

Two Diseases, One Patient

TB/HIV control strategy towards 2015

1. Rationale - HIV, an important threat to TB control

One third of the world's population is latently infected with *Mycobacterium tuberculosis*. HIV is the greatest risk factor for the progression of latent or recent TB infection to active TB disease. Around 10% of HIV negative people with latent infection will progress to TB disease over their lifetime; in comparison, 10% of people with latent TB infection and HIV will develop active TB disease each year.

Conversely, TB is among the most important causes of morbidity and mortality in people living with HIV. Globally, about 13 million people living with HIV (PLHIV) are also infected with TB and at increased risk of developing active TB. In 2003, there were an estimated 765 000 new cases of TB in people living with HIV (9% of all new TB cases) and 264 000 deaths from TB in people living with HIV (15% of all TB deaths). Global TB incidence continues to rise by 1% per year, despite stable or falling incidence in five out of six WHO regions¹. Rising TB incidence in Africa is sufficient to offset the stable or falling TB incidence in the rest of the world. With 29% of TB in the African Region attributable to HIV, HIV presents one of the greatest challenges to achieving the global TB control targets to reduce TB incidence, prevalence and deaths so as to meet the Millennium Development Goals (MDGs) globally². Without HIV, global TB incidence would be falling and HIV is changing the face of TB in other ways. HIV predominantly affects young people and especially young (15-24 years) women, consequently TB incidence in the regions most affected by HIV, is rising among young women, and the TB epidemic, traditionally male dominated, now wears a woman's face.

Although the effect of HIV on TB is most striking in Africa, the rapidly growing HIV epidemics in Asia and Eastern Europe pose a major threat to TB control and thus a global focus must be maintained; collaborative TB/HIV activities must be adapted to different epidemiological situations. UNAIDS predict that the global total of people living with HIV is unlikely to fall before 2010. Unless the continued global spread of HIV can be halted and reversed, the global TB control targets will become increasingly difficult to reach.

The biological link between HIV/AIDS and TB has been evident for some years but TB and HIV/AIDS control policies and programmes have evolved separately. The creation of the TB/HIV working group (WG) of the Stop TB Partnership 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. The aim of the WG is to reduce the impact of the dual epidemic. The basis for TB/HIV collaboration is laid out in WHO's 'Interim policy on

¹ Global tuberculosis control: surveillance, planning, financing. WHO report 2006. Geneva World Health Organization (WHO/HTM/TB/2006.362)

² The Stop TB Partnership's targets for TB control (linked to the MDG to ensure that incidence rate is declining by 2015) are to halve TB prevalence and death rates between 1990 and 2015.

'We cannot win the battle against AIDS if we do not also fight TB. TB is too often a death sentence for people with AIDS'. Nelson Mandela, International AIDS conference 2004

collaborative TB/HIV activities³, which clearly defines the activities that should be undertaken under three objectives (see table 4 below).

2. TB/HIV WG Achievements 2000-2005

The objectives of the TB/HIV WG in first Global Plan to Stop TB 2001-2005 were to:

- coordinate activities of prominent partners (both individuals and institutions) with recognised experience in controlling HIV/AIDS;
- develop a technical framework to guide country strategies to better control TB among HIV infected people;
- integrate the new technical framework into the DOTS strategy;
- form partnerships and promote collaboration between TB and HIV/AIDS programmes; and
- advocate for increased resources to tackle TB as a leading cause of illness and death among HIV infected people.

The WG has since published an essential set of core guidance documents to assist countries in implementing and monitoring collaborative TB/HIV activities⁴. Together, these documents provide a clear technical framework, based on the best available evidence, for reducing the impact of HIV related TB through collaboration between TB and HIV/AIDS programmes and their partners. Collaborative TB/HIV activities are implemented or planned in every WHO region with technical assistance from WG partners. By the end of 2003, 29 of the 41 highest burden TB/HIV countries had a national policy on TB/HIV collaboration, 16 had a national TB/HIV coordinating body and 13 provided ART for HIV positive TB patients. Almost half of the 199 countries surveyed for the Global TB Control report had a national policy of offering HIV testing to TB patients in 2003⁵. However, only 2% of the 1.6 million TB cases reported to TB programmes in countries with a generalized HIV epidemic (adult HIV prevalence >1%) were tested for HIV. Implementation of the 'Interim policy' remains slow for the reasons discussed below and must be greatly accelerated if we are to make progress towards the Stop TB Partnership's 2015 target, linked to the MDG targets. Human resource capacity in TB/HIV has been strengthened through development of training materials and national-level consultant training courses. TB programmes are an important entry point to the HIV/AIDS continuum of care and the DOTS model for TB control has provided many lessons for developing a global strategy to deliver antiretroviral therapy in resource limited settings. HIV/AIDS programmes are becoming important partners in TB control, through intensified TB case finding and provision of TB preventive therapy to people living with HIV. The WG has drawn on the support and experience of HIV activism and advocacy to raise the global profile of TB/HIV.

³ World Health Organization. Interim policy on collaborative TB/HIV activities. Geneva, World Health Organization, 2004 (WHO/HTM/TB/2004.330; WHO/HTM/HIV/2004.1) http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330.pdf

⁴ Interim policy on collaborative TB/HIV activities; Strategic framework to decrease the burden of TB/HIV; Guidelines for implementing collaborative TB and HIV programme activities; Guidelines for HIV surveillance among TB patients; and A guide to monitoring and evaluation for collaborative TB/HIV activities (all available from www.who.int/tb/publications/2005/en/)

⁵ Global tuberculosis control: surveillance, planning, financing. WHO report 2005. Geneva World Health Organization (WHO/HTM/TB/2005.349)

Box 1: TB/HIV collaboration - the context

Collaborative TB/HIV activities are coordinated and governed vertically by TB and HIV programmes but the interventions are delivered by general health services, under the influence of the broader determinants of health, such as poverty, education and the social, political and physical environment. Implementation of TB/HIV activities will be limited by health service constraints and the extent to which the broader determinants of health can be influenced (figure 1).

