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**XVII International AIDS Conference  
Universal Access of TB Services to PLHIV: Harnessing  
Collaboration and Coordination  
August 3, 2008**

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**MICHEL:** To here on the podium and particularly on behalf of Diane and myself as Co-Chairs of this session. Thank you very much for coming on a Sunday afternoon to discuss a very important topic to all of us. It is a pleasure for me seeing you. I feel somehow ambivalent. On the one hand I feel it is wonderful to be again, if I may say so with the scientific community. I miss you, and it is like going back home. On the other hand, I am with you everyday because HIV/TB integration is really the challenge and so much of the challenge in countries within and wherever I travel. And we cannot seriously talk about scaling up if we do not address that issue as a priority.

Before we start, let me thank the co-sponsoring organizations for this particular session. WHO, the HIV/TB Working Group, The Forum, Veronica is here, IAS, the Global Fund and UNAIDS.

We will start right away and let us keep in mind that as I was saying when we are scaling up interventions to serious levels to where we are now in the epidemic. It is absolutely essential that there is TB screening and prevention in all HIV care settings. It is essential that there is access to HIV counseling and testing, and to HIV care in all TB care settings. It is essential that there is infection control, I know Kevin you will talk about the three Is, so that people living with AIDS can attend and some of the staff in this can

attend services without fear and without risk. It is essential that we keep a very close eye on surveillance and that we actually increase our surveillance when it comes to drug resistance TB among people living with AIDS. And it is essential that we mobilize beyond the public sector, the private sector as one of the Global Fund Grants does actually when it comes to adult delivery in India. And it is essential that we mobilize civil society and communities in this priority effort of ours to integrate HIV and TB care for people living with AIDS.

So, thank you all for coming again, and let us just proceed with the session. And our first presentation is by Kevin De Cock, and it is entitled "The Three Is for HIV TB- Intensified TB Case Finding, Isoniazid Preventive Therapy and Infection Control for TB- for People Living with HIV: Why Now?" Kevin.

**KEVIN De COCK, M.D.:** Thank you very much, Michele [misspelled?], colleagues, friends. Good afternoon and thank you for coming, and thank you to the organizers for inviting me to give this presentation.

If you look at the geographical distribution of HIV associated TB cases, it really is quite remarkable that about 80 to 85-percent of them are actually in Sub-Saharan Africa. Almost half of all HIV associated TB actually in just eight countries of Southern Africa that actually account for less than 2-percent of the world population.

In response to what Ministers of Health in the SADC Region actually declared an emergency, WHO some years ago, formulated this 12-point collaborative policy for activities to deal with it. Firstly establishing collaborative mechanisms across AIDS and TB programs, secondly looking at the issue from the point of view of the HIV infected person, and thirdly from the point of view of the TB patient. And it is B, decreasing the burden of TB amongst people living with HIV that is the subject of my brief presentation.

Now, from the HIV perspective really and then from WHO's HIV work, the Declaration of Commitment towards universal access made by the leaders of the G8 in 2005 really has been the sort of conscious if you will of our work, of our technical work. But one thing I have come to realize in the past couple of years, it is essential that we include tuberculosis under this concept of universal access. That has to be a bottom line.

WHO tracks the health sectors progress towards universal access with an annual report that was released at the end of May this year, the second one, and it covers these various elements listed here. But importantly it also covers data on tuberculosis, some of it shared with the annual TB report, and I will just show a quick number of data from this.

I am hoping that this particular slide will become the slide of the conference. I remember attending the really legendary conference in Vancouver ten years ago, was in 2006,

12 years ago in 1996, 12 years ago when John Meller's [misspelled?] famous slide of Viral Load and Progression to AIDS really just dominated the various proceedings. And I am hoping that this achievement, the global achievement of three million people on therapy in low and middle-income countries by the end of 2007 will feature prominently also.

The report, our universal access report covered a number of TB/HIV elements, and they do show progress, but progress is slow. It is not fast enough. Here you have a number of issues relating to collaborative TB/HIV activities, the dark purple 2005, the lighter purple 2006, looking at 63 priority countries and we do see progress. But we are far from in all of these different areas be it establishing collaborations across the two programs, testing and counseling and so on, we are far from where we need to be.

This slide shows the uptake of HIV testing in 64 countries reporting data in 2005, and 2006 the purple, the dark purple histograms refer to 11 priority African countries that make up over half of global TB/HIV. And again, you see that where progress has been made over time, but we are still only testing about 35-percent of TB patients. It is much better in certain individual countries, but across the board we are still lagging behind.

So, I think despite the huge amount of work that remains to be done, I think the TB community actually in the last five, perhaps slightly more years has come a long way to

acknowledging the importance of HIV for TB and initiating specific activities. And I think we, in the HIV community, need to acknowledge that actually we have not yet met our responsibilities. And in that 12 point policy document that WHO brought out, the three areas that the HIV community has to deal with—because it is they that see the patients concerned—are what we have referred to as the three Is. And this refers to intensified case finding for tuberculosis, isoniazid preventive therapy and infection control. And these are really, all of them issues, that have received quite a lot of scientific attention, but not that much programmatic attention.

And so, in April of this year a meeting was held in Geneva bringing together HIV people particularly, to discuss these elements. The recommendations that came out of it were that, isoniazid preventive therapy and intensified case finding really have to become part of standard HIV care an absolute expectation, just as access to prophylaxis with cotrimoxazole is for example.

But this will require re-conceptualizing some of the earlier guidelines. Isoniazid is a fascinating subject when you want to talk about putting research into practice. There have been a very large number of isoniazid preventive therapy trials, and yet almost no country has scaled this intervention up despite the important research findings.

So, we really do feel that this is going to be part of standard care. It will mean that we will have to develop

better algorithms for screening. It will require laboratory strengthening.

We hope that by the end of this year that the preventive therapy guidelines that do exist will be re-conceptualized to bring them up to date, the current reality, and the same is true for infection control guidance. We are also going to have to develop better algorithms for intensified case finding and we will need to develop indicators around these three elements for accountability purposes to the funders of such activities. And obviously, we will have to work on country adaptation.

Infection control has been an extraordinary neglected area in low and middle-income countries. It obviously requires to bring it up to the standards that we see in the industrialized world requires quite a lot of resources, but there is a lot of simple things that could be done. Some of them ten steps outlined in this document released by the World Health Organization in recent time.

So, some of our next steps I think will have to include advocacy. And this will require both a push and a pull if you will. We can at WHO level and with our colleagues in the TB and HIV communities and civil society can work on the technical aspects of this, the guidelines, the normative work. But I think there is also a need for demand creation at a societal level. Mobilizing people with HIV that they demand what was so effectively demanded when it came to antiretroviral therapy.

For example, really demanding that isoniazid preventive therapy, become part of standard care.

There are implications for procurement and supply chain management, and I think this opportunity and need for some creative thinking. Like for example, co-packaging or even co-formulating. Isoniazid with cotrimoxazole. Cotrimoxazole which again, in several clinical trials has been shown to be so beneficial and actually life saving in HIV infected patients with tuberculosis, and yet who is up take still lags behind.

At the global level we can make recommendations, assist with the development of training materials and tool kits and guides and such. But it is at the country level that discussions need to be had about actually adapting these to the local level and including, of course, raising the necessary resources which why it is so encouraging that both senior levels of PEPFAR and the Global Fund are represented at this symposium.

