

Report of the meeting by
the World Health Organization
(Headquarters and Regional
Office for Europe) in collaboration
with the TB/HIV Working Group
of the Stop TB Partnership



Accelerating the implementation of collaborative TB/HIV activities in the WHO European Region

16-17 July 2010, Vienna, Austria

Summary

Scaling-up collaborative tuberculosis and human immunodeficiency virus (TB/HIV) activities in the WHO European region is a priority. The region accounts for 6% of the global burden of TB and has the highest levels of drug-resistant tuberculosis in the world. Approximately 2.4 million children and adults were living with HIV in the region in 2008 with 1.5 million living in Eastern Europe and Central Asian countries, and the region faces the fastest growing HIV epidemic in the world. However, low and middle income countries in the region have amongst the lowest coverage with antiretroviral therapy (ART) globally. The first European TB/HIV regional meeting "Accelerating the implementation of collaborative TB/HIV activities in the WHO European Region" was organized by the World Health Organization (Headquarters and Regional Office for Europe) in collaboration with the TB/HIV Working Group of the Stop TB Partnership prior to the XVIII International AIDS Conference in Vienna in July 2010.



Picture: Evelyn Harvey

A total of 186 people from 37 countries participated to the meeting with representation from all of the 18 high TB burden countries and those countries most seriously affected by HIV, including those with the highest population prevalence from the region. Participants discussed how to strengthen collaboration and coordination between programmes, how to address drug-resistant TB, and how to provide integrated and comprehensive care to most at risk populations such as

people who use drugs, migrants and prisoners. Participants also shared experiences and best practices to inform recommendations to accelerate the implementation of nationwide scale-up of collaborative activities.

National TB, HIV and harm reduction programme managers as well as officials from the penitentiary system were joined by a broad range of TB and HIV/AIDS stakeholders active in the WHO European region, members of the TB/HIV Working Group, and representatives of non-governmental and civil society organizations.

This report summarizes key outcomes, conclusions and recommendations of the meeting.



Picture: Doina Lin

Opening Ceremony - Left to right: Dmytro Sherembey, Deputy Chair All Ukrainian Network of People living with HIV; Dr Julio Montaner, President International AIDS Society; Dr Diane Havlir, Chair TB/HIV Working Group of the Stop TB Partnership; Dr Hiroki Nakatani, Assistant Director General for HIV/AIDS, Tuberculosis and Malaria, WHO; Dr Hans Kluge, Special Representative to the Regional Director to combat M/XDR-TB, WHO Regional Office for Europe; Dr Bernhard Schwartlander, Director Evidence, Strategy and Results Department, UNAIDS.

Implementation of TB/HIV collaborative activities: where are we?

The WHO European region contributes to 6% of the global burden of tuberculosis (TB). Eighteen countries¹ share 86% of the regional TB burden reporting notification rates between 11 and 72 per 100,000 populations. The region is also facing dramatic increase of HIV infection mainly driven by injecting drug use in Eastern European and Central Asian countries.

In 2008, the regional prevalence of HIV among TB patients was estimated at 5.6%. Though nearly 80% of all TB patients were tested for HIV that same year, only less than half (48%) of the estimated number of people living with HIV and TB in the region were identified. Of those found HIV positive, 61% and 28% were receiving cotrimoxazole preventive therapy and ART respectively. Overall, the region has the second lowest level of access to ART for people in need of it (23%). TB case finding among people living with HIV and provision of isoniazid preventive therapy remain very low.

Moreover, both epidemics are spreading within most at risk and highly stigmatized populations such as people who inject drugs, prisoners and migrants, living outside of the system, most often without residence permits and therefore with restricted or no access to health services. Uptake of HIV testing and access to antiretroviral therapy is insufficient in these marginalized groups.

Changing commitments into action: the missing link

There are several regional strategies and political commitments to address the TB and HIV dual epidemic in the European region including the Berlin Declaration on Tuberculosis, the 2007-2015 plan to Stop TB in 18 high-priority countries and the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia. At the global level, prevention, diagnosis and treatment of TB are components of the WHO/UNAIDS essential package to prevent

and treat HIV in people who inject drugs. This essential package has been endorsed at the highest level by, for example, the Economic and Social Council (ECOSOC) and the UNAIDS programme coordinating board.