1. TB and HIV programmes

Traditionally, TB and HIV programmes are vertical structures, with little collaboration despite the close links between the diseases. They often have separate drug procurement, supply management, laboratory, recording and reporting, and adherence support mechanisms which could bring great synergies if they worked in collaboration.

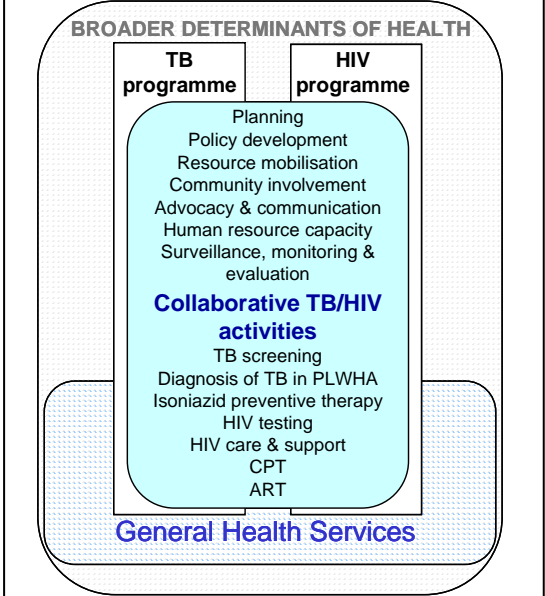
2. General health services

National health policy is primarily implemented through the formal state health sector, and as such is limited by the capacity of the health service to deliver. Health services are often weakest in the low income countries where the TB/HIV burden is greatest. Strengthening the general health system and workforce to be able to deliver TB and HIV care and prevention and ensure that services are accessible to the poorest sectors of society will be vital to attaining the Partnership's 2015 targets, linked to the MDG targets. The Global Plan can only succeed if the general health service and partners are strengthened to be able to deliver the interventions outlined in the plan. Although the focus of health service strengthening in the developing world is on primary care, strengthening of related referral facilities, laboratories and hospitals as well as strengthening the supportive role of communities and the private sector are important. Involving partners outside the traditional health sector can improve delivery of both preventive and clinical health services. The public/private mix (PPM) subgroup of the DOTS expansion WG have demonstrated the benefits of involving a broad range of health providers in TB control including private practitioners, traditional healers and other public providers, such as teaching hospitals. This PPM approach needs to be adopted and adapted for TB/HIV activities. The HIV community have worked hard to engage a broad range of health care providers outside the traditional health sector, including women's groups, faith-based organisations, and community groups of people living with HIV. Although there is good evidence of the benefits of community involvement in TB control, few TB programmes have taken full advantage of the potential community resources that are available. Increased involvement of communities in provision of services can increase access and support health services while they are strengthened. The WG should aim to include all HIV providers in TB and TB/HIV control activities.

3. Multisectoral approach

The powerful influence of the broader determinants of health on HIV/AIDS encouraged the early adoption of a multisectoral approach to the epidemic. The TB community has been slow to adopt a multisectoral approach and engage partners outside the health sector in TB control. Poverty, gender inequality, human rights, living conditions, and other socio-political factors affect TB and HIV and will require the involvement of the non-health sectors, such as education, justice, employment, and the environment, if they are to be addressed. TB must be mainstreamed into the development agenda and included in broader strategic planning approaches and financial frameworks aiming to tackle poverty, such as Poverty Reduction Strategy Papers and Sector Wide Approaches. These hold the potential for addressing health sector constraints and place financing for TB control in a sustainable and flexible long term strategic plan. Health system strengthening must be linked with strategies to address poverty and gender inequities in health.

Figure 1: Context in which collaborative TB/HIV activities occur



'We cannot win the battle against AIDS if we do not also fight TB. TB is too often a death sentence for people with AIDS'. Nelson Mandela, International AIDS conference 2004

The WG has over 230 registered members. The annual WG meeting in Addis Ababa in 2004, was attended by almost 200 participants from 38 countries⁶. The WG meeting provides an information sharing forum for all stakeholders. The Core Group of the WG guides policy, strategy and product development.

3. Modelling the impact and cost of TB/HIV collaboration

A mathematical model was developed to estimate the impact of global expansion of collaborative TB/HIV activities 2006-2015, in combination with the activities of the other WGs, on reaching the MDGs and to assess the cost. The model assumes a rate of scale up of TB/HIV activities consistent with the principle of universal access to HIV prevention, treatment and care services by 2010 and using the UNAIDS predictions for access to HIV testing and ART (see table 1). The best available estimates for the uptake, efficacy and impact of TB/HIV interventions were used.

The model shows that global scale up of collaborative TB/HIV activities will cost \$6.7 billion from 2006-2015 (Table 2). Over the period of the plan, some 200 million people living with HIV will be screened for TB and 24 million will be treated with isoniazid preventive therapy, 27 million TB patients will be tested for HIV, and 3 million HIV positive TB patients will be started on ART. In combination with the activities of the other WGs, this will treat about 50 million people with TB and save 14 million lives. TB/HIV activities will avert over 800,000 deaths (Table 3). These activities ensure that the Partnership's 2015 targets are met globally. However, at regional level, we may not achieve these targets by 2015 in Eastern Europe and may be even later in Africa as a result of additional serious constraints. A scenario exists to achieve the targets by 2015 in these two regions. This scenario depends on rapid, massive improvements in general health system development; an early, 50% reduction in regional HIV incidence; and the rapid availability of new powerful tools to increase diagnostic capacity, shorten treatment substantially and effectively prevent TB. It is unlikely that even massive additional funding or greater effort will be successful in overcoming the constraints in time for us to achieve the Partnership's targets at regional level in Africa and Eastern Europe by 2015. Nevertheless, all efforts must be made to achieve the Partnership's targets as quickly as possible in these two regions. Thus, there is no excuse not to invest massively.

