

Revised Terms of Reference of the Global TB/HIV Working Group of the Stop TB Partnership

The following terms of reference will be valid for five years (2008-2013). By the end of the five years the Working Group will again revisit its performance and will revise its terms of reference accordingly, unless there are unforeseen circumstances otherwise.

Background

The TB/HIV Working Group of the Stop TB Partnership was established in 2001 with the aim of coordinating the global response to the HIV associated TB epidemic. The HIV pandemic presents a massive challenge to the global control of TB at all levels. Globally, TB is also the commonest presenting illness among people living with HIV (PLHIV) both before and after receiving ART. The WG has already developed a core set of policy and program guidance based on the best available evidence to reduce the impact of the TB and HIV epidemics. WHO started to monitor implementation of collaborative TB/HIV activities in 2004. In 2005 key TB/HIV elements were included in the WHO standard data collection form sent to 199 countries. All countries reported on the extent to which TB patients were tested for HIV, assessed for ART (antiretroviral therapy) and provided with ART in 2003. A supplemental questionnaire was sent to 41 (2005) and 63 (2006) priority countries - those with the highest incidence rates of TB with HIV co-infection. This questionnaire was sent to all 211 countries in 2007.

The data collected showed that in 2003, 49% of countries had a national policy of offering HIV testing to TB patients and 46 countries (23%) routinely assessed HIV positive TB patients for their eligibility for ART. The number of countries that reported routine offer of HIV testing to TB patients increase from 7 in 2003 to 113 in 2007. This shows that most countries have only recently begun implementing collaborative TB/HIV activities. There have, however been examples of exceptional progress by some countries such as Kenya and Rwanda. In Kenya in the first quarter of 2006, 50 % of TB patients were tested for HIV, 30% of the HIV positive TB patients were put onto ART and 85% on co-trimoxazole preventive treatment (CPT). The Working Group has been instrumental in fostering these achievements mainly by serving as a forum of experiences and best practice exchange, raising the global and national profile of TB/HIV, and catalysing resource mobilization through funding mechanisms like the Global Fund and PEPFAR, and by developing evidence based policy and programme guidance.

However, the overall progress of implementation of collaborative TB/HIV activities particularly in those countries that carried the brunt of the problem, has been unacceptably low. Most countries still do not offer widely the essential diagnostics and treatment services needed for HIV and TB co-infected patients. Globally, only 14% of the estimated HIV positive TB patients were identified by national programmes in 2005. This figure is 13% in Africa, despite the region having 80% of the estimated burden of HIV-related TB. The current progress of the implementation of the collaborative TB/HIV activities is far short of what was called for in the Global Plan to Stop TB (2006 - 2015). The Global Plan set a target of 1.6 million TB patients to be tested for HIV in 2006 and 220,000 started on ART. The reality is that in 2005, the coverage was only 14% and 11% of what was planned for 2006 respectively. The number of PLWHIV screened for

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TB in 2005 was only 1.7% of the 11 million targeted in 2006. Numbers for those started on IPT in 2005 was 2.2% of the 1.2 million targeted for 2006.

Therefore, in light of these global changes and needs, the WG must review its current strategy and operational framework in order to address these gaps, and ensure the delivery of collaborative TB/HIV activities for patients in need of the services. Recognizing the different factors that influence the implementation of the joint services such as the epidemiological distribution of the disease and regional variations, the expansion of HIV prevention and treatment services, and health system issues needs special attention in addressing the gaps. The huge unmet research needs, particularly in the diagnosis, prevention and treatment of TB in PLHIV is another priority that requires extra measures to be taken. The services mitigating the impact of TB on PLHIV such as intensified TB screening, preventive therapy and TB infection control are essential and ensuring their delivery in the context of the emergence of extensively drug-resistant TB and the associated high mortality is urgent. Additionally, TB is now the commonest presenting illness in PLHIV receiving ART. Engagement of HIV stakeholders in the implementation of collaborative TB/HIV activities is thus an utmost priority.

Mission of the Working Group

To accelerate the implementation of collaborative TB/HIV activities to reduce the global burden of HIV related TB through effective collaboration between National TB and AIDS Control programs and other stakeholders, and through generation of evidence based policy and programme guidance in order to achieve the global TB/HIV targets set for 2010-2015 in *The Global Plan to Stop TB*.

Functions of the Working Group

The Working Group will have the following functions during the next five years (2008-2013). By the end of the five years the Working Group will again revisit its performance and will revise its functions, unless there are unforeseen circumstances otherwise.

- Promote the exchange of best practices and experiences among members and other stakeholders in order to catalyse implementation.
- Advise on the development and revision of evidence based policy and programme guidance to address the intersecting epidemics of the two diseases.
- Promote and encourage TB/HIV research in building a critical evidence base and ensuring the delivery of quality services.
- Build effective collaboration between TB and HIV/AIDS programs and communities and engaging all health providers in implementing TB/HIV activities in countries and communities with a high burden of HIV related TB.
- Increase the global and national visibility of TB/HIV and the mainstreaming of collaborative TB/HIV activities in HIV and TB efforts including research, care and treatment programmes, and funding mechanisms.

