

TB control in HIV/AIDS environment

Purpose

This presentation addresses the crucial role the STOP TB Coordinating Board should take to mobilize the forces and resources to trigger action for TB control in HIV/AIDS environment.

Background

Over the last two decades, the global trend of TB case notifications is static. However, the trend in Former Soviet Union countries and in sub-Saharan African countries (SSA) in particular shows a steep increase in TB case notification rate. In SSA this increase is clearly due to HIV.

Among the first 14 countries (South Africa, Ethiopia, Nigeria, Kenya, India, Zimbabwe, Tanzania, DR Congo, Mozambique, Zambia, Uganda, Malawi, Cote d'Ivoire and Cameroon) ranked by number of TB cases attributable to HIV, 13 countries are in SSA.

In the 13 SSA countries with the highest burden of TB/HIV, **case detection** rate is about 45% with a **cure rate** of 73%, even in countries with well organised national TB programmes. These figures are well below the global WHO target of 70% case detection rate and 85% cure rate. However in SSA countries, even if the global TB targets were met, the annual incidence of TB would still be on the rise because of the HIV epidemic. Further, in Kenya, projections of the TB burden show that even with a stable HIV epidemic the number of TB cases will continue to increase for a further 6 years.

In conclusion, TB control will not make much headway in HIV prevalent settings unless HIV control is also achieved. The WHO-“Strategic Framework to Decrease the Burden of TB/HIV” lays out the available interventions to tackle TB/HIV and provides the technical basis for the development of national implementation strategy of collaborative TB and HIV activities. The “Guidelines for Implementing Collaborative TB and HIV Programme Activities” are designed to implement the interventions as described in the framework. Further, a policy paper to indicate to countries which interventions to take up according to the level of the TB/HIV epidemic, is now underway.

A meaningful response to TB control in high HIV prevalent settings includes not only full implementation of the DOTS strategy (\$ 31 M/yr), but also TB and HIV programme co-ordination (\$ 54M/yr) and a minimum TB/HIV package (\$ 30 M/yr) of :

- VCT for TB patients
- additional care & support for TB patients with HIV
- intensified case finding
- INH preventive treatment

The collaboration between the HIV/AIDS and TB programmes will also contribute to the development of models to deliver HAART (not costed)

This presentation concludes that improving DOTS is not sufficient to meet the TB targets in HIV/AIDS environment. In fact, meeting the targets will, without HIV/AIDS control, not cause TB to fall. TB will fall only through country-wide TB & HIV/AIDS collaborative health delivery.

Recommendations:

The STBCB is uniquely poised to mobilize the forces to:

- Advocate broadly, as well as in a targeted way, the urgency for collaborative TB/HIV actions at all levels to counter the dual epidemic.
- Contact UNAIDS (Piot) and WHO (Lee), and ask to promote structurally, and effectively TB \leftrightarrow HIV/AIDS collaboration.
- Make TB/HIV collaboration a priority message during visits to HBC facing a high and/or rapidly rising TB/HIV burden.