⁶ Report of the 4th Global TB/HIV Working Group Meeting, Addis Ababa, September 2004 " *Two diseases- one patient: scaling up prevention and treatment for TB and HIV*" http://www.who.int/tb/publications/tbhiv_addis_report/en/index.html

Table 1. Regional scale-up of collaborative TB/HIV activities

| | Percentage of PLHIV attending HIV testing and counselling or HIV treatment and care services screened for TB (%) | | | Percentage of TB patients in DOTS programmes HIV tested | | | Percentage of TB patients (HIV positive and eligible) in DOTS programmes enrolled on ART | | |
|-------------------------|--|------|------|---|------|------|--|------|------|
| | 2006 | 2010 | 2015 | 2006 | 2010 | 2015 | 2006 | 2010 | 2015 |
| African - high HIV/AIDS | 63 | 100 | 100 | 51 | 85 | 85 | 45 | 55 | 59 |
| African - low HIV/AIDS | 53 | 91 | 100 | 43 | 77 | 85 | 44 | 55 | 60 |
| Eastern Europe | 48 | 100 | 100 | 34 | 85 | 85 | 45 | 57 | 59 |
| Eastern Mediterranean | 62 | 100 | 100 | 51 | 85 | 85 | 46 | 57 | 62 |
| Latin America | 44 | 82 | 100 | 34 | 68 | 85 | 24 | 33 | 33 |
| Southeast Asia | 56 | 92 | 100 | 43 | 77 | 85 | 45 | 55 | 59 |
| Western Pacific | 66 | 100 | 100 | 51 | 85 | 85 | 31 | 39 | 40 |

Table 2. TB/HIV working group costs (2006-2015)

| | Budget (\$ millions) |
|--|-------------------------|
| Country implementation of collaborative TB/HIV activities (by region) | 6716 |
| ▪ <i>African - high HIV/AIDS</i> | 4605 |
| ▪ <i>African - low HIV/AIDS</i> | 334 |
| ▪ <i>Eastern Europe</i> | 186 |
| ▪ <i>Eastern Mediterranean</i> | 175 |
| ▪ <i>Latin America</i> | 166 |
| ▪ <i>Southeast Asia</i> | 1112 |
| ▪ <i>Western Pacific</i> | 137 |
| Operating costs of the TB/HIV Working Group | 11 |
| Total | 6727 |

Table 3. Estimated outcomes of implementing collaborative TB/HIV activities, 2006-2015

| | 2006 | 2010 | 2015 | 2006-2015 |
|--|------------|------------|------------|------------|
| No. of PLHIV attending HIV testing and counselling or HIV treatment and care services screened for TB (millions) | 11 | 22 | 26 | 206 |
| No. of PLHIV given IPT (millions) | 1.2 | 2.6 | 3.1 | 24 |
| Estimated number of HIV positive TB patients under DOTS (millions) | 3.4 | 3.8 | 3.4 | 36 |
| Number of TB patients tested for HIV (millions) | 1.6 | 3.1 | 2.9 | 27 |
| Number of HIV positive TB patients started on ART (millions) | 0.2 | 0.3 | 0.4 | 3.2 |

4. The vision for 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.

This plan sets out below the specific objectives for the period 2006-2015, and the activities planned to achieve them.

5. OBJECTIVES AND ACTIVITIES

Guidelines have been developed for TB/HIV collaboration ⁷, 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

⁷ 'Interim policy on collaborative TB/HIV activities' www.who.int/tb/publications/tbhiv_interim_policy/en/index.html

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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.

The TB/HIV WG strategic plan lays out the activities that need to be undertaken by the WG and its partners over the next ten years to achieve the 2015 targets under the following four objectives:

1. Scale up and expand collaborative TB/HIV activities.
2. Develop and coordinate implementation of research to improve the prevention, early diagnosis and rapid treatment of TB in people living with HIV and incorporate results into global policy.
3. Increase political and resource commitment to collaborative TB/HIV activities.
4. Contribute to strengthening health systems to deliver collaborative TB/HIV activities.

Activity areas are outlined below, detailed activities, milestones and responsibilities are defined in Appendix 1.

Activity areas:

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

1.1 Scale up implementation of collaborative TB/HIV activities

The priority for the TB/HIV WG is to support countries to establish full coordination between TB and HIV/AIDS programmes, general health services and communities to accelerate joint delivery of the collaborative TB/HIV activities defined in the TB/HIV policy (Table 3). Very 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. This will require much greater engagement of the HIV community in TB/HIV collaboration. In most settings TB treatment services are decentralised to the health facility level whereas few countries have as yet decentralised 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.

Table 4: Collaborative TB/HIV activities defined in the 'Interim policy'

| Establish the mechanisms for collaboration | | |
|---|--|---|
| Activity | Description | Steps that may be required |
| 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 (NTP), National AIDS Control Programme (NAP), Global Fund, private sector, major partners to meet quarterly District level committee - may include District TB Coordinator, District Medical Officer, District AIDS Control Officer, community representatives, local NGOs. |
| Conduct 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. |
| Carry out joint TB/HIV planning | Develop joint plans to include resource mobilization, 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. |
| Conduct 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 | | |
| Establish intensified tuberculosis case-finding | Regular screening of PLHIV 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. |
| Introduce isoniazid preventive therapy | Preventing active TB disease by giving treatment of latent TB infection to PLHIV who do not have active TB. | NAP to liaise with NTP for protocol development, training of staff, drug supplies, follow up, adherence support. |
| Ensure TB infection control in health care & congregate settings | PLHIV 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 | | |
| Provide HIV testing and counselling | Where HIV epidemic is generalized all TB patients should be encouraged to have HIV counseling and testing, ideally within the TB service. | Requires political commitment, NTP to liaise with NAP on developing policy and guidelines, training, accessing test kits, counseling space in clinics, referral mechanism and transport if testing not available on site. HIV tests must be performed confidentially, with informed consent and counseling. |
| Introduce HIV prevention methods | 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. |
| Introduce 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. |
| Ensure 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 infection, referral mechanisms and transport or incentives if care and support not available on site. |
| Introduce antiretroviral therapy (ART) | 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. |

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.

Strategies to improve the diagnosis and management of smear negative TB, extrapulmonary TB and TB in children, prevention of recurrent TB, and adherence to TB and HIV therapy are priorities. Taking a broader approach to attaining the 2015 targets and reducing TB mortality, we have to consider other important causes of mortality in HIV positive TB patients in certain situations, e.g. management of Hepatitis B and C and methadone replacement for IDUs, and preventing malaria through the distribution of insecticide-treated bed nets in malaria endemic areas.