This is my final slide, and I just want to make a point that I think in the world of HIV, we really do need seriously to mainstream tuberculosis, to make this a central concern for everybody associated with HIV at any level to adapt the concept of universal access to include TB. But also to start considering some emerging issues, including social aspects and human rights issues. I think that the protection against these major infectious diseases, malaria, TB, HIV and the vaccine for preventable disease need to be regarded as global public goods.

I think we need to start emphasizing positive aspects of human rights, now that there is so much we can offer and do and not so much the negative rights that for good reasons were emphasized years ago. But it is essential to bring tuberculosis into this discussion because there are many, many issues around things like infection control, the protection of health care workers. The right not to get infected with tuberculosis. And especially drug resistance or extensively drug resistance tuberculosis when you attend a health care setting. The picture at the top there, is actually a South African picture of a guard sitting outside a hospital surrounded by barbed wire where patients with multi drug and extensively drug resistance, many of them for sure HIV infected were being detained against their will on the grounds of public health. These are deep issues and there are no easy answers, but this is the kind of discussion that we need to be beginning to have.

And the final curve at the bottom, just to remind us the modeled epidemic curves of the future of the AIDS epidemic, while incidence may have peaked, you see that the summary curve and the little inset of people living with HIV predict that we are in this for the very, very long haul. Just as the recently released data from the United States about stable incidents, higher than we thought, has been the situation for the last decade. It seems to project into the future.

So with those words, I will close. Thank you.

[Applause]

**MICHEL:** Thank you very much, Kevin. We will keep questions if this is agreeable to you to after we hear from the first three speakers.

So the second next presentation, Kevin you talked about how to go from recommendations to programmatic issues, is Mark Dybul, the U.S. Global AIDS Coordinator and he will speak on "TB Prevention, Diagnosis and Treatment Services for People Living with HIV: Scale-Up Implications for HIV Implementers." Mark.

**AMBASSADOR MARK DYBUL:** Thank you Michel and thank you Diane, both of you for co-hosting this session. And particularly the Global Fund's leadership funding 1.4 billion dollars, I think, in tuberculosis programs and Diane's leadership with the HIV/TB Working Group Committee and WHO. And thanks to the co-sponsors.

I do not have any slides, and I just want to make three simple points. And my apologies to Michel and others who have heard me giving these before.

With HIV/TB we really have fairly simple things to do. One, we need to acknowledge and promote the fact that HIV and TB have been model health care and development programs. Not just health, but development as well. Two, recognizing that we have an obligation to work together, the HIV and TB

communities. And three, it is in our interest as HIV and TB communities to work together.

In terms of the first, it is important to acknowledge particularly in the current almost unfortunate circumstance of vertical and horizontal and all the other debates that we hear to recognize and promote the fact that TB and HIV have been clear successes in global health and in development. And I think it is important that we recognize it is not just in health, but in development. TB and HIV programs have been among the most successful promoting basic development principles, country ownership, whether it is STOP TB or HIV program with national strategies with support from multilaterals and bilaterals coming behind national strategies. Whether it is The Three Ones for AIDS, the Three Is Now for tuberculosis. There has been strong promotion of country ownership and it is a success we need to talk about.

Two, and perhaps most important, there are clear successes where accountable and transparent development in health care, with set indicators and set goals that are measured. Now we might be behind in some of them, but in terms of accountable and transparent development programs and health programs, TB and HIV stand out as great successes. There are also two fields in which we are constantly self-evaluating and changing, and Kevin just went over the latest addition of that for tuberculosis with the three Is. These are fundamental and important principles for health and development. I think we

need to promote more and more the clear successes particularly in the current environment that we are in because these principles are fundamentally the monitoring Paris principles and we have succeeded.

The second point, that we have an obligation to work together, the HIV and TB communities. I actually would refer you to an excellent article by Diane Havlir in *JAMA*. It is an excellent summary of the need for us to work together. But I think we fundamentally need to recognize and talk about the fact that in Africa at least, HIV is TB and TB is HIV. TB is the leading cause of death, as we all know for HIV and HIV is fueling the TB epidemic. That is the bad news. The good news is we know that if we work together we can in fact tackle and solve these problems. And that is one of the reasons we have an obligation to work together because we know by working together we can succeed.

We know from a couple of studies that we can reduce tuberculosis with effective antiretroviral therapy and HIV positive persons. We know now from a number of countries that with intensive effort we can have success in identifying HIV positive people who are tuberculosis positive as well, and treating them.

In Kenya, we have seen an 84-percent rate for TB patients tested for HIV in 2007, up from 41-percent only a couple years before. In Rwanda an 88-percent rate of TB patients tested for HIV, up from 45-percent only a few years

before. Through a collaboration with PEPFAR and WHO and country leadership in Kenya, 42-percent of HIV positive, TB patients started antiretroviral therapy. Ethiopia 28-percent, up from 19-percent, Rwanda 36-percent up from 13-percent, this is all over a couple of years. Three, two threefold increases in key indicators, and so we know if we work together we can succeed.

It is important to have both bilaterals and multilaterals involved. As I mentioned the Global Fund is a leader here. PEPFAR has had nearly a fivefold increase from 26 million dollars in 2005 to 150 million dollars of its resources for HIV/TB this past year. Still not enough, but it is an example of how we need to be pushing forward.

I think one of the problems is that we do not understand this obligation to work together. We have actually made resources available for HIV/TB and people have not utilized them. That is a great tragedy. If money is available it should be utilized for these important efforts.

I was recently in a country that has had a very good STOP TB program, a nascent HIV program. The HIV community there including the bilaterals and multilaterals were actually arguing against using the TB infrastructure to expand HIV programs, mostly for inter political reason. That is a great tragedy. We have an obligation to work together and we know that if we work together, we will succeed.

I would also highlight the point that Michel made, that we need all sectors engaged. This is not just a government activity. The private sector needs to be involved for drug development and in important sectors, like mining and other communities where we know HIV/TB is high. We need private foundations like, the Gates Foundation and others who are doing excellent work here in drug development. We need faith based and community based organizations. Faith based organizations provide 30 to 70-percent of health care in Africa. If they are not engaged we are not going to succeed.

So, if we work together we know we can succeed and we have an obligation to do it because we will save lives. But it is also in our interest to do it. As I mentioned in the current cacophony of vertical horizontal, the almost senseless debates that are occurring right now in the development and in the international community, if we cannot with HIV and TB work together—two diseases that are too closely linked—we are actually basically telling these critics that they are right. If we cannot have so-called vertical programs that are HIV/TB linked, how on earth are we going to link maternal and child health and malaria and education and gender equality and all the programs that need to be linked and leveraged and built off of?

It is in our interest to do this, but more importantly it is our obligation to do it because it will save lives. We

owe it to those we are privileged to serve and to ourselves to tie HIV and TB together.

So, I think it is important we think big, act on the ground, it is great when we all talk together in these meetings, but fundamentally we need the communities and countries to sit down and plan together and solve the issues and leverage each other. And if we do that and if we look to the big picture, and if we have an openness of spirit to break down these bureaucratic and programmatic walls, we can actually tackle this problem.

So, I really appreciate the fact that you all raised this issue, and I hope we can focus on those three issues. We are a model of success and development and health. It is our obligation to work together to save lives, and it is in our self interest to do so. So, thank you. [Applause]

**MICHEL:** Thank you, thank you very much, Mark.

Implications of these new recommendations and of what we all understand is now needed as a priority is not just implications for implementers and for funders, it is also about advocacy and activism. So, that is the title of our next presentation from Musa Njoko from South Africa. And your presentation is entitled HIV/TB for People Living with HIV: Implications for Activism and Advocacy. Musa.