Stop TB Partnership

We, the Ministers of Member States note with concern that in the Region, TB is the most prevalent cause of illness and mortality in people living with HIV/AIDS, and few countries address TB/HIV co-infection in a comprehensive manner.

The Berlin Declaration on Tuberculosis, WHO European Ministerial Forum, 2007

¹ Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Romania, Russian Federation, Tajikistan, Turkey, Turkmenistan, Ukraine, Uzbekistan.

Since 2002, Eastern European and Central Asian countries have received almost 1 billion USD for TB/HIV collaborative activities from the Global Fund to fight AIDS, Tuberculosis and Malaria - from 0.1 million to Bulgaria to 19 million USD to the Republic of Moldova. Such availability of funding coupled with the political commitments should offer an opportunity to mitigate the problem in the region. Resources should also be available from internal sources and plans should include a clear description of the collaboration between TB control and HIV/AIDS programmes in providing integrated TB and HIV services. Strategic advocacy is needed to raise the profile of TB/HIV among politicians and decision-makers and to promote the delivery of integrated TB/HIV services including in harm reduction programmes and in prison settings.

HIV testing for TB patients and suspects: the gateway for HIV treatment and care

Although the region is making progress in the provision of HIV testing for TB patients, there is a wide difference among countries in the proportion of TB patients that received the test. HIV testing is not yet available for all TB patients and is not yet systematically linked to HIV care and treatment, including antiretroviral therapy. In Central Asian countries, more than a third of people living with HIV were estimated to die from TB in 2009. Potential reasons include excessive verticality of and almost non-existent collaboration between the TB and HIV/AIDS programmes with poor understanding of each other's role. Also, these countries

are often characterized by non-existent deliveries of integrated TB and HIV services, poor exchanges of information between HIV and TB health care workers and difficult access to voluntary, free-of-charge and confidential HIV testing and counselling services, all of which results in late diagnosis and delayed provision of HIV treatment and care and in late diagnosis of TB. This is even more applicable to most at risk groups, such as people who use drugs, migrants and prisoners. Likewise, HIV testing is not routinely offered to patients who present with symptoms and signs suggestive of TB (TB suspects) that further delays the access to HIV care.

Excessive verticality: a bottleneck for quality TB and HIV services

In many countries of the Region, if not all, the TB and HIV/AIDS programmes are run separately with their own management and service delivery mechanisms. Similarly the provision of harm reduction and prison health

services are independently carried out by separate entities without formal or effective channels for communication and collaboration. Because of the intertwined nature of TB, HIV, injecting drug use and detention in the region, collaboration and coordination between TB, HIV/AIDS, harm reduction programmes, criminal justice system and civil society is crucial for effective and integrated response to TB and HIV. The establishment or revitalization of effective TB/HIV coordinating bodies at national, regional or local levels is crucial. More emphasis should be given to provide integrated TB and HIV services at all levels and the necessary programmatic and regulatory conditions need to be fulfilled as a matter of urgency.

Integrated delivery of TB and HIV services averts unnecessary mortality

Prevention, diagnosis and clinical management of TB disease in people living with HIV remains challenging despite clear international guidelines. In particular, the rates of undiagnosed TB in people living with HIV, including people who inject drugs, are very high as illustrated by post-mortem studies in Ukraine and in the Russian Federation where



Group discussing key issues and actions for scale-up on TB/HIV in prison settings

over 40% of HIV deaths were related to TB. Tuberculosis remains the overwhelming single cause of death in people living with HIV in the region despite clear guidance to improve the diagnosis and management of TB in people living with HIV, including the provision of antiretroviral therapy. The 2010 WHO guidelines on antiretroviral therapy for HIV infection in adults and adolescents recommend that all HIV-infected patients with active TB disease are eligible for antiretroviral therapy irrespective of CD4 count and that antiretroviral therapy should be started as soon as possible after initiation of TB treatment. The guidelines also recommend early initiation of antiretroviral therapy in all adolescents and adults including pregnant women with HIV infection and CD4 cell count ≤ 350 cells/mm³. The expansion of ART coverage is a powerful strategy to reduce HIV and TB associated morbidity and mortality, and incidence. Revision of national policies as well as appropriate training of staff is therefore critical to provide best standard of care for people living with HIV and TB.

