10.2.3 TB/HIV Working Group: summary strategic plan, 2006–15

The creation of the Stop TB Partnership's TB/HIV Working Group in 2000 initiated a more collaborative approach to the prevention and care of HIV-related TB, which builds on existing DOTS programmes and comprehensive HIV/AIDS prevention and care.

Strategic vision: 2006–2015

The strategic vision of the TB/HIV Working Group for 2006–2015 is to reduce the global burden of HIV-related TB through effective collaboration between TB and HIV programmes and communities, and evidence-based collaborative TB/HIV activities, to achieve the global targets for 2015, including the MDG and Stop TB Partnership targets for TB and HIV. The vision is rooted in the new WHO Stop TB Strategy.

The **mission** of the TB/HIV Working Group is to develop an effective, evidence-based policy to reduce the impact of HIV-related TB and to promote, monitor and evaluate the global implementation and impact of this policy.

The Working Group's **goal** is to understand and address the epidemic of HIV-related TB by:

- promoting and supporting research to establish a comprehensive evidence-based global policy on collaborative TB/HIV activities;
- building effective collaboration between TB and HIV/AIDS programmes and communities and engaging all health providers in implementing TB/HIV activities in countries and communities with a high burden of HIV-related TB.

TB/HIV activities are not a substitute for well-functioning DOTS-based TB programmes and comprehensive HIV/AIDS prevention and care programmes. Instead they aim to build on existing programmes, exploiting the synergies and commonalities between them to deliver comprehensive, high-quality, accessible, patient-centred prevention, care and support services to people affected by TB and HIV – two diseases that often occur in the same community or the same patient.

Objectives

Guidelines have been developed for TB/HIV collaboration,[42] building on DOTS TB programmes and HIV/AIDS programmes to provide comprehensive TB and HIV prevention, care and support services to reduce the impact of HIV-related TB. While the TB/HIV policy still needs to be refined and some gaps remain to be filled (e.g. TB/HIV services for injecting drug users), the priority is now to deliver, monitor and maintain these standards in the context of the overall Stop TB Strategy and the goal of universal access to HIV treatment and care by 2010 endorsed by the G8 in 2005.

Urgent implementation of the TB/HIV policy in all settings with a high HIV burden is at the core of the TB/HIV strategic plan for 2006–2015, together with expansion of the evidence base through country experience and new research, in order to refine and adapt the policy and address the needs of at-risk populations. The plan considers what is needed to overcome general health service constraints to the adoption of new policy and the provision of universal access to TB/HIV services. The declaration, by the WHO Regional Committee for Africa, of TB as an emergency in Africa and the severity of the TB/HIV epidemic in Africa merit urgent attention. The plan also reflects the Blueprint for Africa 2006–2007, a more detailed, intensified, short-term action plan developed to accelerate progress in the Region.

The TB/HIV Working Group strategic plan sets out the activities that need to be undertaken by the Working Group and its partners over the next 10 years to achieve the 2015 targets, under four objectives.

Objective 1: Scale up and expand collaborative TB/HIV activities

1.1 Scale up implementation of the TB/HIV policy.[43]
Ambitious rates of scale-up of TB/HIV activities are needed to achieve universal access to HIV treatment and care by 2010, and to reach Partnership targets for 2015, linked to the MDGs. TB control will need to be fully coordinated with the HIV community and general health services. In most settings, TB treatment services are decentralized to the health facility level, whereas few countries have as yet decentralized ART to health facility level, making this an urgent priority. The TB/HIV Working Group must foster decentralization of comprehensive HIV care to facility level. Where possible, TB/HIV services should be delivered at community level to increase accessibility.

1.2 Expand the scope of existing global policy to increase accessibility and acceptability of collaborative TB/HIV activities.
The TB/HIV policy will be finalized and refined using country experience and new evidence. It will be adapted to ensure that TB/HIV services are appropriate, accessible, acceptable and affordable to populations not specifically covered in existing policy, including women, children, mobile or remote populations, the poor, intravenous drug users and prisoners. Collaboration will need to be expanded to include other services, e.g. maternal and child health, harm reduction, and prison services, in order to respond to the needs of these populations, and increase TB and HIV case-finding through targeted screening and contact tracing. Tools to identify, measure and reduce stigma should be developed.

1.3 Address immediate gaps and bottlenecks in the implementation of TB/HIV services.
Policies and guidelines on antiretroviral treatment of HIV-infected people with TB are urgently required. Diagnostic algorithms are needed for more rapid identification of people with smear-negative or extrapulmonary TB, which are more common in those with HIV. Generic training materials (see objective 4.3 below) should be made available for countries and technical assistance should be available, if needed, to help countries translate policy guidance into specific implementation plans.