**MUSA NJOKO:** Good afternoon ladies and gentlemen.

Hello, Hi. How are you doing?

I hope my presentation will be great.

As I have been introduced, my name is Musa Njoko, I come from South Africa. I am not proud to be HIV positive, but I am also not ashamed. I am not a disgrace or an embarrassment to my family. I am not a liability to my family and country, but I am an asset with so much to give.

As I was saying, I am not a liability to my family and country, but I am an asset with so much to give. I am an African woman pride of my nation. I am a woman of courage and strength. I am a mother who brings hope and love who count the sums of life for her children who tends to hear adversity to victory. I am powerful and dynamic. I am sensible and innovative. I am wise and I am strong. I am more than a conqueror. I am a proud African Zulu woman, pride of my nation.

My voice today represents voices of many women, women from South Africa, women from Africa and women from around the world. We, the women who will never be slaves again, slaves of oppression, manipulation, poverty, abuse, disease and disrespect. Today we choose to take our rightful place, place of power, leadership and authority, within the tide against HIV and TB and all those things that are holding us hostage. Spiritual bondages, cultural looks and traditional change, for every person here today, I will challenge you to turn the tide against TB and HIV.

I discovered that I was HIV positive in 1994. At the time I was 22 years old. I was already a mother of a baby boy

who is now 16. It was at the turn of the South African Liberation, 1994 political change it was at its peak. Everything was changing, and for me my life changed. I had HIV. That meant I was not going to be part of the transformation. I was told I was going to die in less than three months.

It was devastating, totally confusing. Other than Freddie Mercury, I was the first person I knew to be HIV positive. I had limited knowledge about HIV. There was complete absence of dialogue on this issue. My doctor told me to go home and die, denying me any care as she advised it was an incurable disease.

The severe stigma caused by stereotyping and lack of knowledge made me an outcast at the church and community where I grew up. I sank into isolation, awaiting death, experiencing paralyzing frustration and anger. When death did not come three months later as had been promised by the doctor, my anger took over and I rebelled against the treatment I had endured. I publicly disclosed my HIV status through a national newspaper and suddenly I began to meet many others who had similar experiences, often worst than what I had gone through.

From disclosing my status, stigma and the results thereof, flooded me and my family. For months I was harassed and threatened by the man that had been my boyfriend, whom I know I contracted HIV from. There was no protection or any security when I went to report the case to the police. They

told me he had not physically done any harm to me and so they could not arrest him. Basically, we had to wait until he beat me or even killed me before they could do anything about it, if at all.

I remember one policeman asked if I would not be angry if my partner had told people he had AIDS. This was embarrassing and shameful, he said. All these reactions from the community drove me mad and fueled my rebellion and caused me to want to fight for my rights and for others that were suffering in silence. I realized that I was not a special case, there were many more and since I continue to be involved in HIV programs. Being vocal and visible in the public I saw that it was challenging their attitudes and stereotypes and providing information and knowledge.

Over the years I have learned the critical importance for us people living with the condition to be part of the discussions and be ever forefront as others may have medical or scientific understanding, but we know the reality of what it means to live with HIV. And the up sense of people living HIV, we might end up with views which are limiting because of the limited opinion. Our lived experiences bring about a comprehensive picture with which leaves me to the next point.

I was HIV positive and asymptomatic for quite a few years. Also my family became all comfortable. HIV was unreal. It was there, but invisible. There was nothing different about me, except that it was known I had it.

Until in 2000, I came down with meningitis and that is when the reality struck. It was bad, very bad. I was so shocked. It was the first time I ever got sick with an HIV related illness. We were not prepared for this. We were all thinking this could be the beginning of the end, AIDS stage.

Fortunately, in six months it was treated, I was fine and again went back to my volunteer community work, I was an AIDS activist. My career as a musician and television personality had taken off so well, it was all good. Little did I know how real HIV was and the opportunistic infections. In 2002, I suffered from bone marrow TB. This was the biggest blow ever. Much as the infection was bad, what really drove me mad was the failure to diagnose TB in good time.

Because for full three months I kept going to hospital telling them I was suspecting I had TB. I gave them all the symptoms I had observed, but on the lung examination was done which came back clear. And certainly no further investigations were done until my body crumbled. I had lost so much weight from 56 kilograms to 36, and from then on it was down hill.

I was an informed HIV positive person, but I am not a doctor or medical person. The people who should have known better let me down at that critical point of my life. I had done everything I could as an HIV positive person. This leaves me to wonder how many lives are still lost due to TB because of this carelessness and great lack of proactiveness.

I was then hospitalized in a private hospital. Thank God I had medical insurance. A number of tests were done, and only and only then it was discovered it was bone marrow TB. I was wheel chair bound for over ten months. My life came to a standstill. I was psychologically messed up, not crazy, but horror struck of my reality. I was then the exact picture of those people I had seen in videos and posters who had eventually died of AIDS.

As a bread winner at home, besides my mom and son, I have my sister's daughters whom I am responsible for since she died in 1996. When we talk to HIV positive people in those counseling rooms, we always advise them that speak to someone, tell someone, tell your family what is going on with you. That is what I had done with my sister. She was the closest person to me. Few months later after I had disclosed to her, she killed herself by burning herself. On her suicidal note, she wrote she could not bear the fact that I was going to die and there was nothing that the family could do for me.

I remember I had people were counting on me, 100-percent, but there was not assurance I could give them. I remember my mom once saying, but you said this is manageable. I had no answer for my mother. My family had to endure the pain of seeing me disappearing in front of their eyes, and there was nothing they could do. Suddenly, not only HIV was real, but AIDS was a reality, anything could happen, I could

die. We had heard of thousands of people living with HIV dying of TB and I was in line to become one of those people.

I was informed, do not forget that. I had spoken to the doctors, but with the limited resources maybe and lack of information, I was not treated as should have. As a consultant my savings went dry and we had to live on my mom's pension. I could no longer afford expensive health care. My medical insurance had lapsed, as I could no longer pay. I had to rely on contributions from friends and extended family which was never guaranteed.

I am giving all these details just to give you a picture that maybe sometimes HIV is not an issue as much as TB is an issue for people living with HIV. My nieces had to help with the bathing, feeding, dressing and et cetera as my Mom who has poor eye sight, she could not assist me physically. My son had to be moved from a private school to a public school. This change was very hard on him as I was not even available to support him to adjust to this change. This was a difficult case of the real reality of HIV in Africa.

Wow. I was treated, I survived. Thereafter my whole family had to go for TB checkup. Fortunately, no one had it. You may call me paranoid. I did that. We had all witnessed what TB can do, life was back to normal. Three years later, 2006, after I had fully recovered and started on ARV treatment, I moved back to Durban, closed office in Johannesburg because the business was basically bankrupt. On my arrival in my home

city five months later which was in KwaZulu-Natal. I was bedridden once again, I had TB. This time around it was even worse. It was at the outbreak of and drug resistant TB.

In that period, I had once again been visiting hospital, presenting TB symptoms but the same routine as the last time was followed. They went as far as lung checkup, nothing deeper and beyond was ever considered until I suffered bad fever on Christmas Day in 2006. I was hospitalized and kept in isolation for about three weeks while tests were being done to establish what kind of TB I had. Thank God it was just normal lung TB, nothing resistant to any drug. That was a relief, though I was very weak.

