

FOLLOW-UP TO THE THEMATIC SEGMENT FROM THE 42ND PROGRAMME COORDINATING BOARD MEETING

Additional documents for this item:

UNAIDS/PCB (42)/18.15; UNAIDS/PCB (42)/18.16; UNAIDS/PCB (42)/CRP3

Action required at this meeting: The Programme Coordinating Board is invited to:

51. Take note of the background note ([UNAIDS/PCB \(42\)/18.16](#)), the summary report of the Programme Coordinating Board thematic segment on *Ending tuberculosis and AIDS—a joint response in the era of the Sustainable Development Goals*, and the 2018 *Political Declaration of the high-level meeting of the General Assembly on the fight against tuberculosis (A/73/L.4)*.
52. Call on Member States to:
 - a. Establish ambitious national coverage and mortality reduction targets that are reflected in acceleration plans to achieve the 2020 target of a 75% reduction in TB deaths among people living with HIV;
 - b. Better coordinate efforts between TB and HIV and other health and social programmes, and with civil society, to find “the missing millions” living with TB;
 - c. Increase access to rapid TB and HIV diagnostics to reduce delays between symptom presentation, diagnosis and treatment and to ensure adequate treatment literacy, adherence support and retention in care;
 - d. Accelerate efforts to initiate all newly diagnosed adults and children living with HIV on antiretroviral treatment and ensure access to either TB treatment or TB preventive treatment;
 - e. Integrate TB prevention and treatment into HIV services (and vice versa) and broader health systems to ensure more efficient, effective and equitable service delivery for all who are in need;
 - f. Develop better coordinated plans to address the common social and structural determinants of HIV and TB, including poverty, inadequate living conditions, stigma and discrimination.
53. Call on Member States and key donors to invest in TB research to develop health technologies, new funding models and new approaches for Fast-Tracking research, as well as innovative approaches and regulatory reforms to ensure access and affordability of TB diagnostics and treatment;
54. Call on the UNAIDS Joint Programme to:
 - a. Provide clear guidance to national stakeholders on how to measure, monitor and reduce the impact of TB and HIV stigma and discrimination in health-care, workplace and community settings;
 - b. Better engage, empower and support communities of people living with, and affected by TB and HIV to be fully involved in the development, decision-making, implementation, monitoring and evaluation of national HIV and TB responses.

Cost implication: none

INTRODUCTION

1. The thematic segment was devoted to the joint response to tuberculosis (TB) and HIV. Presentations and discussions included empirical evidence and analysis of these interlinked epidemics and responses, accounts of successful activities and programmes, and proposed actions for further integration.
2. The PCB chair, Ms Wechsberg introduced the thematic segment by stressing the need for greater cooperation around TB and HIV and for dealing more effectively with the structural drivers of the two diseases. The deadline for reducing TB deaths among people living with HIV by 75% (against a 2010 baseline)¹ was only two years away, she said.
3. The moderator, Vinay Saldanha, Director of the UNAIDS Regional Support Team for eastern Europe and central Asia, outlined the agenda and process of the thematic segment and reminded that the SDG 3.3 target called for ending the AIDS and TB epidemics by 2030.
4. Mona Balani of the National Coalition of People living with HIV in India told the meeting she had been living with HIV since 1999 and then contracted TB. Her husband was also living with HIV and TB disease and has since died. Her son also has TB. She recounted experiences of people living with TB and/or HIV, including the stigma and discrimination they face.
5. Improved technologies are making TB diagnoses more accurate. However, it is necessary to repeatedly screen people living with HIV for TB. Adherence to TB treatment has to be better supported; each year some 37 000 people living with HIV drop out of TB treatment. Ms Balani appealed for increased investment in community organizations (which are key to treatment programmes) and for improved drug supply management systems.
6. Dan Namarika, Secretary for Health, Malawi, described the HIV and TB epidemics in his county, where an estimated 29 000 people developed TB in 2016, 15 000 of whom were also living with HIV. Health is a central pillar in Malawi's new Growth and Development Strategy, and HIV and TB are included in Malawi's essential health package. The TB and HIV departments present integrated Global Fund grant proposals and jointly collect data, draft plans and develop guidelines.
7. Partnerships have been built with the Africa CDC (focusing on antimicrobial resistance), with neighbouring countries (to tackle TB among mineworkers and perform cross-border disease surveillance), with donors (to build capacity for community involvement) and with the private sector and traditional healers.
8. The public sector provides HIV and TB services at the same facilities, using a "one-stop-shop" approach. District-level TB/HIV coordinators are linked with community-based health surveillance workers who support local people living with HIV and TB on treatment and report pertinent issues to the nearest health facility. Mobile health vans provide TB and HIV services in areas with high TB and HIV prevalence. eHealth tools are also used and community volunteers perform door-to-door screening visits, capture data on mobile phones and transmit the information to health facilities.