1.4 Improve quality improvement through surveillance, monitoring and evaluation
The Working Group should take the lead in global coordination of collaborative TB/HIV activities and in demonstrating the impact of TB/HIV activities. This will require effective monitoring and evaluation systems to provide reliable and regular information on the progress and impact of national level TB/HIV activities. This information must feed into TB and HIV planning cycles at all levels, turning results into best practices, improvement in programme quality, and strong advocacy messages to support investment in TB/HIV activities. Monitoring and evaluation should demonstrate whether services are accessible and responding to the needs of the poor, women and marginalized groups.

Objective 2: Develop and coordinate implementation of research to improve the prevention, early diagnosis and rapid treatment of TB in PLWHA and incorporate results into global policy.
2.1 Continually refine the prioritized research agenda for collaborative TB/HIV activities and support operational research on TB/HIV at country level.
There is an urgent need for more TB/HIV research to strengthen the evidence base for prevention, diagnosis and management of TB/HIV. The Working Group will play a key role in pursuing the global TB/HIV research agenda. This will require close collaboration with TB and HIV policy-makers, affected communities and researchers, to direct the research agenda and mobilize the necessary resources. The agenda must cover basic science research, research into new tools (in collaboration with the new tools working groups of the Partnership), and operational research. Innovative ways of coordinating delivery of TB/HIV services need to be explored, e.g. "one-stop shops" for both TB and HIV services, and integration of service delivery at district level.

2.2 Translate research findings into global policy and practice.
One of the most important roles of the Working Group will be to manage the process of disseminating research findings and translating them into global policy and practice. A continuous cycle, in which policy-makers and policy-users inform research priorities, and research informs policy, must be maintained. Close collaboration with the Partnership's new tools working groups will be necessary to facilitate testing of new drugs, diagnostics and vaccines as they become available and ensure their rapid application.

Objective 3: Increase political and resource commitment to collaborative TB/HIV activities.
3.1 Mobilize technical, financial, and human resources
National policy-makers, health professionals and affected communities, including PLWHA, need to be encouraged to take the lead in TB/HIV activities, to define country priorities and allocate available national financial resources for comprehensive TB and HIV prevention and care, supplemented as necessary by external funds. The TB/HIV Working Group will work with the other working groups to help countries to mobilize additional resources for TB/HIV control from bilateral and multilateral donors, as well as nongovernmental organizations, and other international and philanthropic funding initiatives. Donors must be encouraged to allow TB- or HIV-specific funding to be used for TB/HIV activities.

3.2 Advocacy and communication
International advocacy and communication efforts need to be directed at placing TB and TB/HIV near the top of the health and development agendas, alongside HIV/AIDS. Grassroots TB and HIV activists can work together to considerably enhance impact. Messages should be sustained, directed and tailored to specific audiences. This community mobilization approach needs to be adapted to increase political commitment to TB/HIV activities. These objectives will be implemented in collaboration with the ACSM Working Group.

Objective 4: Contribute to strengthening health systems to deliver collaborative TB/HIV activities.
4.1 Strengthen DOTS-based TB control and comprehensive HIV/AIDS prevention, care and support.
Diagnosis and treatment of TB under DOTS and HIV prevention are the most effective interventions to reduce the impact of HIV-related TB. The TB community needs to work more closely with the HIV community to advocate at community, district, and country level, as well as internationally, for comprehensive TB and HIV prevention, care and support. The WHO Department of HIV/AIDS and UNAIDS are planning for universal access to HIV/AIDS prevention, care and treatment by 2010, and the TB community must become a major partner in this ambitious plan.

4.2 Develop a multisectoral approach to collaborative TB/HIV activities with strong programme planning, management and sustainable financing.
Many of the broader determinants influencing TB and HIV are outside the direct influence of the health sector, but could be effectively addressed through a collaborative approach. The multisectoral approach to HIV/AIDS prevention and care, adopted by UNAIDS and UNICEF, should be adapted to include TB and TB/HIV on the agendas of the major sectors that have an influence on health, e.g. economy, education, employment, and justice. Ministries of health should work with other line ministries (e.g. defence, prisons, and police), national NGO networks and professional associations to promote their engagement in policy formulation, planning and implementation of national TB control activities.

