<td>3,901</td>
<td>60,930</td>
<td>11,162</td>
<td>12,017</td>
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<td>2005</td>
<td>141,006</td>
<td>73,385</td>
<td>52,963</td>
<td>20,033</td>
<td>47,615</td>
<td>24,283</td>
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<td>2006</td>
<td>285,826</td>
<td>147,406</td>
<td>137,760</td>
<td>60,958</td>
<td>128,558</td>
<td>51,630</td>
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<td>2007</td>
<td>510,014</td>
<td>260,319</td>
<td>186,377</td>
<td>74,633</td>
<td>326,382</td>
<td>58,266</td>
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<td>2008</td>
<td>661,204</td>
<td>309,830</td>
<td>226,777</td>
<td>93,177</td>
<td>729,026</td>
<td>104,603</td>
<td>61,530</td>
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<td>2009</td>
<td>796,675</td>
<td>364,557</td>
<td>246,571</td>
<td>118,345</td>
<td>1,064,980</td>
<td>118,616</td>
<td>69,104</td>
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Collaborative TB/HIV activities per Region, 2009

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of TB Patients with Known HIV Status (Thousands)</th>
<th>% of Notified TB Patients Tested for HIV</th>
<th>% of Tested TB Patients HIV-Positive</th>
<th>% of Identified HIV-Positive TB Patients Started on CPT</th>
<th>% of Identified HIV-Positive TB Patients Started on ART</th>
<th>Number of HIV-Positive People Screened for TB (Thousands)</th>
<th>Number of HIV-Positive People Provided with IPT (Thousands)</th>
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<tbody>
<tr>
<td>AFR</td>
<td>788</td>
<td>53</td>
<td>46</td>
<td>76</td>
<td>36</td>
<td>1052</td>
<td>61</td>
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<tr>
<td>AMR</td>
<td>87</td>
<td>41</td>
<td>17</td>
<td>62</td>
<td>73</td>
<td>45</td>
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<tr>
<td>EMR</td>
<td>41</td>
<td>8.6</td>
<td>3.6</td>
<td>43</td>
<td>50</td>
<td>21</td>
<td>0.5</td>
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<tr>
<td>EUR</td>
<td>244</td>
<td>86</td>
<td>4.9</td>
<td>24</td>
<td>23</td>
<td>239</td>
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<td>SEAR</td>
<td>316</td>
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<td>13</td>
<td>75</td>
<td>52</td>
<td>310</td>
<td>0.5</td>
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<tr>
<td>WPR</td>
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<td>11</td>
<td>9.1</td>
<td>64</td>
<td>16</td>
<td>10</td>
<td>1.6</td>
</tr>
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<td>Global</td>
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<td>26</td>
<td>27</td>
<td>75</td>
<td>37</td>
<td>1678</td>
<td>79</td>
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</tbody>
</table>

* Data as per June 2010
ICF among people living with HIV, 2005-2009

* Numbers under years show the number of countries reporting data followed by the percentage of total estimated HIV-positive people accounted for by reporting countries.

* Data as per June 2010
PLHIV screened for TB, 2009

* Data as per October 2010
IPT provision for people living with HIV, 2005-2009

* Data as per June 2010

* Numbers under years show the number of countries reporting data followed by the percentage of total estimated HIV-positive people without active TB accounted for by reporting countries.
People living with HIV receiving IPT, 2009

* Data as per October 2010
CPT and ART for TB patients with HIV, 2003-2009

* Data as per June 2010
Challenges

• Many
• BUT;
• We have overcome them before
Enablers for nationwide scale-up

• Good collaboration between TB and HIV programmes
• National plans and targets
• Participatory development of national policy
• Revision of TB and HIV technical manuals and guidelines
• National policy on HIV testing (PICT)
• Revision of recording and reporting formats

Nationwide scale-up of TB/HIV is possible
Other critical enablers

• Intensive, continuous training and supportive supervision

• Stakeholders engagement and community mobilization

• Effective and constant supply of commodities
WHO 2010 IPT/ICF Recommendations

- Use four symptom screen to rule in for IPT
- No need for TST or chest radiography
- Simplified algorithm
- HIV program leadership
Expanding access to ART: *Treatment 2.0*
Global goals