¹ This is from a baseline of 509 000 (range 445 000 – 577 000) TB deaths in 2010 to a target of 127 000 by 2020. Current progress amounts to a 41% reduction to 300 000 (range 266 000 –355 000) deaths by 2017. Data are from Global tuberculosis report 2018. Geneva: WHO; 2018.

9. The results of these collaborations are impressive. TB screening coverage among people living with HIV was 98% in 2017, 85% of presumptive TB cases were screened for HIV, community referrals increased and the rate of TB patients who were also living with HIV has fallen from over 70% in 2008 to 49% in 2017. Overall, TB incidence has declined by 40% in the past 4 years and there has been a steady decline in TB mortality. This is likely due to improved access to ART for people living with HIV and improved integrated TB and HIV collaboration to increase early case detection, access to testing and treatment.
10. Michel Sidibé, UNAIDS Executive Director, noted the timeliness of the thematic segment three months ahead of the first UN High-Level Meeting on TB. He recounted evidence showing that people living with HIV are 20–30 times more likely to contract TB and that TB remains the leading cause of hospitalization and deaths among people living with HIV. Yet almost 60% of TB cases among people living with HIV are not diagnosed and treated. Increased access to ART can have a huge impact on TB incidence and mortality.
11. TB and HIV are two sides of the same coin, Mr Sidibé said. Accelerated action is needed on both fronts. He then singled out five priority points:
 - The High-Level Meeting on TB should not be treated as a technical debate; it is a fundamentally political process, as the HIV High-Level Meetings have shown;
 - Integration is crucial. There should be zero tolerance for parallel approaches and this should be a major objective of the High-Level Meeting;
 - Community-based approaches are essential, along with family-based care, and that requires greater investment in community capacities;
 - Solid data and strategic information are vital. Greater investment is needed to fill the remaining data gaps; and
 - Improved and more affordable access to rapid and reliable diagnostic tools must be ensured. The millions of people who are not yet benefiting from current programmes must be reached with the life-saving services that exist.

Overview

12. Tereza Kasaeva, Director of the Global Tuberculosis Programme, WHO, said that although TB and HIV programmes have saved more than six million lives since 2005, neither TB nor HIV incidence is declining quickly enough to achieve the global targets by 2020. Summarizing recent trends, Ms Kasaeva said that both the epidemics and responses differ widely between regions, with 86% of TB deaths among people living with HIV occurring in Africa. Disease surveillance systems are weak in some countries with high burdens of disease.
13. There are significant opportunities to reduce the impact of the interlinked TB and HIV epidemics, including the High-Level Meeting on TB. Key factors for success are deeper integration of the two programmes and close engagement with civil society. Ms Kasaeva also underlined the need for increased investments, including in research and innovation. Only two new TB drugs have been introduced in the past 40 years, she told the meeting.
14. Lucica Ditiu, Executive Director of the Stop TB Partnership, said the next 3–5 years would be crucial for deepening collaboration and engagement. She reminded that the 90–90–90 targets exist for TB as well: 90% people with TB disease and infection should be diagnosed and treated, 90% of key populations should be reached with services, and 90% of TB cases should be successfully treated.