Scale-up harm reduction programmes that include opioid substitution therapy

The provision of prevention, treatment and care services for people who inject drugs remains extremely low in Eastern European and central Asian countries: a recent systematic review shows that only 10% of people who inject drugs have access to needle and syringes programmes, that only 1 per 100 people who inject drugs receives opioid substitution therapy and only 1 per 100 people living with HIV and who inject drugs accesses antiretroviral therapy. Contrary to the belief of many health care workers, the adherence of people who use drugs to TB treatment and

Drug treatment/harm reduction programmes: challenges and opportunities, the Ukraine experience

Since 2006, the All-Ukrainian Network of people living with HIV provides integrated care for injecting drug users, including opioid substitution therapy, within the TB and HIV/AIDS programmes as well as within the general health care system. The Ukrainian NGO presented several challenges in implementing integrated model of care:

- **Legal and administrative licenses are a barrier to universal access to integrated care for people who use drugs. TB, HIV and harm reduction services still work "in silos" and TB treatment provided on a hospitalization basis deprives people who inject drugs of opioid substitution therapy. The NGO worked to ensure registration of TB facilities as methadone centres for continuation of substitution therapy while on TB drugs. However, integrated and holistic services will only be possible if hospitalization of TB treatment is abandoned and TB treatment be provided on an outpatient basis throughout.**
- **Death from TB among HIV positive staff working in the NGO sector has been identified as a major issue of concern. Strict rules were introduced to prevent HIV-positive community workers to be on the front line with the clients. Masks are recommended and provided, but are regarded by care workers as a barrier to developing relationships with clients. This calls for a better definition of infection control measures in these types of settings and service provision.**

antiretroviral therapy² can be as good as in non-drug users. A recent meta-analysis shows that rates of loss to follow-up and virological failure on antiretroviral therapy were similar in people who inject drugs and in people who do not³. There is no reason that this should not apply to TB treatment. As mentioned by one meeting participant: "if there is one thing that people who use drugs are good at, that is taking drugs!"

Nationwide scale-up of opioid substitution therapy (OST) is still far away in the region. Four of the high TB burden countries (Armenia, Russian Federation, Turkmenistan and Uzbekistan) have not yet made OST available and in all other countries OST is provided through pilot-sized programmes with few people enrolled. Even Ukraine, with

the highest number of people on OST in the region (5.000), is far from providing the recommended 40% coverage⁴ in a country of estimated hundreds of thousands of people who inject drugs. Furthermore, these programmes are usually provided by non-governmental organizations and externally funded.

Provision of integrated services for TB, HIV and harm reduction is feasible in prison settings

Prisoners and people living in places of detention are exposed to some of the highest risk for TB and HIV co-infection. Multi-drug resistant TB is also more common in prisons settings.

² Mathers et al; HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage; Lancet 2010; 375:1014-28.

³ Werb et al; Risk of resistance to highly active antiretroviral therapy among HIV-positive injecting drug users: a meta-analysis; Lancet Infectious Diseases 2010; 10:464-9.

⁴ WHO, UNODC, UNAIDS; Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users; 2009, World Health Organization; Geneva, Switzerland,

In the Republic of Moldova, TB/HIV services and harm reduction interventions including early TB case detection, directly observed TB treatment, voluntary counselling and testing, antiretroviral therapy, needles and syringes programmes, and psychosocial support are provided by a non-governmental organization with support of national authorities. However, challenges remain such as absence of rapid test to diagnose TB, low implementation of isoniazid preventive therapy, absence of opioid substitution therapy, and high rates of loss to follow-up after release from prison which is seen as a major contributor to poor treatment outcomes in many countries in Eastern Europe. The removal of passports as a result of imprisonment and the absence of a registered residency address

upon release mean that ex-prisoners face difficulties to register for and continue TB or HIV treatment or any other medical services. In the Republic of Moldova, psycho-social support, incentives and DOTS supporter to encourage ex-prisoners to maintain a link with the health system on release are potential ways to reduce default from treatment and loss to follow up. Prisoners should obtain care equivalent to that provided to the civilian population, and care should be continuous on transfer in and out of places of detention.