The role of contact tracing to identify children at risk of both TB and HIV in the households of TB patients must be promoted, along with isoniazid preventive therapy for HIV infected children. Communities should be mobilised to care for children with TB, who often have one parent or both with TB (and HIV) and too sick to be able to care properly for the child.

Collaborative TB/HIV activities must be gender-sensitive with appropriate recording and reporting, IEC materials, training of health workers in reducing gender-specific barriers to TB diagnosis and treatment, involvement of women in planning, evaluation and delivery of services.

Stigma remains a major barrier to accessing health services. TB, HIV and their related risk factors (e.g., poverty, commercial sex work, injecting drug use) are often highly stigmatised in society and among health care workers. The stigma for those who have both TB and HIV may be even greater. It is important to understand how stigma can be overcome in the community and the health service. We need to develop the tools necessary to identify measure and reduce stigma.

1.3 Address immediate gaps and bottlenecks in the implementation of TB/HIV services

Policies and guidelines on antiretroviral treatment of HIV-infected people who are on concurrent TB treatment 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) and technical assistance should be made available to help countries translate policy guidance into specific implementation plans.

1.4 Improve quality 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 of TB/HIV activities should be incorporated into existing national M&E systems with a dedicated budget and should demonstrate to what extent services are accessible and responding to the needs of the poor, women and marginalized groups. HIV surveillance among TB patients should be promoted in all countries to monitor the burden of HIV related TB and the impact of the HIV epidemic on TB.

Objective 2 - Develop and coordinate implementation of research to improve the prevention, early diagnosis and rapid treatment of TB in people living with HIV and incorporate results into global policy

2.1 Continually refine the prioritised research agenda for collaborative TB/HIV activities and support operational research in 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. Operational research should be encouraged and supported at country level to tailor TB/HIV activities to country needs, learn lessons for scale up and programme improvement, and develop national research capacity. 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 Mobilising technical, financial, and human resources

National policy-makers, health professionals and affected communities, including people living with HIV, 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

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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

The HIV community has demonstrated that advocacy and activism are powerful tools for increasing access to effective prevention, treatment and care services for people living with HIV. TB and HIV are important development issues contributing significantly to the cycle of poverty in many countries. Robust and sustainable plans need to be made to support national efforts to tackle these diseases of poverty in the long term. Advocacy efforts are needed to place TB and TB/HIV high on the development agenda and included in broad strategic planning, development, and financing frameworks, such as the Poverty Reduction Strategy Papers, Medium Term Expenditure Frameworks, and Sector Wide Approach. Grassroots TB and HIV activists can work together to considerably enhance impact and increase political commitment to TB/HIV activities. Advocacy for comprehensive health sector strengthening is needed to reverse the chronic under-investment in health services. Messaging should be sustained, directed and tailored to specific audiences. Community awareness of TB and HIV, the links between them and their symptoms, diagnosis and treatment is important to increase early presentation with symptoms and promote community support for those on treatment.

Objective 4 - Contribute to strengthening health systems to deliver 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. Collaborative TB/HIV activities must build on existing, high quality TB and HIV prevention, care and support services. The approach to strengthening DOTS-based TB services is detailed in the DOTS Expansion Working Group strategic plan. There is no long term global strategic plan for comprehensive HIV/AIDS prevention, care and support and it is beyond the scope of this strategic plan to lay out the global requirements for establishing comprehensive HIV/AIDS prevention, care and support. However, the WHO HIV department 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 control of the health sector. However, most of these social, cultural, environmental and political factors are common to both TB and HIV and 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, justice. Ministries of Health should work with other line ministries (e.g. defence, prisons, police etc.), 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. TB and HIV programmes face the same constraints, often relying on the same overstretched, under-trained and under-supervised health care worker to deliver all TB and HIV prevention, care and support services. A long-term visionary global human resources development strategy is needed that addresses the international constraints to HR development (hiring freezes, salary caps, foreign recruitment, etc) and increases training of health care workers to fulfil the HR needs. A collaborative approach to human resource capacity development will have benefits to both programmes, e.g., advocating for more staff, more attractive salaries, better working conditions, better HIV and TB prevention and care services for staff, improved pre-service and in-service training, more efficient working practices, and making use of alternative cadres of staff.

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 need for externally funded staff at country level will decline however, as national health workforces are strengthened through human resource development plans. 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. Funding for such technical assistance will need to be found either at country level or from external sources. 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 providers in collaborative TB/HIV activities

Many health 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.

Greater involvement of people and communities affected by TB and HIV in planning, delivering and monitoring TB/HIV activities is needed to ensure that services respond to community needs. Communities need to be empowered with a sense of ownership over their health resources and to take responsibility for

supporting the health services where possible. In low resource settings, especially where human resource capacity is limited, communities and community groups, such as faith based organizations and PLHIV groups, can play an important role in supporting delivery of collaborative 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 needs⁸. At the same time we need to recognise the competing healthcare demands made on communities, especially the poorest communities with greatest disease burden and frequently the weakest health services.

4.6 Strengthen laboratory capacity for collaborative TB/HIV activities

Overall laboratory capacity, infrastructure and quality needs to be greatly improved to better assist in the diagnosis and management of HIV related TB, especially smear negative, extrapulmonary and multi-drug resistant TB, and TB in children. The speed and reliability of TB diagnosis must be improved to ensure that HIV positive people with TB can be accurately identified and quickly started on appropriate treatment to reduce TB mortality. It is necessary to develop the capacity of laboratories to diagnose and stage HIV infection and monitor effect and side effects of dual TB and HIV treatment.

6. KEY RISK FACTORS

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

HIV epidemic continues to spread - It will not be possible to reach the 2015 targets and the 2050 goal to eliminate TB as a public health problem if the HIV epidemic continues to spread. The TB community must advocate for all efforts to be made to mitigate the impact of HIV/AIDS and to promote HIV prevention and treatment as a vital component of the TB control strategy.