I was then put on treatment for six months until I was cured. Am I confident that I am TB free? No I am not. I do not have the confidence in the approach of this as the two past experiences of diagnosis and assessment had proven very poor. I am feeling strong and no obvious TB symptoms, but hey you may never know. So, ladies and gentlemen, do stay clear.

But on a serious note, to control and stop TB, we have to look at the policies, procedures, quality and service of treatment and accessibility. These experiences made me realize how little is being done about TB, not only in my country but globally. Yet, TB is the leading cause of death amongst people living with HIV, it also the most common presenting illness amongst people with HIV on ARV treatment worldwide.

The burden of TB on people living with HIV is immeasurable and it is despicable that the AIDS community has chosen to turn a blind eye on this critical issue, this injustice towards people living with HIV and affected by it. The increasing emergence of extensively drug resistant TB and the associated mortality rate amongst people living with HIV calls for urgent action to be taken by all stakeholders, particularly HIV policymakers and service providers.

Due to the lack of focus on TB and the relationship with HIV, communities are struggling to deal with it. Stigma and stereotypes is further fueling the spread of TB and failure to treat. Back at home in South Africa especially in KwaZulu-Natal there is now a perception that if you have TB it means you have HIV. So TB is now being used as a diagnostic measure for HIV, and as people are in any case reluctant to know their HIV status, this drives them even further away from seeking medical help, and only to find that these people may not even be HIV positive, but probably now exposing persons living with HIV to TB at home or in the workplace.

It is now also believed that you cannot be put on TB treatment if you are HIV positive, and on ARV treatment. The limited access to correct information and services is leading people to create their own theories. Know that nothing at all is being done. The challenge is that from the stakeholders, service providers, donor agencies and policymakers, there seems

to be great passions for HIV, but not TB, which in my view needs radical action and response now.

The further delay in responding to TB and its challenges is going to cause immense damage on people living with HIV and communities affected by it, and a huge setback on successes that have been achieved over the years regarding HIV work. Failure to educate communities and providing services and most importantly making them accessible will lead to more death of people living with HIV and increasing the impact of HIV. There needs to be more passion and focus on TB, not neglecting HIV as the previous speakers said, there needs to be collaboration between HIV and TB communities. But we need to look at the relationship and comprehensive response. Urgent advanced training and education for health care workers on TB and HIV and specialized services on this matter are required. Urgent research on pregnant women living with HIV, as women may have seen more and more pregnant women suffer with TB during pregnancy and we need to look at the implications on TB on the mother and the baby, urgent accessibility of advance current technology systems and equipment to diagnose TB without further waiting and delays.

Also, still talking about what can be done we need urgent TB prevention programs that can assist in combating the spread of TB as well as HIV and thereof treating, treatment availability and accessibility today. First I would like to also commend the sponsors or rather the organizers of this

session because at this time of the HIV epidemic, this issue is quite imperative. We need to develop leadership skills and enable people living with HIV to speak up, challenge and inform policies and decisions and be part of the TB response as we continue to do with HIV.

As part of my contribution, I have a poster that I would like to show you. As part of my contribution, having lived through the experience as a mother I have put together this campaign which seeks to despond myths, wrong information about TB and HIV and raising awareness on the issue and providing education. The main message really is TB is curable even if you are HIV positive. Generally in my community back home in South Africa, once you are HIV positive people generally think it cannot be treated, you are right at the end. So the poster seeks to do that. I am going to ask Sobae Loet [misspelled?] and Rosette just to lift up the poster. This is an intervention aimed at people living with HIV encouraging them to seek medical help, but now it must be made available.

The poster, it has a number of elements to it. It is a poster, DVD, CD and public events and workshops. The campaign is centered around me in this case, but it is something that can also be translated to a country context. The poster has a picture of me and the story. It really just says, TB is curable even if you are HIV positive, and then it talks that I have had TB, I was treated because I took my treatment as advised by medical health care workers, and I have been cured

of TB, which I think is a critical message that we need to send out to communities to say TB is preventable, TB is curable, even if you are HIV positive.

Well, as I am on with many facets, I am not an HIV/AIDS activist, but I also sing, and I would like to sing you the song, which I wrote at the time when I was very, very sick and it is a song that I wrote really just talking to my son. It is definitely not going to show up on the screen. [Singing a song] Thank you very much. [Applause]

**MICHEL:** Thank you. Thank you Musa for sharing your story with us and for the powerful message you delivered.

Coming back to what I was saying earlier about how much we need beyond our public sector activities to join altogether in that effort.

We now have a little time for discussion on these three presentations, and please come to the microphone. Do identify yourselves and ask your questions.

**MATT CAVANAUGH:** Hi there, I am Matt Cavanaugh [misspelled?] from the Result Educational Fund in the U.S. Thank you all for putting together this event, it is an important one.

I wanted to—

**MICHEL:** Could you please speak slowly somehow because there is from where we sit, it is the same from all colleagues there is sort of echo and the sound turns and returns to you somehow as a boomerang.

**MATT CAVANAUGH:** Often yes, so, thank you for all of the great work that you have profiled thus far. I think we are seeing some really good beginnings of scale up on TB/HIV, and as Mark was saying, just a beginning, but really, really some good, good progress.

I am concerned however, about the extent to which the HIV community is still failing on TB, and as Ms. Njoko said, people living with HIV who are still dying of TB. And one area that seems glaring, Mark mentioned many of the increased testing of people in TB settings for HIV. But as far as we can tell that same thing is not happening in HIV settings, that we are actually screening people for TB. So I wonder if you could speak to that and what the barriers are moving forward to that. Thank you.

**MICHEL:** Thank you. Kevin or Mark? Kevin would you take the—

**KEVIN De COCK, M.D.:** I think there is a number of reasons, and so the question they finally answered correctly is although we are doing better with getting TB patients tested for HIV, why are we continuing to do so badly. Getting HIV patients screened for tuberculosis, correct? Yes.

I think there is a number of reasons for it, one we have not yet succeeded, and I do not know what because after the first time that the association between these two diseases was documented in the literature, apart from case reports. The first epidemiologic of data, as far as I remember, I think I am

correct was about 1986. That is over 20 years ago, that is 22 years ago and there were many. There was already data before that. I am talking about case series and so on.

We have managed to get the HIV community to feel TB, and I do not really know why. I think then there are technical reasons as well that we have not done well with screening algorithms, diagnostic algorithms. A lot easier to do a rapid HIV test than it is to deal with the difficulties of tuberculosis diagnosis. Even pulmonary, let alone extra pulmonary, those are some reasons, but I think others on the panel may wish to comment.

Mark, what do you think as a clinician?

**AMBASSADOR MARK DYBUL:** Well, I actually think there is a real bureaucratic, I would not say political, but issue between communities and people are afraid of certain things and I think there is some fear in the HIV community about TB. There certainly has been concerned in the TB community about HIV overwhelming it. I really do believe there is almost a psychological component that we need to break down, in addition to the real clinical, medical issues of diagnosing TB in HIV settings.