15. Only 6.4 million of the 10.4 million people who developed TB received treatment in 2016, leaving 4 million behind. In addition, only 50% of cases were successfully treated in 2016 and the treatment success rate for drug-resistant TB was a low 12%. Poor diagnostic tools and an overall lack of urgency around TB are the main culprits.
16. The WHO policy on collaborative TB/HIV activities was launched in 2004, but these have not reached the scale and quality needed to achieve the required impact. Of the 10.4 million people who developed TB in 2016, 1.03 million (10%) were estimated to be living with HIV. But only 46% of TB patients living with HIV were diagnosed and notified as HIV-positive TB, and only 39% were put on ART. The global treatment success rate for HIV-positive TB on first-line TB treatment was 78% in 2016. It was highest in the WHO Africa and Western Pacific regions (80% and 78%) and lowest in the Americas (55%) and Eastern Mediterranean (59%).
17. TB preventive therapy reduces the risk of TB disease and death among people living with HIV, including people on ART but it is not being used to full effect: fewer than 1 million people received such therapy in 2016 in the 72 countries reporting the data. Countries have policies to expand preventive therapy but are not implementing them at sufficient scale.
18. Encouraging developments include closer engagement with HIV programmes to promote people-centered approaches and integration, reach key underserved populations, address stigma and discrimination, and reduce human rights and gender-related barriers to services. An "app" for community-based treatment monitoring is being introduced in 14 countries and tools for community-based gender assessments and legal rights monitoring are being rolled out.
19. Ms Ditiu cited Tanzania as an example of practical integration, with vans and other mobile facilities providing multiple health checks and testing in remote areas. In Pakistan, TB/HIV outreach services are successfully identifying people living with TB and HIV, especially in key populations. Successful community-based monitoring is underway in Cambodia and Tajikistan, while community, rights and gender support is being rolled out in countries in Africa and Asia.
20. She noted that the HIV and TB responses also differed in important ways. National AIDS commissions tend to be robust and often report directly to the national executive. TB programmes on the other hand are highly medicalized and technical, and seldom have access to the upper tiers of political power. India and South Africa are trying to move TB higher on the political agenda.
21. HIV programmes have the capacity to offer TB services to all people living with HIV. TB screening and TB preventive coverage must expand. Gender, human rights and other barriers persist, but there are many examples of overcoming them, as well. Civil society and communities must become better at demanding joined-up TB and HIV services.
22. Regarding funding, Ms Ditiu noted that the budget lines for TB and HIV are separate. The Global Fund's integration of funding proposals has not gone far enough, she said, partly because it remains unclear who is responsible and accountable for activities, resources and assets.
23. Technological weaknesses are a further stumbling block. GeneXpert diagnostics machines are not properly decentralized which reduces access. Current TB treatment,

especially for drug-resistant TB, is difficult to adhere to and not effective enough. Second-line treatment (which last two years) has serious side effects, she said, reiterating the fact that only two new TB drugs have been developed in the past 40 years.

24. The world has to seize the important opportunities that exist. They include the TB High-Level Meeting later in 2018 and the "Find.Treat.All" initiative of WHO, the Stop TB Partnership, the Global Fund and other partners to have 40 million on TB treatment by 2022. The tools exist to provide "one-stop-shops" for people needing both TB and HIV services by offering integrated testing, treatment and adherence services.
25. Ms Ditiu ended her presentation by outlining key next steps:
 - Improve demand and uptake of TB prevention and treatment services among people living with HIV;
 - Increase the allocation and use of funds, within HIV budgets, towards TB services for people living with HIV;
 - Jointly address and remove access barriers to ensure the TB/HIV response is equitable, rights-based and people-centered;
 - Change mindsets and empower national and local stakeholders for a joint response; and
 - Strengthen accountability at all levels.
26. During discussion, speakers described some of the experiences and lessons from their countries, including introducing TB/HIV services in some prisons (Russian Federation) and incorporating TB and HIV services in national health insurance schemes (Indonesia).

What is required to achieve the 2016 Political Declaration target to reduce TB deaths among people living with HIV by 75% by 2020?

27. Dimitry Pinevich, First Deputy Minister for Health in Belarus, said his country is making progress against TB but multidrug-resistant TB is a major challenge, along with identifying and diagnosing patients. Increased resources are needed, though greater efficiency is also possible: for example, Belarus is achieving savings through centralized procurement of medicines.
28. Nongovernmental organizations feature centrally in the country's response, including in the allocation of resources, he said. Social protection packages are provided to patients to support treatment adherence, and transport costs to clinics are paid to help retain patients in treatment and care. Various sectors meet on a weekly basis to review and strengthen their collaboration.
29. Evaline Kibuchi, African Regional Director of the Global TB Caucus, described some of the everyday difficulties people face, including stigma. Politicians have major roles to play, she said. The Global Parliamentary TB Caucus was created in 2014 and now includes about 2,000 members of parliament from around the world. In Kenya, Members of Parliament have challenged discriminatory laws and policy directives and are promoting the expansion and integration of TB and HIV services.
30. Ambassador Deborah Birx, US Global AIDS Coordinator and US Special Representative for Global Health Diplomacy, said high TB mortality among people living with HIV reflects the collective failure of HIV programmes. For example, the Spectrum model developed by UNAIDS is an essential tool for the HIV response, with 11 surveys in the field having validated its accuracy. Similar TB surveys, however,

have only just been standardized and are starting to bring in more accurate estimates on TB and HIV-related TB. Better collaboration could improve this further. While the need to integrate HIV into the wider health system is widely recognized, separate TB programme models persists. Ms Birx also questioned the "paternalistic" DOTS model of treatment surveillance used in TB programmes.