Monitoring and evaluation is crucially needed

Meeting participants also discussed the need to coordinate the monitoring and evaluation of TB and HIV to improve follow-up of patients

in care. In the Russian Federation, an integrated and linked monitoring system is in place tracking people living with HIV in care presenting to the various branches of the civil health system. However, the penitentiary system is separate and reconciliation between the two systems happens once every quarter. The separate monitoring system was highlighted as a bottleneck to care. In addition, the use of harmonized and internationally agreed TB/HIV indicators⁵ and standardized recording and reporting formats is crucial to assess progress in nationwide implementation of TB/HIV collaborative activities. Both TB and HIV/AIDS programmes should report the numbers of patients in care being treated for both TB and HIV. Data cross-checking is also important to validate data coming from the TB and HIV care registers.



Picture: Dmytro Sherembey

I was diagnosed with TB, HIV and hepatitis immediately after my release from prison. I was told that I had no chance of survival. Fortunately I survived. I received education, got married, and I have two wonderful children, hundreds of friends and a nice job. But the most terrible thing is that I am an exception.

Dmytro Sherembey

Country experiences

Beyond the plenary presentations, country experiences in implementing collaborative TB/HIV activities were shared in an interactive forum with poster displays and discussions. Presentations were made by Armenia, Azerbaijan, Belarus, Estonia, Georgia, Netherlands, Republic of Moldova and the former Yugoslav Republic of Macedonia. They included activities run by ministries of health, academic institutions, partner organizations, technical agencies and non-governmental organizations. Country-level implementation is happening but still falls short of national coverage of all the 12 collaborative TB/HIV activities⁶. There are no longer valid excuses for countries not to plan nationwide scale-up collaborative TB/HIV activities, particularly when clear policy recommendations exist since 2004.

⁵ A guide to monitoring and evaluation for collaborative TB/HIV activities, Stop TB Department and Department of HIV/AIDS World Health Organization, United States President's Emergency plan for AIDS Relief, The Joint United Nations Programme on HIV/AIDS, 2009, WHO/HTM/TB/2009.414

⁶ Interim Policy on Collaborative TB/HIV activities, Stop TB Department and Department of HIV/AIDS World Health Organization, 2004, WHO/HTM/TB2004.33010:464-9.

Armenia

With support and information, key stakeholders can commit to address TB/HIV issues in a collaborative way. To move this commitment into action, several steps are still needed: continuous involvement of TB/HIV advocates including communities most affected by TB and HIV in collaborative activities, scaling-up provider-initiated HIV testing for TB patients, improvement of the national monitoring and evaluation system to include TB/HIV indicators and the development of appropriate recording and reporting formats.

Azerbaijan

Government support is key to the implementation of collaborative TB/HIV activities. Management of HIV-infected TB patients by TB doctors was authorized by the Ministry of Health and several trainings were conducted for medical doctors and primary health care service providers. Challenges remain such as the lack of an appropriate monitoring and evaluation system, shortage of qualified health care workers and drugs, and poor awareness among patients and health care workers.

Belarus

More than half (55%) of HIV patients died of TB in 2009 compared to 17% in 2002 while the incidence of HIV-associated TB has increased by 7.5 fold from 2002 to 2009. The following groups have been identified as particularly at risk of both TB and HIV: people who inject drugs, alcoholics, former prisoners, and the unemployed. Knowing the country epidemic is important to implement appropriate interventions and reduce the burden of both TB and HIV.

Estonia

Collaborative TB/HIV activities are being implemented such as HIV testing of TB patients and TB screening among people living with HIV, co-treatment with anti-TB drugs, antiretroviral therapy and opioid substitution therapy if indicated, information to patients and training of medical doctors. These resulted in earlier detection of both TB disease and HIV infection, decreased default rate among HIV-infected TB patients and increased TB awareness among people living with HIV.