So, as I mentioned we made money available for TB and HIV settings and it has not been used, so part of it is psychological, part of it is expertise. There are a lot of HIV people who do not know much about tuberculosis and we need to do a better job of educating them and bringing it along. I

think we have an awful lot of work to do. The good thing is we are seeing success where we concentrate in WHO and we focused on this. The Global Fund is trying to get people who are applying for HIV and TB grants to link them. I think it really gets to getting to the ground level to force national plans for how they work together rather than more high level things, because it has got to be done on the ground unless the people are talking to each other it is not going to happen.

**MICHEL:** Yes, I would just like to emphasize one of the points Mark made, which is yes, funds are available and yet that verticalization between programs still is very strong. TB programs have been in place for many, many year and they are usually been very strong, independent, vertical and then HIV programs came in and had to sort of fight their way and also tended to be very vertical, and that created a basic difficulty in having the two bridge together and communicate.

As you may know, the Global Fund would only accept an HIV proposal to come to us if it has a TB component, and would only accept a TB proposal to come to us if it has an HIV component, unless people really explain why they would not have the second component in the proposal.

So, there are a lot of measures we are trying to take all of us funders to help bridge between the two, but there is still a way to go. Diane.

**DIANE HAVLIR:** I think just one other comment. I think everyone would acknowledge that when the rollouts started, the

logistics of getting ARV programs launched and in place were absolutely enormous and people were very focused on. If we do not get this going, people are going to die immediately. And now as we are transitioning to this is a disease of decades people are now realizing that TB is a very important part of that management, and incorporating diagnostic algorithms when people walk in the doors is starting to happen. And then as we just saw you can get TB more at one screening for people along the way it is starting to happen.

So, I completely agree with the person who answered the question, that we have a long way to go, but I think we are going to start seeing the HIV programs take a lot more ownership of this. And I think Rubin Greenich [misspelled?] and the leadership that he has shown with the WHO, with Charlie and the Three Is Initiatives is going to really carry this forward.

**MICHEL:** Please, go ahead.

**CHESTER MORRIS:** My name is Chester Morris, Sorim [misspelled?] Institute in South Africa. I just have a specific question about the—

**MICHEL:** Do go slowly it is very difficult for us to hear.

**CHESTER MORRIS:** Sorry, the IPT component of the three Is. I have a recent experience in two large programs in South Africa and Nigeria, two countries where there is current policies on INH use. And my experience in those programs and

experience that we had was intense provider level opposition to the use of INH. And this is even in experienced, clinicians even infectious disease specialists in some cases.

So in terms of the three Is strategy and the IPT, I heard the demand component. In terms of supply component, is there going to be a focus on providers because, like I say, in some large programs that I have had experience in the provider has been a key block and actually the provision of INH.

**MICHEL:** It is about the three Is.

**KEVIN De COCK, M.D.:** It is almost impossible up here to hear. I heard about a third of your question. It is not going to be any clearer.

**CHESTER MORRIS:** The INH provision.

**KEVIN De COCK, M.D.:** Could you come to the front and repeat your question, why do you not come to the front up here.

**MICHEL:** What I suggest is that indeed people come here, ask the question and the one person on the panel who is answering will repeat the question in the microphone so that everyone can hear, because we just cannot understand what you are saying. I am sorry, but do please come here. Thank you.

**KEVIN De COCK, M.D.:** So, the question is, in the speakers experience an obstacle to the provision of Isoniazid Preventive Therapy has often been the medical profession, the providers who resist this even infectious disease strength physicians, so how does one deal with this and it is all good

and well to create demand, but how do you deal with that provider issue? Perhaps I could have a first stab at it.

I think this is exactly the sort of area that normative bodies like the World Health Organization need to take on. I think WHO being an evidence based organization with its convening ability to convene people from countries, I think can push to have affected countries reexamine this, and really use moral persuasion as well as technical data. The technical data that really support this very strong, how many more control trials do we need before we say, okay the reduction in incidents in people at least with a positive skin test is 60-percent, people untested with Tuberculin is about 40-percent. How many more trials do we need? So, I think that is the way to go. There will be resistance, but in some places it will change and I think one at a time.

**MICHEL:** Thank you. So, would you mind coming here, let us try with the microphone close to us, we will here you as you speak in the microphone and everyone in the room will hear you through the microphone.

**PAULA KWESEWARE:** Okay, can everyone hear me? My name is Paula Kweseware [misspelled?] I am from the AIDS and Rights Alliance for Southern Africa. And I just wanted to make a comment on the issue of creating community demand for TB/HIV action.

In our experience working with other HIV groups around the regions and one of the main reasons for a reluctance to

engage in advocacy around the Three 'Is' is the lack of a common understanding and consensus when it comes to a lot of fundamental issues in defending the Three 'Is'.

When it comes to TB/HIV advocacy sometimes gets frustrating because it feels like there is more debate than consensus, especially with IPT for example. One questions the efficiency this, but activists want to know if we are going to advocate for this, how much can we rely on current screening tools to include access to TB when we often hear that they routinely fail to diagnose TB in people living with HIV, what is the risk of INH resistance, how effective are standard first time regimens where INH is consensus occurs. It is a lot base funders, but a lot of it is conflicting, and I just think if we really wanted to generate some advocacy it is important to verify all the differences because people need to understand the implications what they are advocating for, and right now it is just more confusion than understanding.

**MICHEL:** Thank you. Who wants to commend? Musa!

**KEVIN De COCK, M.D.:** I think that is a very, so the comment was. One of the frustrations that activists have to the plea for community involvement, community demand generation and so on, is the lack of clarity around the Three 'Is', the lack of technical clarity, the lack of clear messages about things like. Well, what about the risk of Isoniazid of Resistance, what are the best screening algorithms. What about

first line anti tuberculosis regimens if there is INH resistance and so on?

And I think that is extremely well put. In fact, I thought you said it so well that you should write it down and give it to us. Because I think you are right. I think we in a way, we have gotten a little ahead of ourselves. I think that is okay, we have gotten a little ahead of ourselves saying we need to do this, but we have not quite. It is what in parts of the United States say, describe as all hat and no cattle. We are talking about it but actually we have not gotten all the ducks lined up technically. But I think there is a commitment to do this. We going to do the refashion the guidance on Isoniazid Preventative Therapy and so on.

On the other hand, I think we need to be realistic we did not have all the information when we started ART scale up either. So I think-

**MICHEL:** Jerry wanted to say-

**AMBASSADOR MARK DYBUL:** I would just add we do not know a lot of things as Kevin said, and that is part of the problem, but everyone is pointing at each other. The HIV community is pointing at the TB community, the TB community is pointing at the HIV community and saying you do it, and no one is actually in a lot of places sitting down to work it out.

There is also a lack of understanding about the best way to do. Diane's article talks about this. You build off the TB programs or you build off the HIV programs. The fact of

the matter is it does not matter. Build out of whatever you can to get it done, and until the community as talked to each other. They will work through these issues, but people have to sit down and talk about it, and I think the community can be very helpful in forcing that dialogue.

**FEMALE SPEAKER:** Hi, there. Supervisor with Treatment Action Group. I have been working really closely on International Health Partnership, which is an initiative trying to fulfill a Paris Declaration and to help support countries to reach the health MDGs. And I had two questions. One is partly based on my impression of WHO. So I guess my first question is directed to Kevin.

It seems that WHO is very vertical, and in terms of the IHP, within WHO it is housed within the health systems cluster. So I just wonder with all the evidence and the information that you have been gathering from the field in terms of how TB/HIV integration works. How are you and the STOP TB Department within WHO feeding that information to the health systems cluster so that that kind of conversation does not get lost in the whole discussion around health systems strengthening?