31. PEPFAR is screening 50–70% of HIV patients for TB and is developing new indicators and guidelines for preventive TB therapy. It is also developing cascades to pinpoint problems and it is using the integration of HIV into primary health care systems as a basis for integrating TB services.
32. Speakers said the High-Level Meeting is a unique opportunity to re-energize both the TB and HIV responses. They also provided examples of steps taken in countries, including:
 - the provision of integrated HIV/TB services at 200 primary health clinics (Iran, Islamic Republic of) where more than 75% of people diagnosed with HIV have been linked to TB services;
 - the creation of a 35-year action plan for HIV and TB plus increased funding and inclusion of HIV and TB treatments in the medical insurance catalogue (China); and
 - improvement of technical guidance and integrated provision of essential health services free of charge to realize citizens' constitutional right to health (Ecuador).
33. Speakers expressed strong concerns that in many countries TB incidence is highest among the most marginalized communities—e.g. indigenous people in Canada, which has announced a plan to eliminate TB in this community by 2030.
34. Poor progress in diagnosing and treating children living with TB was also highlighted. The majority of children dying of TB are younger than five years. Once a family member is diagnosed with TB it should automatically trigger screening and preventive therapy for the rest of the family, especially children under five and household members living with HIV. TB screening should be routine in the context of child health programmes, including malnutrition services.
35. Speakers called for an accurate and easy-to-use diagnostic test for young children and for a specific target for paediatric diagnosis and treatment for TB. About 1 million of the 10 million new TB cases in 2016 were in children, yet only 3% of research and development funding for TB is focused on paediatric technologies.
36. It was suggested that a narrow focus on a small set of collaborative activities has obscured building broader linkages around political support, design of services and use of community-based approaches in the two responses. TB cases are constantly being missed at HIV clinics. Private health-care providers should be engaged more effectively. Speakers reminded that user fees continue to pose a big barrier.
37. In reply, Ms Ditiu said the global post-2015 TB strategy adopts a people-centred approach and has moved beyond the DOTS approach. Given the high rates of HIV associated TB in Africa, integration efforts should be particularly strong in that region. Despite the constraints, TB programmes have saved 53 million lives since 2000. Improved technologies, stronger political will and greater investments could achieve miracles in the TB response, she said.

How can the TB and HIV communities work together to reduce the impact of the social and structural determinants of disease and impact on the broader SDGs?

38. Professor Charlotte Watts, Chief Scientific Adviser at the Department for International Development, United Kingdom, told the meeting that success against TB requires changing the structural factors that allow the epidemic to thrive. Even the best medicines and diagnostics would not suffice. Historically, countries have made inroads against TB even before effective biomedical tools were introduced—by improving living conditions and combatting poverty. Social welfare is one of the most powerful tools against the epidemic, she said.
39. In a good practice in Lima, Peru, for example, the addition of cash, support and community interventions led to a range of improved outcomes for both HIV and TB (including testing, treatment and preventive therapy access for children) and it addressed some equity issues. In South Africa's Eastern Cape province, a "cash plus care" approach and improved clinic support led to improved HIV treatment adherence and retention and it reduced the risk of TB mortality. Each additional form of social support cumulatively improved outcomes.
40. Professor Watts said that the impact of biomedical interventions is greatest when they are supported by socioeconomic and structural interventions that tackle poverty, poor living and working conditions, pollution etc. HIV and TB programmes should be integrated—and they in turn should be integrated with the other health SDGs, and across the rest of the SDGs.
41. Dmytro Sherembei, Head of the Coordination Council of the All Ukrainian Network of People living with HIV, shared his experiences as a person living with HIV, TB and hepatitis C infection. He was alive, he said, because he had access to testing and treatment services, but millions of people never make it onto the "bridge of life" he has managed to cross. He insisted that sufficient resources exist to expand treatment to all. Despite its many challenges, Ukraine had chosen to provide the necessary resources and other countries should do the same, he said.
42. Lynette Mabote, Regional Programmes Lead at the AIDS Rights Alliance for Southern Africa, told the meeting that HIV and TB services still involve expenses for individuals (e.g. transport, loss of wages, service fees etc.) Countries have weak health systems and disjointed programmes that stem from the debts and loans they are saddled with. She called for more homegrown solutions, saying countries of the global South cannot rely totally on donors and outside support. She congratulated the South African Ministry of Health for tabling two health insurance bills which could help equalize access to health services in that country.
43. A representative from the Global Fund said it had decided in 2013 that countries with a high TB/HIV burden would develop single funding requests. More than 40 countries have done so. In some, this prompted the two departments to cooperate for the first time. Increased funding for HIV/TB has also helped strengthen community health systems. However, the initial momentum was not sustained everywhere. The Global Fund is now using catalytic funding to enhance the diagnosis of people living with TB and/or HIV and to address gender and human rights barriers.
44. Speakers agreed that integration should be pursued across three dimensions: HIV and TB, SDG3 and all the SDGs. Integration requires strong, visionary leadership and governance, including in the religious and private sectors, along with the meaningful participation of communities. Calls for upgrading the TB response must reach

politicians and should penetrate beyond health ministries. Financing is key. Domestic and innovative financing is important, but international financing remains necessary.