4.3 Human resource capacity development.
Of all the health system constraints limiting TB and HIV control, the most acute is the health workforce crisis. A collaborative approach to human resource capacity development will benefit both programmes. A joint TB and HIV programme approach to TB/HIV training should be adopted, and coordinated with other disease-specific programmes, such as the WHO Integrated Management of Adult and Adolescent Illness. In the short term, externally funded international and national staff will be required to assist national programmes in scaling up activities. The major technical agencies in TB/HIV, such as the Centers for Disease Control and Prevention (CDC), Damien Foundation, the

German Leprosy Relief Association (GLRA), IUATLD, the Royal Netherlands Tuberculosis Foundation (KNCV) and WHO, can provide technical assistance to plan, implement, monitor and evaluate TB/HIV activities. Experience shows that initial training must be followed by on-the-job supervision if it is to be fully utilized.

4.4 Engage all health care providers in collaborative TB/HIV activities.
Many health care providers outside the traditional public health system are providing care for TB and HIV, and could be engaged in providing comprehensive, high-quality TB/HIV prevention and care services in line with national programmes. The Public Private Mix DOTS Subgroup has pioneered the principles of involving health providers outside the public health system in TB control and this model will be adapted to include collaborative TB/HIV activities and HIV/AIDS prevention and care.

4.5 Engage people with TB and HIV and affected communities in planning, delivering, monitoring and evaluating collaborative TB/HIV activities.
People and communities affected by TB and HIV should be empowered to play a central role in planning, delivering, monitoring and evaluating TB/HIV activities. Resources must be identified to support community activism and involvement in TB/HIV. In low-resource settings, especially where human resource capacity is limited, communities and groups, such as faith-based organizations and PLWHA groups, can play an important role in delivering TB/HIV activities, provided that adequate training and supportive supervision are provided in partnership with the formal health sector to ensure quality care that responds to individual and community needs.

4.6 Strengthen laboratory capacity for collaborative TB/HIV activities
Overall laboratory capacity, infrastructure and quality need to be greatly improved to assist in the diagnosis and management of HIV-related TB, especially smear-negative, extrapulmonary and multidrug resistant TB, and TB in children. The speed and reliability of TB diagnosis must be improved, as well as the capacity of TB laboratories to diagnose and stage HIV infection, and monitor effects and side-effects of dual TB and HIV treatment.

Key risk factors

The key risk factors for not achieving the objectives of the Working Group include the following:

- The HIV epidemic continues to spread. The TB community must advocate for all efforts to mitigate the impact of HIV/AIDS and to promote HIV prevention and treatment as a vital component of TB control strategy.
- Poverty and inequality increase. Unless the level of absolute poverty can be reduced, it will be difficult to reduce the incidence of TB and HIV.
- Weak health systems. Weak capacity to deliver TB/HIV control strategies in low-income countries will be among the greatest constraints to achieving the 2015 targets.
- Lack of commitment to TB/HIV collaboration. TB and HIV programmes and communities must be committed to, and agree on, the principles and methods. Political commitment is key to allocation of human and financial resources.
- Lack of global coordination. Inadequate funding for the Working Group will mean that it is unable to direct new research, refine policy, provide technical assistance to countries, and undertake monitoring and evaluation.

Monitoring and evaluation

A guide to monitoring and evaluating collaborative TB/HIV activities defines core indicators.[44] Existing globally recommended data collection tools for TB and HIV/AIDS are being adapted to capture additional TB/HIV data. TB/HIV activities are now included in the global TB reporting system and should be included in the global AIDS reporting frameworks. The impact of TB/HIV activities will be measured in terms of existing impact indicators, such as TB mortality, TB incidence, and HIV incidence.

See Table 23: Collaborative TB/HIV activities defined in the TB/HIV policy
See Table 24: Budget requirements for the TB/HIV Working Group: 2006-2015 (US$ MILLIONS)