Poverty and inequality increase - The influence of poverty on TB and HIV will make reducing incidence of both diseases difficult unless absolute poverty can be reduced, bringing the poorest nearer to the global average. Global economic and development strategy needs to be aligned to benefit the poorest countries.

Weak health systems - The lack of capacity of health services in low income countries to deliver TB/HIV control strategies will be among the greatest constraints to achieving the 2015 targets. Existing services are least accessible to the poor and most marginalised members of society who can most benefit from the services. Advocacy for health systems strengthening to improve access to and quality of comprehensive TB and HIV prevention and care services, especially for the poor is key.

Lack of commitment to TB/HIV collaboration - The TB and HIV programmes and communities must be committed to, and agree on, the principles and methods for collaboration. Political commitment is necessary to establish collaborative TB/HIV

⁸ World Health Organization. Community contribution to TB care: Practice and policy. (WHO/CDS/TB/2003.312) http://www.who.int/docstore/gtb/publications/communityTBcare/tb_2002_312/tb_2003_312.pdf

activities and for the appropriate allocation of human and financial resources in the long term. Global funding mechanisms cannot necessarily be relied upon in the long term to support activities.

Lack of global coordination - Policy development and implementation benefit from a global perspective. The TB/HIV Working Group has been instrumental in coordinating global efforts to address HIV related TB, translating the lessons learnt from countries in the forefront of TB/HIV activities into evidence based global policy and assisting countries to plan, implement and monitor TB/HIV strategies. 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.

7. MONITORING AND EVALUATION

The guide to monitoring and evaluation (M&E) of collaborative TB/HIV activities defines the core indicators that are necessary for monitoring collaborative TB/HIV activities⁹. 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.

⁹ World Health Organization. A guide to monitoring and evaluation for collaborative TB/HIV activities. Geneva, World Health Organization 2004 (WHO/HTM/TB/2004.342 and WHO/HIV/2004.09) http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.342.pdf

Appendix 1: Activities, milestones and responsibilities

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

| Activities | Milestones | Responsibility |
|---|---|---|
| Activity area 1.1 Scale up implementation of the TB/HIV policy | | |
| <ul style="list-style-type: none"> • Prioritise technical and financial assistance to countries with a high burden of TB/HIV to implement the appropriate package of TB/HIV activities defined in the TB/HIV policy.¹⁰ • Support high TB/HIV burden countries to develop national TB/HIV health policy and implementation plans (stand alone or incorporated into TB and HIV plans). • Ministries of Health, National AIDS Commissions and other line ministries should endorse, support and expand the implementation of the activities recommended in the TB/HIV policy.⁶ • Ensure that TB/HIV activities are highlighted in TB and HIV 3-5 year medium-term strategic plans and outline 10 year plans (2006-2015) to identify resources required to achieve the Partnership's targets for 2015 • Implement urgent and intensified short term (2006-2007) outline action plan for accelerating TB and TB/HIV control in Africa (the Blueprint). • Advocate for increased participation of HIV community at all levels. • Increase HIV prevention activities in TB service (e.g. behaviour change, PMTCT, injection safety, and STI screening). • Advocate for regular budgetary commitment to TB/HIV control from national resources, supplemented where necessary by international funding sources. • Organise regular intra-regional missions to promote experience and share best practice among high burden countries. | <p><i>By end 2007</i></p> <ul style="list-style-type: none"> ▪ All high burden (Category 1) countries to have established national TB/HIV coordinating bodies and started implementing TB/HIV activities. ▪ National TB/HIV coordinating bodies established in countries with administrative areas where HIV prevalence is greater than 1% (Category 2). | <ul style="list-style-type: none"> - TB/HIV WG, NTPs/NAPs - National Ministries of Health and national stakeholders in TB & HIV |
| | <p><i>By end 2010</i></p> <ul style="list-style-type: none"> ▪ All Category 1 countries to have implemented recommended TB/HIV activities countrywide. ▪ All Category 2 countries to have commenced scale up of TB/HIV activities in all administrative areas where HIV prevalence is greater than 1%. ▪ Establishment of national HIV surveillance among TB patients in all Category 3 countries. | <ul style="list-style-type: none"> - TB/HIV WG, NTPs/NAPs - TB/HIV WG, NTPs/NAPs - TB/HIV WG, NTPs/NAPs |
| | <p><i>By end 2015</i></p> <ul style="list-style-type: none"> ▪ Full global implementation of TB/HIV activities as defined in TB/HIV policy. | <ul style="list-style-type: none"> - TB/HIV WG, NTPs/NAPs |

¹⁰ The Interim policy on collaborative TB/HIV activities (www.who.int/tb/publications/2005/en) defines 3 separate categories of country for collaborative TB/HIV activities depending on the HIV prevalence in each country. Category 1: Countries in which the national adult HIV prevalence rate is $\geq 1\%$ OR in which the national HIV prevalence among tuberculosis patients is $\geq 5\%$. Category 2: Countries in which the national adult HIV prevalence rate is below 1% AND in which there are administrative areas with an adult HIV prevalence rate of $\geq 1\%$. Category 3: Countries in which the national adult HIV prevalence rate is below 1% AND in which there are no administrative areas with an adult HIV prevalence rate of $\geq 1\%$.