The same thing goes at the country level, where health sector coordinating teams are talking about developing a revised national health plan with a budget, really focusing a lot on health systems, but as we know the health MDGs also include six, which is AIDS, TB and malaria. And so the WHO representatives in the countries, how are they contributing to

that process of developing that national revised health plan to insure that TB/HIV integration and the lessons learned in best practices from that is also helping to support the process? And also the conversations in how that plan is actually designed.

So a two part question, and I know that Paul is over here, so perhaps he can answer from the TB department side, but I really, if there is anything that I can support in terms of the vertical departments within WHO to help support you all to insure that that evidence is brought up in these discussions. I would love to have that conversation with you because right now I am serving as a civil society rep and trying to generate a civil society agenda and mobilize that across the global community civil society and also at the country levels. So, thank you.

**KEVIN De COCK, M.D.:** I am going to ask Mark Dybul to answer that question. [laughter]

Again, that question is as eloquent as the previous one. And we do not have answers for it. I think one of the things we have to accept as reality is that there is no structure that is perfect. And even with the best will in the world, if you are in different departments, via it the country level or at the big organizational level, if you are in a different department it takes super human effort to really work together well and there will still be misunderstandings. And we live this, and I think the relationship between HIV and TB

at WHO is very good and very close. But they are different departments and we see this played out at the country level as well.

I think with the health systems agenda we face even bigger problems, because these debates about health systems strengthening, vis-à-vis the disease specific programs are very recent and we do not have a lot of the data. We do have some, and I fully support what Mark said in his comments.

But we are just beginning to gather the data more systematically. A lot of what is said in these discussions is personal opinion. I am very worried that this discussion about systems, which is literally beginning to dominate global health discussion, is extremely theoretical and very non practical and we have had that for 20, 30 years. What we need is discussions about health systems that provide services for diseases that have names that affect people with families. We need that specificity to these health systems discussions. The only way I can see it going forward is by dissecting what are the components of the health system, the human resources, the management supply chains, the laboratory capacity, the infrastructure, etc., the management. And looking at those individually and tagging on the disease specific elements, that is the way I would like to see the discussion go forward. We talk to people in the health systems cluster at WHO, we do talk. At country level, I am afraid I am not in a good position to know what is happening at country level. But I

think people like yourself, involved in this discussion have a lot to offer and please do it, because it is at country level and these discussions are needed.

**MICHEL:** Thank you. Let us take two more questions. Jim you also wanted to say something, so three and then we will move to the rest of the session. Thank you.

All difficult questions are directed to Kevin. That is the way we set this session. [Laughter]

**GABRIEL MAHASSEY:** I am Gabriel Mahassey [misspelled?]. I am training as a medical student at a teaching hospital in Kenya. It is a teaching hospital that does heart, quite a huge spotting of TB and HIV, so I have had a chance to see quite a number of these patients.

And my question is, the available diagnostic methods at teaching hospitals in such poor settings are chest X-ray, tuberculin skin test, smear testing, that is for [inaudible] that basically caused the TB and probably culture. Which culture we know takes a lot of time before the results are out.

I am not surprised by what Musa Njoko is saying from South Africa that they took so long before they could diagnose TB of the bone marrow because we do not have facilities really, or if they are there, they are quite expensive so they cannot be implored in routine testing of extra pulmonary TB. So the smear testing we know after 51-percent of patients in Kenya on TB treatment are smear magnitude and for their ideological test, the chest X-ray to be significant, the patient has to

have pulmonary TB. That means a lot of extrapulmonary TB is treated on the basis on anecdote information on the basis of— it's like empirical sort to speak. Someone would come in probably with Meningitis, that is unresponsive to antibiotics, then after sometime of treatment with antibiotics someone thinks that this could TB meningitis, so we begin the person on TB meningitis treatment. Like Musa is saying TB of the bone marrow probably the most sensitive thing in situations would be culture of the bone marrow aspirate to detect the presence of TB in the bone marrow. But that takes a lot of time and it is not available in a setup.

So, my question is by the chance that people are finding all this programs in health care systems like in Kenya and many other African settings can allocate much more funds to evade better diagnostic techniques, better diagnostic tools setup so that extra pulmonary TB can be pickup at an earlier stage and be amendable to treatment other than let it run in the stages of the disease at which mobility and mortality is much higher.

And the second question is, the IPT, Isoniazid Preventive Therapy has been taunted as a modern way of helping people to stopping the progression of the disease to the severest forms of TB. So IPT, isoniazid preventative therapy has been really brought forward and advocated for something that should be practiced much more regular than before.

But with the emergence of multi drug resistance TB and extreme drug resistant TB, is it still a viable thing to do. Is it still something that you would advocate for to be rolled out on large scale as probably other speakers who have advocated for? Thank you.

**DIANE HAVLIR:** Thank you for your questions and it is wonderful to hear someone who is working with the patient and to point out what is some of the biggest obstacles are. There is absolutely no doubt among the field and among the funders that our diagnostic tools right now for TB are really in the stone ages, that is dramatically hurting our patients.

When you can only diagnose 50-percent of the patients with Pulmonary TB by a smear, and most places do not even have the facilities to do a smear, we are in very deep trouble.

I would like to assure the person who answered the question, this is very, very improvement of diagnostics for TB is extremely high on the global agenda for tuberculosis, a great amount of resources, although not enough are being put into this and the focus is really to develop rapid diagnostic tests and even PCR based ones that can be used in exactly the setting where you work.

I would also like to deflect the question to another aspect that we all are involved in, all the HIV movement. One of the ways to diminish the proportion of people who suffer from Disseminated TB, which is extremely difficult to diagnose, is to find people earlier in the course of HIV disease so they

never progress medically to the point where they develop Disseminated TB. And I think we all need to keep this in mind as we are developing global strategies. So, once again I am sorry that I did not address maybe some of the other panelists want to address some other things, but I want to thank you for excellent questions.

**MICHEL:** Jerry.

**JERRY:** I think all of the panel members have basically said what I was wanting to say. Let me just summarize one or two things and then add one additional thing.

So, I think we talked about integration as if you just put two things together and they integrate, and it is really is an evolutionary process because the worlds are very, very different, and I think those of us who have worked in each understand that. So that we have to be although there is a tremendous urgency, we also have to be a little tolerant of the process by which things come together and not forget that it is urgent, but also I think this is a wonderful opportunity at this meeting and among the first to actually, that this kind of discussion takes place in HIV meeting and continue to do that.

But I also want to say that when you talk about integration, it is really on the ground very heterogeneous. There is not a single way of integrating, because these programs now have either a long history tuberculosis or a short, but very intense history, HIV and each circumstance and each country and within each country urban, rural, township,

rural, KwaZulu-Natal are very, very different. They are different in resources, expertise, will, commitment, training, so there has to be some flexibility in the integration process that really takes into account a whole array of different models. And I think we have to learn how to be flexible in terms of the integration from collaboration integration.

The last thing I wanted to say because it has not come up in this discussion is to reemphasize the I that usually still gets forgotten and that is Infection Control. And that is an issue that people put on the list but then do not talk about. And this is another example of it, and this is critical in areas of high HIV and TB prevalence, and I think we all appreciate the risk of transmission of TB within the HIV setting. Not only the identification of TB within the HIV setting, but the risk of the people and how that has to be addressed and it is a combination of training, but also structure because the facilities that are available for most infection control and most settings are really so abysmally poor that it makes it almost impossible to do. So we have to think really very creatively about how to do simple infection control practices within the context of how we work in Sub Saharan Africa. So we should not omit infection control because it is so problematic, but really struggle with how to identify ways of making it possible.