Georgia

The prevalence of active TB disease among people living with HIV is as high as 22% while latent TB infection was detected in up to 32.6% of patients. Prevalence of HIV among TB patients ranges from 1.7 to 2.2%.

A national TB/HIV strategic plan 2007-2011 has been developed and a TB/HIV working group has been established to ensure the effective implementation of collaborative activities such as TB screening, including TST and interferon gamma assays to detect latent TB infection, among people living with HIV, HIV testing for TB patients and universal and free access to both TB and HIV treatment.

Netherlands

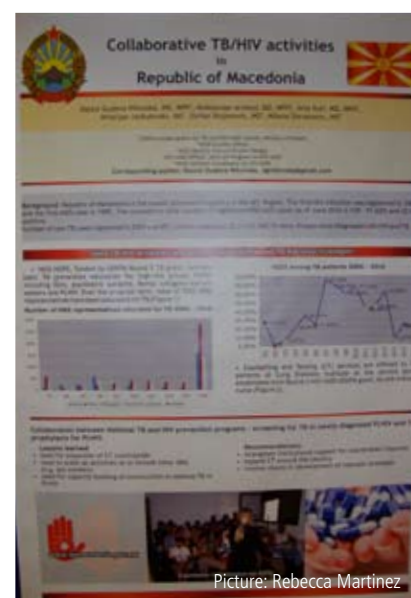
Computer-based training on TB diagnosis and care for HIV/AIDS health care workers has been developed by Health[e]Foundation and piloted in Uganda. The learning format includes a 3-month computer based self study on or offline and a 3-day onsite workshop. TB[e] Education provides an opportunity to large groups of health care workers to study at their own pace on a wide range of TB-related topics. The programme will be further rolled-out in other parts of the world.

Republic of Moldova

Sperenta Terrei, a community-based organization in Balti where TB and HIV rates are higher than the national average, provides personalized TB treatment support to vulnerable patients. Defaulter rates are low where Sperenta Terrei operates: 4% whereas the national TB default rate is 11%. Treatment support from the community and practitioners is essential to treatment completion.

The former Yugoslav Republic of Macedonia

Despite a low burden of TB and HIV, joint TB/HIV activities are being implemented in the country. Information, education and communication on TB is provided to high risk groups, including people living with HIV by non-governmental organizations, HIV testing is offered to TB patients but which still needs to be scaled-up, and people living with HIV are screened for TB and given TB prophylaxis when indicated.



Countries shared experience in scaling-up collaborative TB/HIV activities



Picture: Alex Miranda

"Let's face reality: tuberculosis remains the leading cause of death among people living with HIV"
Dr Sampaio said at the special plenary session on TB/HIV at the AIDS conference

Drug-resistant TB and HIV: the overlapping epidemics

In 2008, there were 440,000 cases of multi-drug resistant (MDR) TB cases worldwide and 150,000 deaths estimated to be due to MDR-TB. The WHO European region has the highest levels of drug-resistant TB in the world, with 1 in 4 new TB patients in some areas of Eastern Europe having MDR-TB. By March 2010, 24 countries⁷ of the region had reported at least one case of extensively drug resistance TB. To date, it has not been possible to show an association between HIV and MDR-TB at population level. However, new HIV infections are also on the rise in those countries with higher proportions of multi-resistant TB cases. Based on current data, HIV-infected TB patients in Estonia, Latvia and the Republic of Moldova appear to be more at risk of harbouring MDR-TB strains⁸.

Programme management of drug-resistant TB: urgent nationwide scale-up needed

Only a small proportion of MDR-TB cases are currently treated: about 10,000 MDR-TB patients worldwide were enrolled under the Green Light Committee (GLC) standards in 2009. To address the weak national and international responses to drug-resistant TB, a workshop was held in March 2010 in Geneva. Main barriers to MDR-TB scale-up were identified such as diagnostic capacity, drug procurement, insufficient human resources, and poor coordination of global players. Consensus was reached on the need to scale-up nationwide MDR-TB diagnostics and treatment and to include MDR-TB as part of regular TB control programme. Increased political commitment, country ownership, accountability, and harmonized monitoring and evaluation of patients wherever they are treated or not under GLC programme are crucially needed.