| Activity area 1.2: Expand the scope of existing global policy to increase accessibility and acceptability of collaborative TB/HIV activities | | |
|---|--|---|
| <ul style="list-style-type: none"> • Develop new policy on TB/HIV activities in women, IDU, prisons, children and mobile populations. • Develop guidelines on TB infection control in high HIV prevalence settings and intensified TB and HIV case finding through contact tracing. • Develop guidelines on addressing TB and HIV stigma. • Broaden collaboration to include maternal and child health, harm reduction and prison health services. | <i>By end 2007</i> <ul style="list-style-type: none"> ▪ Global TB/HIV policy guidelines for women, IDU, prisons, children and mobile populations produced. ▪ TB/HIV guidelines on infection control and intensified TB case finding produced. | <ul style="list-style-type: none"> - TB/HIV WG - TB/HIV WG |
| | <i>By end 2010</i> <ul style="list-style-type: none"> ▪ New TB/HIV policy and guidelines implemented in all high TB/HIV burden countries (Cat 1) ▪ TB/HIV activities included in maternal and child health, harm reduction and prison health services in all high TB/HIV burden countries. | <ul style="list-style-type: none"> - NTPs/NAPs - NTPs/NAPs |
| Activity area 1.3 Address immediate gaps and bottlenecks in the implementation of collaborative TB/HIV activities | | |
| <ul style="list-style-type: none"> • Urgent guidelines on ARV treatment in HIV positive people on TB treatment are needed along with improved diagnostic algorithms for rapid diagnosis of smear negative and extrapulmonary TB. • Generic TB/HIV training materials needed for national, district and facility level. | <i>By end 2007</i> <ul style="list-style-type: none"> ▪ Updated guidelines on TB/ART co-treatment and improved diagnostic algorithms produced. ▪ Training materials published | <ul style="list-style-type: none"> - TB/HIV WG - TB/HIV WG |
| Activity area 1.4 Improve quality through surveillance, monitoring and evaluation | | |
| <ul style="list-style-type: none"> • TB/HIV WG (in collaboration with Health Metrics Network and other M&E partners) to promote and support establishment of reliable, standardised monitoring and evaluation for TB/HIV activities that is integrated with existing health information systems and national planning cycles. • Countries and partners to strengthen national M&E systems to collect reliable, timely and useful information on TB and HIV for programme improvement that can demonstrate that services are reaching women, the poor and marginalised groups. • TB/HIV WG to compile national data on implementation and demonstrate impact of TB/HIV activities in an annual global TB/HIV report and use this information to advocate for and improve TB/HIV activities. | <i>By end 2007</i> <ul style="list-style-type: none"> ▪ Annual global report on TB/HIV activities, focusing on the highest TB/HIV burden countries, to be produced as part of the WHO Global Tuberculosis Control Report. ▪ All high TB/HIV burden countries to be reporting core TB/HIV indicators¹¹ to WHO. ▪ Develop practical toolkit for HIV surveillance in lower HIV prevalence settings. | <ul style="list-style-type: none"> - TB/HIV WG - NTPs/NAPs - TB/HIV WG |
| | <i>By end 2010</i> <ul style="list-style-type: none"> ▪ All countries to be reporting data from HIV surveillance among TB patients to WHO. | <ul style="list-style-type: none"> - NTPs/NAPs |
| | <i>By end 2015</i> <ul style="list-style-type: none"> ▪ All countries achieving the Partnership's 2015 targets and the MDGs. | <ul style="list-style-type: none"> - TB/HIV WG, NTPs/NAPs |

¹¹ See 'Guide to monitoring and evaluation for collaborative TB/HIV activities' available from www.who.int/tb/publications/2005/en

Objective 2 - Develop and coordinate implementation of research to improve the prevention, early diagnosis and rapid treatment of TB in PLHIV and incorporate results into global policy

| Activity area 2.1: Refine prioritised research agenda for collaborative TB/HIV activities and support operational research in TB/HIV at country level | | |
|---|--|--|
| <ul style="list-style-type: none"> • Maintain a prioritised research agenda for TB/HIV activities based on the needs of programme implementers and policy makers. • Promote and support operational and fundamental research in TB/HIV and multi-centre studies designed to strengthen the evidence-base for prevention, diagnosis and treatment of HIV related TB and develop local research capacity. Research should include population/community-based interventions. • Close collaboration with Drugs, Diagnostics and Vaccines WGs to rapidly test and implement new diagnostics, treatments and vaccines as they are developed. • Advocate for resources to support priority research in TB/HIV activities and new tools, and promote transfer of existing technologies to less developed countries. | <p><i>By end 2007</i></p> <ul style="list-style-type: none"> ▪ All high TB/HIV burden countries to include operational research on TB/HIV activities in their national TB, TB/HIV and/or HIV strategic plans. ▪ TB/HIV operational research planning and proposal development workshops conducted in all regions. ▪ At least 10 high TB/HIV burden countries to conduct TB/HIV operational research activities according to the regional needs. | <ul style="list-style-type: none"> - TB/HIV WG, NTPs/NAPs, academic institutes - TB/HIV WG - TB/HIV WG, NTPs/NAPs, academic institutes |
| | <p><i>By end 2010</i></p> <ul style="list-style-type: none"> ▪ Research planning and proposal development follow up meetings held in each region to present results ▪ All high TB/HIV countries to establish TB/HIV OR programmes to inform national scale up of TB/HIV activities ▪ TB/HIV research agenda adapted to reflect regional needs ▪ New tools from Drugs, Diagnostics and Vaccines WG tested and implemented in high HIV settings. | <ul style="list-style-type: none"> - TB/HIV WG - TB/HIV WG, NTPs/NAPs, academic institutes - TB/HIV WG and regional partners - TB/HIV WG, NTPs/NAPs, academic institutes |
| Activity area 2.2 Translate research findings into global policy and practice | | |
| <ul style="list-style-type: none"> • Disseminate TB/HIV research findings globally and translate them into improved global policy and practice. • Collaborate with the Partnership's new tools Working Groups to facilitate testing of new drugs, diagnostics and vaccines as they become available and rapid implementation of those that are demonstrated to be effective. | <p><i>By end 2007</i></p> <ul style="list-style-type: none"> ▪ Annual TB/HIV WG meetings held either globally or regionally to disseminate research findings and best practice and to define policy needs. | <ul style="list-style-type: none"> - TB/HIV WG |