The HIV/AIDS Department strategy reaffirms commitments international HIV and development goals and targets:

• Reduce HIV incidence
• Eliminate HIV infection in children
• Achieve universal access to HIV prevention, treatment and care
• Reduce HIV-related mortality
• Reduce TB-related mortality
• Contribute to achievement of MDGs 3, 4 and 5
Global Fund 18th Board Meeting: decision point 12 (Delhi 2008)

Decision Point GF/B18.DP12:

1. The Board acknowledges and commend the Stop TB Partnership’s Global Plan to Stop TB 2006-2015 (the “Global Plan”), which aims to halve current tuberculosis prevalence and death rates by 2015. As the largest external financier of tuberculosis programs worldwide, the Global Fund is committed to ensuring that it is a key partner in supporting the implementation of the Global Plan.

2. The Board recognizes that almost 40% of the estimated 9.2 million new tuberculosis infections per year worldwide are not detected/diagnosed, posing a major risk to an increased transmission of tuberculosis. Therefore, the Board encourages applicants to the Global Fund and implementers of tuberculosis programs to develop innovative actions to accelerate case detection and effective treatment of these cases. This will require investment to: increase the speed and precision of tuberculosis diagnosis using new tools; strengthen in-country monitoring and evaluation (M&E) and surveillance systems; increase community-based responses. The Board specifically urges use of the dual track financing and other mechanisms to expand funded, well-trained community-based services for case detection and Directly Observed Treatment Short-Course (DOTS) provision.

3. The Board recognizes that the slow progress in implementing core TB-HIV collaborative services is a risk to achieving successful outcomes under current and future Global Fund tuberculosis and HIV grants. Given the large gap in tuberculosis screening in HIV settings and vice versa, the Board emphasizes that all applicants should include and implement significant, robust tuberculosis interventions in their HIV/AIDS proposals and HIV/AIDS interventions in their tuberculosis proposals. The Board requests the Secretariat to review the guidelines for phase 2 requests to require that, in respect of continued funding for tuberculosis or HIV grants, CCMs explain their plans for scale up to universal TB-HIV collaborative services and explicitly articulate what TB-HIV activities, funding, and indicators will be included in each proposal.

4. Noting the upcoming Ministerial meeting on MDR-TB in Beijing, the Board of the Global Fund urges substantive proposals be submitted to support MDR- and XDR-TB plans and that countries make use of budget and planning flexibilities to ensure programs utilize emerging technologies. The Board recognizes that the first line in reducing the risk of MDR-and XDR-TB is through effective DOTS treatment programs with high cure rates. In addition to expanding high quality DOTS to prevent MDR-TB, a successful response will necessarily include a major scale up of drug susceptibility testing for all people suspected of having drug-resistant tuberculosis and effective treatment of these cases by expanding community-based DOTS-Plus programs. As such, the Board urges applicants to scale up laboratory capacity and community-based management of MDR- and XDR-TB cases.

5. Recognizing that, according to the Global Plan to Stop TB, there is a gap between estimated needs and available resources, the Board urges countries to undertake a comprehensive situational gap analysis and to submit ambitious proposals that are appropriate to the specific country context through future funding Rounds, or the Rolling Continuation Channel, or national strategy applications, which requests for funding are particularly aimed at achieving major and rapid expansion of case detection with high cure rates, universal coverage of TB-HIV collaborative services, as well as scaling up laboratory and care capacities to expand DOTS and to address MDR- and XDR-TB, and at
## Summary

<table>
<thead>
<tr>
<th><strong>Intervention, 2009</strong></th>
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<tbody>
<tr>
<td>% TB Patients Tested</td>
<td>53 %</td>
</tr>
<tr>
<td>% HIV+ TB on CPT</td>
<td>76%</td>
</tr>
<tr>
<td>% HIV+ TB on ART</td>
<td>37%</td>
</tr>
<tr>
<td>% ICF among PLHIV</td>
<td>5.2%</td>
</tr>
<tr>
<td>% IPT provision for PLHIV</td>
<td>&lt;0.3%</td>
</tr>
</tbody>
</table>
Thank you…

• All Stakeholders