Examples of MDR-TB diagnostic and management were presented. In Latvia, routine TB care include sputum culture and drug susceptibility testing on solid media for all TB suspects while liquid media and line probe assays are used for groups at high risk of drug-resistant TB, including people living with HIV, in order to speed up the diagnosis. Regarding management, the challenge is to abandon the hospitalization of TB patients and to implement new models of patient care including home based treatment for both drug susceptible and drug resistant TB. The "Expand TB" project (EXPanding Access to New Diagnostic for TB) to assist selected countries with the introduction of the newly WHO endorsed TB diagnostic technologies (automated liquid culture and drug susceptibility testing, rapid immunoassay for MTB speciation and line probe assays) was also presented. It involves several international partners such as FIND, the Global Drug Facility, UNAIDS, and the Global Laboratory Initiative. Eight countries in Eastern Europe and Central Asia, namely

⁷ Armenia, Azerbaijan, Belgium, Czech Republic, Estonia, France, Georgia, Germany, Ireland, Italy, Latvia, Lithuania, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Slovenia, Spain, Sweden, Tajikistan, Ukraine.

⁸ Multidrug and extensively drug-resistant TB (M/XDR-TB), 2010 Global report on surveillance and response, World Health Organization, WHO/HTM/TB/2010.3

Belarus, the Republic of Moldova, Azerbaijan, Uzbekistan, Kyrgyzstan, Kazakhstan and Tajikistan, have been targeted to benefit from the project. Countries are in various phases of implementation with some, like Uzbekistan, having already started to use new TB diagnostics on a routine basis.

Infection Control: best practices need to be scaled-up

In this context of high drug resistance, sound implementation of infection control measures is critical. In Ukraine, where MDR-TB prevalence among new and re-treatment cases reaches 16% and 45% respectively, a pilot project on infection control, supported by WHO and other partners, was started in 2006 in Donetsk oblast. The project included the creation of four MDR-TB wards, the renovation of five laboratories, training of health care workers, and involvement of local partners such as the sanitary-epidemiological services for routine monitoring and evaluation. In order to implement infection control measures at scale, national authorities were sensitized on infection control issues and orders or "prikaz" were developed and approved: the national policy on infection control is now in its final phase of elaboration.

The pilot experience also has several challenges:

- ▶ **A lack of managerial capacity, financial resources and coordination among different players;**
- ▶ **Unnecessary prolonged hospitalization of TB patients with the risk to mix drug-resistant TB patients with people living with HIV in the majority of TB hospitals;**
- ▶ **A lack of implementation of infection control measures in HIV health facilities;**
- ▶ **Insufficient information, education and communication on infection control among health care workers: the majority still believe that one can not be protected from infection if working in TB health facilities;**
- ▶ **Weak advocacy, communication and social mobilization due to poor involvement of civil society in TB issues in general;**
- ▶ **A need to develop checklists in line with international guidelines to facilitate routine monitoring and evaluation of infection control activities at facility level.**

Isoniazid preventive therapy in high drug resistance settings: it works.

Only 9% of people living with HIV without active TB in the region were receiving isoniazid preventive therapy (IPT) in 2008 despite overwhelming evidence that IPT reduces the risk of active TB. The evidence that shows that most people will benefit from IPT with a background of high isoniazid mono-resistance was presented and discussed. There is no evidence about threshold prevalence of isoniazid resistance at which IPT risks exceed benefits. IPT does not promote isoniazid resistance when used to treat latent TB infection. Screening people living with HIV for TB is a corner stone activity for scaling up IPT. It benefits those with active TB by earlier TB treatment initiation and decreases exposure of clinic attendees and health care workers to infectious TB cases. The meeting participants called upon the expedited implementation of the WHO Intensified Case Finding and Isoniazid preventive Therapy guidelines, which is based on four symptoms screening algorithm that can reliably allow clinicians to screen people to determine whether they are eligible for IPT or need further evaluation for diagnosing TB.



TB and HIV in people who use drugs: the

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