| Objective 3 - Increase political and resource commitment to collaborative TB/HIV activities | | |
|---|--|---|
| Activity area 3.1: Mobilising technical, financial, and human resources | | |
| <ul style="list-style-type: none"> Monitor resources needed and available for TB/HIV activities in each country and use the information to advocate for additional resources. Global advocacy to mobilise resources for TB/HIV. Governments to allocate adequate resources to controlling TB and HIV by including these health priorities in national development strategies. Increase involvement of HIV NGOs, CBOs and FBOs in TB/HIV activities. | <i>By end 2007</i> <ul style="list-style-type: none"> Resource needs for TB/HIV activities mapped for all high TB/HIV burden countries. Resource mobilisation plans developed for all high TB/HIV burden countries Forum on involvement of HIV organisations in TB/HIV activities held at global HIV/AIDS meeting | <ul style="list-style-type: none"> TB/HIV WG, NTPs/NAPs TB/HIV WG, NTPs/NAPs TB/HIV WG, WHO HIV Dept., UNAIDS, IAS |
| | <i>By end 2010</i> <ul style="list-style-type: none"> All high TB/HIV burden countries have adequate financial resources for planned activities to 2015. | <ul style="list-style-type: none"> TB/HIV WG, donor countries/organizations, NTPs/NAPs |
| Activity area 3.2: Advocacy and Communication | | |
| <ul style="list-style-type: none"> Advocacy, Communication and Social Mobilisation (ACSM) WG to lead coordination of TB and HIV community mobilisation and TB/HIV advocacy. Ensure that TB communities lobby for comprehensive high quality HIV/AIDS prevention care and support services and HIV communities lobby for quality TB control services Working with the ACSM WG to develop a strategy to ensure sustained and targeted ACSM for TB/HIV activities Advocate for TB/HIV activities to be included in TB and HIV/AIDS work plans of partners and countries. Develop the role of communities, civil society and non-governmental organizations in advocating for greater political commitment to TB/HIV activities. High-level advocacy to place TB and TB/HIV high on national development agendas and secure long-term sustainable financing. | <i>By end 2007</i> <ul style="list-style-type: none"> Global advocacy and communication strategy for TB/HIV activities Ensure that Stop TB Partnership high level missions address TB/HIV TB/HIV to feature at high level political meetings in the high TB/HIV burden regions, e.g. regional Ministers of Finance and Heads of States meetings and meetings of regional political partnerships (African Union, NEPAD). | <ul style="list-style-type: none"> ACSM WG, TB/HIV WG TB/HIV WG TB/HIV WG, regional and national Stop TB Partnerships, Ministers of Health |
| | <i>By end 2010</i> <ul style="list-style-type: none"> TB/HIV activities included in TB and HIV work-plans of national ministries of health and development agendas of all high TB/HIV burden countries. | <ul style="list-style-type: none"> TB/HIV WG, MoH, NTPs/NAPs |
| Objective 4 - Contribute to strengthening health systems to deliver TB/HIV activities | | |
| Activity area 4.1: Strengthen DOTS-based TB control and comprehensive HIV/AIDS prevention, care and support | | |
| <ul style="list-style-type: none"> Advocate for high quality DOTS based TB control services and comprehensive HIV/AIDS prevention, treatment and care service as the essential basis on which to build TB/HIV activities in high HIV prevalence settings. Services must be decentralised to lowest level to provide integrated comprehensive care close to affected communities. TB community to support and advocate at all levels for HIV prevention activities in the context of comprehensive HIV/AIDS | <i>By end 2007</i> <ul style="list-style-type: none"> Intensified action plan for Africa (Blueprint /Roadmap) fully implemented. DEWG goals achieved | <ul style="list-style-type: none"> TB/HIV WG, DEWG, NTPs/NAPs DEWG, TB/HIV WG |
| | <i>By end 2010</i> <ul style="list-style-type: none"> DEWG goals achieved All eligible HIV positive TB patients have access to ART | <ul style="list-style-type: none"> TB/HIV WG, DEWG TB/HIV WG |

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| <p>care, as an important TB control intervention.</p> <ul style="list-style-type: none"> • Support the activities and targets of TB and HIV/AIDS partners and ensure complementarity with TB/HIV WG activities and targets. • TB and HIV programmes to collaborate with general health service and health workforce managers to ensure that TB/HIV interventions can be implemented where needed. | <p><i>By end 2015</i></p> <ul style="list-style-type: none"> ▪ DEWG goals achieved | <p>- TB/HIV WG, DEWG</p> |
| <p>Activity area 4.2: Develop a multisectoral approach to collaborative TB/HIV activities with strong programme planning, management and sustainable financing</p> | | |
| <ul style="list-style-type: none"> • Develop guidance on role and inclusion of non-health sectors in addressing TB and TB/HIV. • Develop or build on existing multisectoral partnerships at all levels to tackle HIV-related TB. Regional and national Stop TB Partnerships should be supported and regional TB/HIV working groups (or TB/HIV sub-groups of existing partnerships) considered to increase multisectoral approach to TB and TB/HIV control. • Incorporate TB/HIV into development agendas, Ministry of Health work plans and financial frameworks of high burden countries through engagement with relevant national and regional political bodies (e.g. national Ministries of Health). • Establish TB/HIV representation on national and regional TB and HIV/AIDS partnerships. • Establish TB/HIV WG input into global and regional development and health financing initiatives, including Core Technical Frameworks for health systems strengthening and Health Systems Action Network, coordinated by WHO. | <p><i>By end 2007</i></p> <ul style="list-style-type: none"> ▪ Produce global guidelines on developing a multisectoral, partnership approach to TB/HIV. ▪ Establish a regional Stop TB Partnership for Africa. ▪ All Category 1 TB/HIV countries to <ul style="list-style-type: none"> ○ develop a national multisectoral partnership to address TB and TB/HIV, ○ include TB/HIV activities in annual and mid term plans of the Ministry of Health, ○ have a plan for financing TB/HIV activities to reach the 2015 targets. ▪ HIV community representatives included in national and regional Stop TB partnerships. ▪ TB community representative included in national and regional HIV/AIDS partnerships. <p><i>By end 2010</i></p> <ul style="list-style-type: none"> ▪ Establish regional TB/HIV WGs in the regions with the highest burden of HIV related TB. ▪ Sustainable financing plans for achieving the 2015 TB targets in all high burden TB/HIV countries ▪ TB and TB/HIV included in national development plans of all high burden TB/HIV countries | <p>- TB/HIV WG</p> <p>- Stop TB Partnership</p> <p>- TB/HIV WG, national partners, MoH, NTPs/NAPs</p> <p>- TB/HIV WG</p> <p>- TB/HIV WG</p> <p>- TB/HIV WG, regional partners</p> <p>- Donors, Governments, MoH, NTPs/NAPs</p> <p>- TB/HIV WG</p> |