TABLE 23: COLLABORATIVE TB/HIV ACTIVITIES DEFINED IN THE TB/HIV POLICY

Activity	Description	Steps that may be required
ESTABLISH THE MECHANISMS FOR COLLABORATION		
Set up a coordinating body for TB/HIV activities effective at all levels	Representative body to plan, coordinate and implement collaborative TB/HIV activities, advocate for resources, build capacity and involve all stakeholders.	National-level working group, with representatives of national TB programme, national AIDS control programme (NAP), Global Fund, private sector, major partners, to meet at least quarterly District level committee - may include district TB coordinator, district medical officer, district AIDS control officer, community representatives, local NGOs.
Surveillance of HIV prevalence among TB patients	Establishing the burden of HIV disease among TB patients, to understand the overlap between the two diseases and assist in rational planning of services.	Assessment of HIV epidemic status, TB situation and available resources and expertise, to identify the best surveillance method, e.g. special periodic surveys, sentinel surveys, or data from routine HIV testing of TB patients.
Joint TB/HIV planning	Develop joint plans, to include resource mobilization, standard operating procedures, capacity-building and training, advocacy, communication and social mobilization, community involvement and research.	NTP and NAP to develop and implement a joint plan for collaborative TB/HIV activities or to incorporate TB/HIV activities into their respective NTP and NAP plans.
Monitoring and evaluation	Adapt TB and HIV monitoring and evaluation systems to capture information on collaborative TB/HIV activities.	Revise TB and HIV recording and reporting forms and registers to be able to capture information on collaborative TB/HIV activities. Train staff in revised recording and reporting. Joint analysis of results.
DECREASE THE BURDEN OF TUBERCULOSIS IN PEOPLE LIVING WITH HIV/AIDS		
Intensified tuberculosis case-finding	Regular screening of PLWHA for active TB in all HIV care and support settings and HIV testing settings.	NAP to liaise with NTP for protocol development, training of staff, ensuring access to TB diagnostic services for those found to have TB symptoms on screening.
Isoniazid preventive therapy	Preventing active TB disease by giving treatment for latent TB infection to PLWHA who do not have active TB.	NAP to liaise with NTP for protocol development, training of staff, drug supplies, follow-up, adherence support.
TB infection control in health care and congregate settings	PLWHA are at high risk of developing active TB after exposure. Every effort must be made to reduce exposure in institutional settings where HIV prevalence is high e.g. medical clinics, hospitals, prisons.	NTP and NAP to establish infection control policy and monitor implementation of policy in all high HIV prevalence settings; will require liaison with other sectors, e.g. industry, prisons.
DECREASE THE BURDEN OF HIV/AIDS IN TUBERCULOSIS PATIENTS		
HIV testing and counselling	Where HIV epidemic is generalized all TB patients should be encouraged to have HIV counselling and testing, ideally within the TB service.	Requires political commitment, NTP to liaise with NAP on developing policy and guidelines, training, accessing test kits, confidential counselling space in clinics, referral mechanism, and transport or incentives if testing not available on site.
HIV prevention	Appropriate HIV prevention advice and methods should be made available to TB patients where HIV prevalence is high.	NTP to liaise with NAP to develop IEC materials, train staff, provide condoms, safe injection practice, needle exchange, methadone replacement, as appropriate.
Co-trimoxazole preventive therapy	Co-trimoxazole preventive therapy reduces mortality and morbidity among HIV-positive TB patients	Requires staff training, drug supplies, adherence support, IEC materials.
HIV/AIDS care and support	HIV-positive TB patients must be able to access comprehensive HIV care and support, ideally within the TB service	NTP to coordinate with NAP to provide training, ensure access to treatment for opportunistic infections, referral mechanisms, and transport or incentives if care and support not available on site.
Antiretroviral therapy	NTP can be an important entry point for ART as a high proportion of HIV-positive TB patients are eligible for ART	NTP to liaise with NAP on protocols, training, access to drugs, ensuring that ART and TB treatment regimens are compatible, recording and reporting, adherence support, IEC materials.

TABLE 24: BUDGET REQUIREMENTS FOR THE TB/HIV WORKING GROUP: 2006-2015 (US$ MILLIONS)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	ALL YEARS	% TOTAL
COUNTRY NEEDS												
ALL REGIONS	418	470	536	615	689	742	768	795	825	858	6,716	100%
AFR- HIGH	304	337	380	428	471	493	512	534	559	586	4,605	68%
AFR LOW	19	20	23	28	32	37	40	42	45	47	334	5%
EEUR	3	4	7	13	19	23	26	28	31	33	186	3%
EMR	8	9	12	14	16	24	23	23	22	22	175	3%
LAC	6	8	10	14	17	20	21	22	23	24	166	2%
SEAR	68	79	91	104	117	130	130	131	131	132	1,112	17%
WPR	9	11	13	14	16	16	15	15	14	14	137	2%
INTERNATIONAL AGENCY NEEDS												
TECHNICAL COOPERATION*	-	-	-	-	-	-	-	-	-	-	-	-
WG OPERATIONAL NEEDS												
	1	1	1	1	1	1	1	1	1	1	11	0.2%
TOTAL	**419**	**471**	**537**	**616**	**690**	**744**	**769**	**796**	**826**	**859**	**6,727**	

* Some aspects of technical cooperation will be undertaken jointly for DOTS Expansion, TB/HIV and DOTS-Plus. Since it is difficult to identify what share of these costs applies to each working group, the total is shown in the budget for DOTS Expansion. Annual total cost ranges from US$220 millions to US$280 millions