



8 March 2005

Peter Piot
Executive Director
Joint UN Program on HIV/AIDS
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Dear Dr. Piot:

For several years, civil society organizations and advocates have been lobbying to ensure that decision-makers focus greater attention and effort on the critical role of TB programs in the delivery of HIV/AIDS prevention, control, treatment and care. TB is among the most common causes of illness and death among people living with HIV. Today 70% of TB patients are HIV-positive in some high HIV prevalence settings. Without prompt diagnosis and treatment for TB, early mortality among HIV-co-infected TB patients is unacceptably high – in some cases as high as 30% in the first two months of TB treatment. High rates of TB/HIV co-infection are seen wherever the HIV epidemic is expanding, most notably in 41 countries in sub-Saharan Africa, but also in Central Asia, China, Eastern Europe, India, the Russian Federation, and Southeast Asia. To combat the rapid rise of co-infection, WHO's Stop TB Partnership TB/HIV Working Group has set out a policy to ensure that TB and HIV activities are jointly planned and coordinated. The three overarching elements in this policy are:

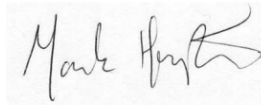
1. Establish mechanisms for collaboration between TB and HIV/AIDS programs;
2. Decrease the burden of tuberculosis in people living with HIV/AIDS; and
3. Decrease the burden of HIV in tuberculosis patients.

The policy can be found at: http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330.pdf
The WHO '3 x 5 report' of December 2004 shows how implementation of the TB/HIV collaborative program activities can improve survival and quality of life for HIV infected persons with active TB. For example, Cameroon is using 140 tuberculosis screening centers to assess eligibility for ARV treatment. Malawi is using lessons learnt from the DOTS strategy to accelerate access to ARV therapy by developing standard definitions of who is eligible for ARV treatment, developing simple treatment regimens, establishing reliable drug supplies, recruiting treatment supporters to ensure adherence, and establishing standardized recording and quarterly reporting systems. Consequently Malawi is maximizing uptake and adherence to ARV therapy while minimizing drug resistance. The 3 x 5 reports states that in Malawi, "Collaboration between TB clinics and HIV counseling and testing clinics has led to more than 70% of people

being treated for TB accepting the offer of HIV testing... By January 2005, all 44 hospitals in Malawi's 28 districts provided routine HIV counseling and testing for people being treated for TB. As of December 2004, 23 of 59 earmarked sites in the public sector are providing ARV therapy and more than 9000 people are receiving ARV therapy."

Please ensure that tomorrow's high-level meeting on "Making the Money Work" incorporates the objectives of establishing the mechanisms for collaboration between tuberculosis and HIV/AIDS programs under the "three ones" element – One coordinating authority. Please highlight the critical role of TB programs in high-burden countries when planning HIV/AIDS-related prevention, detection, treatment and care, and help place this issue higher on the HIV/AIDS policy and funding agenda. As you know, without collaboration among key partners, program effectiveness is compromised and lives are squandered needlessly. I call upon you to embody the vision of the three ones by ensuring that collaborative TB/HIV activities are incorporated into "One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners."

With best regards,

A handwritten signature in black ink, appearing to read "Mark Harrington". The signature is written in a cursive, flowing style.

Mark Harrington
Executive Director
Treatment Action Group

cc: Cate Hankins, UNAIDS
Jim Kim, WHO
Mario Raviglione, WHO