45. Several contributions focused on the realities of indigenous peoples and urged that the highest standard of health be assured for indigenous peoples everywhere. Human rights and the law have not received enough attention in the global TB response, even though the epidemic is tied in with the discrimination and inequalities that shape the world. Professor Watts reiterated that TB is essentially a disease of poverty and marginalization. The response therefore must also be political, social and economic. That requires strong, compelling messages and advocacy that can gain political buy-in from powerful ministries (including the finance ministry).

Conclusion, way forward and closure

46. Eric Goosby, the UN Special Envoy on Tuberculosis, reminded the meeting that treatment exists that is 87% effective for drug-sensitive TB within 6 months of treatment. The world also has procurement and delivery systems capable of bringing those drugs to the people who need them. What is lacking are adequate resources, ensuring they are used as effectively as possible, and monitoring the outcomes. Also needed is more research and development, including for diagnostics to identify TB cases among children. He added that essential services are still not entirely free; the epidemic response must compensate for that fact.
47. Greater investment in communities is vital, as is a more holistic and integrated appreciation of people's health-related needs and the health system's response to those needs. The High-Level Meeting is a big opportunity to validate the unfinished work around TB and it should be used to "pivot" to the upcoming global engagements around noncommunicable diseases and on Universal Health Coverage.
48. Chieko Ikeda, Senior Assistant Minister for Global Health, Japan, said that tackling TB is a political choice. TB had been the leading cause of death in Japan in the 1950s, when the country was in relatively early stages of economic development. Leaders took the political decision to allocate substantial resources for TB control, a decision that became the starting point for Universal Health Coverage in Japan.
49. Tim Martineau, a.i. Deputy Executive Director for Programmes at UNAIDS, said the Joint Programme was working hard to help achieve a strong High-Level Meeting Political Declaration and was supporting the event at country and international levels. He urged stakeholders to be ready for immediate follow up actions after the Meeting. He closed the thematic segment by stressing that the Joint Programme has a key role to play in promoting and supporting an effective integration process. It would continue to track and examine the social and structural barriers and determinants, including user fees.
50. It was agreed that the PCB Chair, Ms Wechsberg, would send a letter containing key messages and recommendations from the thematic discussion to the coordinators of the UN General Assembly High-Level meeting on Tuberculosis.

Proposed Decision Points

The Programme Coordinating Board is invited to:

51. Take note of the background note (UNAIDS/PCB (42)/18.16), the summary report of the Programme Coordinating Board thematic segment on *Ending tuberculosis and AIDS—a joint response in the era of the Sustainable Development Goals*, and the 2018 *Political Declaration of the high-level meeting of the General Assembly on the fight against tuberculosis (A/73/L.4)*.
52. Call on Member States to:
 - a. Establish ambitious national coverage and mortality reduction targets that are reflected in acceleration plans to achieve the 2020 target of a 75% reduction in TB deaths among people living with HIV;
 - b. Better coordinate efforts between TB and HIV and other health and social programmes and with civil society to find “the missing millions” living with TB;
 - c. Increase access to rapid TB and HIV diagnostics to reduce time between symptom presentation, diagnosis and treatment and to ensure adequate treatment literacy, adherence support and retention in care;
 - d. Accelerate efforts to initiate all newly diagnosed adults and children living with HIV on ART and ensure access to either TB treatment or TB preventive treatment;
 - e. Integrate TB prevention and treatment into HIV services (and vice versa) and broader health systems to ensure more efficient, effective and equitable service delivery for all who are in need;
 - f. Develop better coordinated plans to address the common social and structural determinants of HIV and TB, including poverty, inadequate living conditions, stigma and discrimination.
53. Call on Member States and key donors to invest in TB research to develop health technologies, new funding models and new approaches for Fast-Tracking research, as well as innovative approaches and regulatory reforms to ensure access and affordability of TB diagnostics and treatment;
54. Call on the UNAIDS Joint Programme to:
 - a. Provide clear guidance to national stakeholders on how to measure, monitor and reduce the impact of TB and HIV stigma and discrimination in healthcare, workplace and community settings;
 - b. Better engage, empower and support communities of people living with, and affected by TB and HIV to be fully involved in the development, decision-making, implementation, monitoring and evaluation of national HIV and TB responses.

[End of document]