**MICHEL:** Thank you, Jerry for those points, and I think your point on flexibilities is well taken, and from experience

as we travel to countries we see many, many different examples, and I think that flexibility should somehow help us, not delay things to much because it offers a broad scope of flexibilities.

The last question please.

**MALE SPEAKER:** Thank you very much for the last question. My question is very short. First commend the last message, the story of lady from South Africa give us the message that TB is curable even if you are HIV positive. I would like to ask more one would preventable.

In term of the prevention come to the question. I am looking expert around the room and Professor from WHO. So the story, now tell me. There was an opportunity to prevent the second TB of the lady or not, because we have evidence of IPT or the people not yet the TB disease. But now they are already accuse of TB, so IPT can provide for the people already treated for TB successfully. Thank you.

**DIANE HAVLIR:** In terms of the second part of your question, secondary isoniazid prophylaxis, that is to say after you have one episode of TB, trying to prevent the next episode, there is two randomized controlled studies that demonstrated that INH was beneficial in the setting. One of the things that we do not know is in the era of antiretroviral therapy, whether Isoniazid will show a similar benefit. There are epidemiologic data would suggest that perhaps it will, but that remains an open ended question.

But I think the questionnaire's point of that we need to make sure in terms of our programs developing approaches to TB that consider not only they need to consider prevention, treatment and diagnosis, but also reinfection, and reinfection in the setting of perhaps infection control needs to be a part of the programs. Thank you.

I think we will move on to our next speaker. There has been quite a bit of reference to what is happening at the country level, and what do know and what are some of the challenges there.

And I am pleased to introduce our next speaker, Dr. Chitwarakorn, who works in the Department of Disease Control in the Ministry of Public Health in Thailand.

Dr. Chitwarakorn has worked for many years on in some unique approaches to integrating diseases, HIV/TB and STIs, and he is paid particular attention to the private sector which something we have not talked about yet in civil society.

So, we appreciate you coming to join us and look forward to your insights on the country level.

**DR. ANUPONG CHITWARAKORN:** Thank you for the very nice introduction. Just would like to begin with the situation of HIV and TB in Thailand. As you can see from this slide that approximately about 80-percent of the HIV patients in Thailand are transmitted through secure transmitted root, and if you look at the most common OI, you can see that approximately about 30-percent of the cases were having tuberculosis.

In Thailand, we have about 63 million population, and we also one of the 22 high tuberculosis burden countries, with an estimation of about 90,000 cases of TB patients every year. And also we estimated that we already have probably one million people infected with HIV, of which half of them has already dying.

The 100-percent coverage of DOTS implementation has implemented since 2003 and you can see that in general about 0.9-percent of our pregnant women has HIV. Anyway, the latest development is that antiretroviral therapy services are now accessible to all people who are living with HIV in Thailand at the district level, which means that every public hospital in Thailand about 1,000 hospitals in Thailand are now providing antiretroviral therapy free without any charge for the patients in Thailand. And this is some progress of TB/HIV implementation. We heard a lot of discussion, but this is what is happening in Thailand.

Actually there are some activities that happened before this, but this is the major development in 2003. We are piloting some TB/HIV activities in Thailand with the support from the U.S.A. and from the CDC Collaboration Site. 2004 we have developed a national guidelines for TB and HIV collaborative activities. And also in the same year we have established what we call the National TB/HIV Committee that trying to promote TB and HIV collaboration. And in 2005, we started to pilot TB/HIV activities in small scales. And after

we learned some mistakes and lessons learned, we revised and in the same year we also started to try to revise record and reporting form so that we know what happening with TB patient.

So, two years ago, we started to implement our TB/HIV activities countrywide and this is some target that we set at the beginning in 2006. For example, we set the target of having HIV testing in all TB patients starting at 25-percent in 2006 and we hope that by the end of 2009, more than 90-percent of TB patients should be screened for HIV. Antiretroviral treatment at least 50-percent in the first year in 2006 of TB patients should be treated with antiretroviral and in 2009 more than 60-percent.

One of the three Is, intensify tuberculosis fighting. We set the target at 80-percent in 2006 and we hope that in 2009 should be more than 90-percent. And this just some symbol of what we create or what we could form that we newly introduced before the TB patients so that we could know what happen in our TB patients. I am not going into detail.

And this is just what the outcome of our TB/HIV activities in the year 2006 and 2007. And you can see from this slide that the HIV testing in TB patients increased from 52-percent in 2006 to 68-percent in 2007, and also the Cotrimoxazole prevention therapy for tuberculosis patients also increased from 64-percent to 67-percent. It is not so good as the antiretroviral, we set the target of more than 60-percent, but we still have 32-percent.

The major achievement I think we have good guidelines for TB/HIV collaboration and also for the ITC for antiretroviral therapy for TB and HIV patients. We also have incorporated TB/HIV monitoring indicator into our routine TB register form, and the good thing is that now our new TB register form has been adopted by our health district hospital and you can see from this slide that almost more than 90-percent of them start to report because in Thailand so we know happened in our TB patients.

As I just mentioned, we could increase our HIV testing in drug resistant patients from 52-percent in 2006 to 68-percent in 2007 and the high coverage of ICF, I put a question mark here because we still could not collect the number form the nationwide, but I have an example of one region in 2007 it was reported more than 90-percent of the new cases of HIV new diagnosed cases patients has received ICF and that is good sign.

This is just an example of how we try to promote what we call the PITC. We have many models. For example, the model one, the pre-test or PITC would be done in the TB clinic and if the patient IV is negative, the TB clinic do look after those patients, but for TB patients who have HIV positive they were referred to the HIV clinic. This is one of the first model in Thailand. The second model has a different that the TB patient will be screened and will be looked after by the HIV clinic even regardless the HIV status and are in some model the pre-

test we started the HIV clinic. And then it depends on the still status of the patient if the HIV is negative then the TB clinic do take over the example.

Right now I think the first model is what recommended and it just has been published in the *International tuberculosis Standard Thesis* this year that the best model for PITC is the first model which started at the TB clinic and the TB clinic will be screened for the HIV. If the HIV is negative the TB clinic to carry on and look after that patient, and once the HIV is positive, then the patient will be referred to the HIV clinic. But however, there are still some different models going on in Thailand. This is the example of one region in the North Eastern part of Thailand that you can see from this slide that the services in 2007, the place to perform PITC, 97 of them were performed in the TB clinic, only 3-percent in HIV clinic and in other health facility. And the staff who provide TB and HIV care in the TB/HIV integrated services you can see that the same person about 25-percent. Different person but from the same section about 40-percent and different person from different section about 35-percent. So in general more than 25-percent are from same person or in the same section, and about one-third from different section.

And when you look at the details of the service you can see that most of them about 82-percent of district hospital in this region has already established what we call TB/HIV teams so that the TB/HIV service could be more collaboration than

what happened in the past when they have to separate team. And the staff who provide the PITC you can see that the TB staff 52-percent, HIV staff 16-percent and both 28-percent.

There are a lot of major challenges and the most important one I think is the lacking of the joint planning together within the TB and HIV program at also we just heard many opinion from the floor that there are still a lack of planning.