| Activity area 4.3: Human resource capacity development | | |
|--|--|---|
| <ul style="list-style-type: none"> • Advocate for TB/HIV WG involvement in global, regional and national initiatives for human resources for health, e.g. Core Technical Frameworks for Health Systems Strengthening, Health Systems Action Network coordinated by WHO. • Assess and monitor country and regional requirements for technical assistance for TB/HIV activities. International funding agencies should ensure that an adequate proportion of all grants is allocated for technical assistance. • Ensure that international technical assistance for TB/HIV is coordinated through a global body (e.g. Stop TB Partnership or UNAIDS) to achieve the most efficient use of resources. • Increase global and regional and country technical assistance capacity by supporting additional national and international TB staff posts in high TB/HIV burden regions and countries. • Support countries to assess human resource requirements for health, define gaps, and develop regional and national human resource for health capacity development strategies, which address TB/HIV. Including regional and country TB/HIV training of trainers, integration of TB/HIV into national training curricula and country specific strategies to increase human resources for health, strategies to retain health workers in the public sector, and civil society involvement in healthcare provision. | <p><i>By end 2007</i></p> <ul style="list-style-type: none"> ▪ Annual TB/HIV consultant training courses in all regions. ▪ Develop integrated training materials on TB and HIV for use in high TB/HIV burden countries. ▪ All high burden TB/HIV countries to assess human resource requirements for health and develop a long term human resource for health development plan. ▪ Technical assistance needs defined for implementing TB/HIV activities in the high burden TB/HIV countries ▪ Attain levels of externally funded technical assistance staff at country and national level defined in the optimistic realistic scenario. | <ul style="list-style-type: none"> - TB/HIV WG - TB/HIV WG - NTP/NAP - TB/HIV WG and technical partners - TB/HIV WG, technical partners and donors |
| | <p><i>By end 2010</i></p> <ul style="list-style-type: none"> ▪ Attain levels of externally funded technical assistance staff at country and national level consistent with the intensified action approach. | <ul style="list-style-type: none"> - TB/HIV WG, technical partners and donors |
| | <p><i>By end 2015</i></p> <ul style="list-style-type: none"> ▪ All high TB/HIV burden countries to have adequate human resources for TB/HIV activities | <ul style="list-style-type: none"> - TB/HIV WG, technical partners and donors, MoH, NTPs/NAPs |
| Activity area 4.4: Engage all health providers in collaborative TB/HIV activities | | |
| <ul style="list-style-type: none"> • Establish TB/HIV WG input into global, regional and national initiatives for involving the private sector in health, e.g. Core Technical Frameworks for Health Systems Strengthening, Health Systems Action Network, coordinated by WHO. • Develop policy on engaging the private health sector and other government health providers, such as academic hospitals, in TB/HIV activities • Governments (Ministries of Health, Justice, other line ministries) to develop supportive policies to encourage the involvement of the private and NGO sector in TB and TB/HIV control. | <p><i>By end 2007</i></p> <ul style="list-style-type: none"> ▪ Develop guidance on involvement of health providers outside the public health sector in TB/HIV activities. ▪ Establish pilot projects on public/private and public/public mix for TB/HIV. | <ul style="list-style-type: none"> - TB/HIV WG - TB/HIV WG, PPM subgroup, NTPs/NAPs |
| | <p><i>By end 2010</i></p> <ul style="list-style-type: none"> ▪ All high burden TB/HIV countries have plans for engaging all health providers in TB/HIV activities. | <ul style="list-style-type: none"> - TB/HIV WG, NTPs/NAPs |

| Activity area 4.5: Engage people with TB and HIV and affected communities in planning, delivering and monitoring collaborative TB/HIV activities | | |
|---|--|---|
| <ul style="list-style-type: none"> • Collaborate with ACSM WG to include TB/HIV activities in community mobilisation strategy. • Develop capacity of HIV activist community to advocate for TB/HIV • TB/HIV WG to support HIV and TB community groups to develop community participation in the prevention, detection, treatment and care of people with TB and/or HIV. • Develop strategies at all levels to involve communities in TB and TB/HIV activities, to empower community members to take responsibility for their health and the health of their communities, including training and incentives where appropriate. | <p><i>By end 2007</i></p> <ul style="list-style-type: none"> ▪ Develop community mobilisation strategy for TB/HIV activities. ▪ Hold activist training workshops once a year in the highest HIV burden regions. ▪ Include TB/HIV activities in TB and HIV community mobilisation strategies in all high burden TB/HIV countries. | <ul style="list-style-type: none"> - TB/HIV WG, ACSM WG - TB/HIV WG, HIV activist groups - TB/HIV WG, NTPs/NAPs, community based organizations |
| Activity area 4.6: Strengthen laboratory capacity for collaborative TB/HIV activities | | |
| <ul style="list-style-type: none"> • Develop a laboratory strengthening strategy in collaboration with the other WGs to address constraints to implementation of TB/HIV activities in high burden countries. • Develop appropriate protocols for the rapid, accurate diagnosis of smear negative TB among PLHIV using available tools. • Expand access to rapid TB culture and drug sensitivity testing methods. • Work with new diagnostics WG to pilot new methods for improving TB diagnosis in PLHIV. | <p><i>By end 2007</i></p> <ul style="list-style-type: none"> ▪ Comprehensive global laboratory strengthening strategy to support TB/HIV activities. ▪ New diagnostic protocols to improve TB diagnosis among PLHIV, especially addressing smear negative TB using existing technologies. ▪ Plan to expand access to rapid TB culture methods in the high TB/HIV burden countries. | <ul style="list-style-type: none"> - TB/HIV WG, DEWG, DPWG - TB/HIV WG, DEWG - TB/HIV WG |
| | <p><i>By end 2010</i></p> <ul style="list-style-type: none"> ▪ Plan to test and implement new diagnostic tools in high TB/HIV prevalence countries. | <ul style="list-style-type: none"> - TB/HIV WG, Diagnostics WG |