And the other that were important is that we still have the other two I that we could not achieve that is the TB infection control and also the other one is IPT because we need more strong evidence and we heard about re infection or we heard about drug resistance. So, I think there are still a lot of things going on and the low uptake of the antiretroviral in the TB/HIV patients. So far we could achieve only about 35-percent and we set the target as more than 60-percent, so we still need to speed the antiretroviral in the TB/HIV patient.

I think this is the last slide. I think what Thailand has been achieving because we have many technical and financial assistance and the government has really also commit to both TB and HIV and we have the World Health Organization, both financing and technical support and lastly we have also the Global Fund that start initiative for both TB and HIV services.

So, thank you for your attention. [Applause]

**DIANE HAVLIR:** Thank you very much. Thank you for sharing your progress and your challenges and seeing infection

control up on the challenge is just a testimony to the cutting edge of your program.

Our final speaker for today is Dr. Paul Nunn. I am sure whom many of you know, Paul has worked on the field, done some pivotal work on HIV and TB epidemiology early in his career and now really has taken a global leadership role in HIV and TB and was recently has taken a leadership role in the MDR and XDR epidemic.

This afternoon he is going to focus on country implementation and the title of his talk is Commentary in Country Implementation: What are the Triggers?

**PAUL NUNN, M.D.:** Well, good afternoon, and I will be as quick as I can. For those of you who want to get away for the opening ceremony.

What I am really presenting is a non systematic review of what has enabled those countries who have made progress in TB/HIV to make that progress.

So, if you are a firm addict of systematic reviews and evidence based medicine, you can go to the opening ceremony now.

This is just to introduce very quickly the fact that we are making progress in TB/HIV activities across the board as Mark Dybul very nicely pointed out. So, year on year there is progress, but still we are a long way from achieving our goals, both on the TB side if you like, and in the three columns on the right there on the HIV side of the equation, as Kevin

pointed out earlier. We did not go into the details and the numbers of that slide.

But one enabler which many countries have pointed out is that the policy scene internationally was clear, and this I think has enabled a number of countries perhaps to move a littler quicker than they might otherwise have done. And this is the so called interim TB/HIV policy on collaborative activities. And again, we need not go through each of these lines, but one important enabler is to make sure that at international level the policy is clear. And I actually think that although there are a number of details that need to be sorted out in a number of areas, enough is known already for us to make serious progress at country level on APT, on infection control and on intensified phase finding, and that is in response to Paula's previous question.

I think it was Robert Louis Stevenson who said that leadership is the art of making decisions in the absence of complete data. And it maybe that what is required in countries is leadership.

Now moving on to those critical enablers at national level. The one thing that is clear is that things do not happen unless there is communication and interaction, usually between the program managers of the national TB program and the national AIDS Control Program. It is so blindingly obvious, but nevertheless that is clearly a problem if you do not have it.

However, communication interaction alone are not enough. What needs to be there as well is a neutral appreciation of the scale of the problem and the determination to address it. A number of countries I think have been put off by some of the obstacles that they have encountered.

We recommended in original policy that there be TB/HIV focal points pointed at national level, and as far down the regional and district level as you can. And that certainly seems to have worked in a number of countries, particularly in Kenya for example.

Again, not much would have happened without the wave of additional financial resources that came with the Global Fund and with PEPFAR. That is a great shame that the heads of those two agencies had to go for the opening ceremony.

But it was not just a question of money, the technical advice and resources and so forth were also quite important, not just from WHO, but from other partner agencies as well. And that has certainly stimulated a number of countries and I am thinking an example of here of Nigeria and Kenya.

Each country then needs to establish it's what we call here its own conducive policy environment. Again, many countries have found it very important to set their own national targets and define their own national plans. Kenya and Nigeria again are examples and on the right hand side here, we have some of the documents, these documents here are from Rwanda.

The country needs to develop its own national TB/HIV policy. That again is kind of obvious, but it certainly helps enormously if that formulation of policy is carried out in a participatory manner involving all those stakeholders who like being involved in its implementation. And particularly civil society has been really quite important in this role. And then making sure that once the policy is established it does not just sit on manager's desk, but is actually disseminated. And that involves, of course training programs and process.

It will of course also mean that the individual TB and HIV technical manuals guidelines and so forth will need to be revised, and that is quite a heavy, well it is hard work, but needs to be done.

One of the key things on the TB side, has been HIV testing. This is really the gateway to the services on the TB side. And Kenya I think has really taken the lead in this regard and their document on guidelines for HIV testing is on the right hand side of the slide.

But the policy on provider initiated counseling and testing has clearly been a major facilitator in terms of making HIV testing available. And many countries have decided to move towards HIV testing to TB suspect who are very likely to have HIV as well as TB patients.

Rapid testing has been absolutely key, particularly if it can be done by the health provider in the same room.

Although, as we have heard Thailand has a number of different

ways of doing it, but certainly in the protest projects in Malawi and in Zambia, the introduction of rapid testing increased the amount of testing in TB suspects by four or five fold. The Kenya guidelines even go so far as to say that not offering HIV testing to persons presenting with HIV associated illness including TB is substandard care and should be sanctioned.

Another fundamentally important thing for countries, but also very important for us in WHO, who have to brand, watch what is going on in the world, is the revision of recording and reporting, and making sure that when policies are changed, when implementation is changed, what is done is actually recorded and reported. And that involves putting in TB components in HIV registers, and HIV components in TB registers.

This is involved now quite some discussion on country and international level on harmonizing the ways in which this data is collected. So that data that comes up to WHO or the Global Fund or PEPFAR is actually the same data. And we are actually begun, Christian Gunnerberg [misspelled?] and my team has been leading the charge on this. We now realize that all these three organizations are getting different sets of numbers, with different denominators, and so there is really some serious work to done in harmonizing this, which of course will be significantly assisted by having internationally recommended tools and registers to make sure that it is standardized.

And then finally, but perhaps more importantly, making sure that all the stakeholders are involved and engaged and communities are mobilized. Many countries have found it very important to be supported by the PEPFAR, by their Global Fund Interlocutors at country level. And if they are TB/HIV skilled and informed, so much the better, similarly assistance from NGO's has been fundamentally in a number of countries.

People living with HIV, members of the HIV community have really provided major pressure, major stimulus for action in countries like Kenya, Tanzania to, and I am sure other countries as well. And it is that generation of demand and the push and the shove by affected communities that I think has really been very important.

Intensive, continuous training, constant supervision is essential. You cannot make real progress without it. As well as making sure the supply chain of all the necessary commodities is fully in place. There is nothing more demoralizing than starting off providing ART TB patients and you run out of drugs.

And if you have been, thank you for listening.

[Applause]

**DIANE HAVLIR:** Thank you very much, Paul.

I think now with the late hour and opening session, we are going to close this session and I wanted to close this session with some words that I heard from Musa during her story.

Musa, thank you for sharing your very personal story with us, and making what we are talking about today very real. Some people going through what you have gone through would just go on their merry way, instead you have gone out and you have challenged us to turn the tide against HIV and TB.

And Kevin, in his usual way slipped in a sentence I would like share with you before we go is that we need to turn words into action. So that is the charge of this group that is the charge of this meeting. There is many HIV/TB activities at this meeting and there is some materials outside.

Thank you for joining us today and I hope the rest of the meeting goes well. [Applause]

[END RECORDING]