Structure and composition

The Working Group is one of the Working Groups of the Stop TB Partnership, which is established to eliminate tuberculosis as a public health problem and ultimately to realize a world free of TB. It comprises a network of more than 500 international organizations, countries, donors from the public and private sectors, and nongovernmental and governmental organizations that have expressed an interest in working together to

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achieve this goal. The Stop TB Partnership Coordinating Board provides leadership and direction, monitors the implementation of agreed policies, plans and activities of the Partnership, and ensures coordination among Stop TB Partnership components. The TB/HIV WG will collaborate and coordinate with other Working Groups of the Stop TB Partnership to fulfill its mission and carry out its functions.

Membership to the WG is open to any one who is committed to address TB/HIV, contribute to the global fight on the intersecting epidemics of the two diseases through stimulating discussions, debate and generation of evidence. Membership is free of charge and can be individual or organizational.

The WG Secretariat is hosted by the World Health Organization, is answerable to the TB/HIV WG, and operates under the WHO system within the Stop TB and HIV/AIDS Departments. The Working Group will have a Core Group and Infection Control sub-group.

The TB/HIV Core Group

The Core Group (CG) aims to facilitate and accelerate decision making and guide the strategic direction of the WG. The CG will have a membership not more than twenty five, equally distributed between HIV and TB expertise and organizational representation. Members will be requested to allocate time for their function in the Core Group at their discretion, and expected to serve as spokespersons for the TB/HIV cause and the work of the WG in their routine professional work. Members who missed two consecutive face to face meetings primarily for lack of time will be requested to reconsider their membership so as to allow room for new active members.

Standing members of the CG: Organizations with a track record of *demonstrable global commitment, ongoing global policy and implementation work, and resources for TB/HIV* will serve as standing members of the CG. The Chair and Secretariat hold the prerogative of deciding which organizations qualify as such. Exceptionally the representation for the standing community post will be rotating every two years. It is desirable that the organizations with standing membership in the Core Group will have a permanent representative in order to keep continuity. However, if need arises, the organizational representatives can be rotated after serving as members at least for three years. New global organizations with a strategic and comparative advantage for the mission of the WG and the cause of TB/HIV will continuously be included as new standing members of the Core Group.

Standing members for 2008-2013 include: Centers for Diseases Control (CDC), a community representative (a rotating post), Consortium to Respond Effectively to the AIDS/TB Epidemic (CREATE), Family Health International (FHI), International AIDS Society (IAS), the International Union Against TB and Lung Diseases (the Union), KNCV TB Foundation, National Institutes of Health, USA (NIH), Office of the Global AIDS Coordinator (OGAC), Treatment Action Group (TAG), United States Agency for International Development (USAID), Joint UN Programme on AIDS (UNAIDS) and the chair of the Infection Control sub-Group (rotating post). WHO as the Secretariat of the Working Group will be a standing member of the Core Group and will vote.

Rotating individual members of the CG: All individual members except for representatives from the community (who should be nominated through a transparent selection process), will be invited to join the Core Group based on their individual

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capacity, outstanding skills and contribution they will bring to the mission of the Working Group and the cause of TB/HIV. They will have a three year rotating membership into the Core Group and they will serve a maximum of two terms. Six of the rotating individual membership posts will be held by National AIDS or TB control programme managers who will be selected based on their individual merit and added value they will bring to the WG. The Chair and Secretariat will select all individual members based on their application with due consideration of their TB or HIV expertise, geographical representation and outstanding contribution, and present it to the approval of the Standing members of the Core Group.

The TB Infection Control Subgroup

The TB Infection Control Sub-group will facilitate the development of policies, strategies, and guidelines for implementing effective tuberculosis infection control practices, monitoring and evaluation systems. It will particularly build strategic partnerships and capacity for effective TB infection control of both the HIV, TB and other stakeholders active in infection control. The Chair of the TB Infection Control sub group will be a standing member of the TB/HIV Core Group for the duration of his or her term. The TB Infection Control Sub-group will have its own terms of reference and independent mechanism of function. The Chair of the TB Infection Control Sub-group will regularly report its activities to the meetings of the Working Group and the Core Group.

The Meetings of the Global TB/HIV Working Group

The Working Group meets once a year, depending on availability of resources, to review progress, determine priorities, share experiences and to outline specific actions that will promote implementation of collaborative TB/HIV activities. The Core Group will meet regularly through telephone or video conferencing as deemed necessary with a maximum of two face to face meetings annually. Invited speakers and observers can be invited to address specific areas during the meetings of the CG. The site of the meeting is not fixed: rotation between high burden countries and industrialized countries is desirable. Standing members of the Core Group are requested to consider hosting meetings of the Working Group and its Core Group. The cost of attending meetings by members of the WG and CG should be covered either by their organizations or themselves. The Secretariat will solicit funding to cover the travel cost of members from resource-limited and HIV prevalent countries.

The Chair of the TB/HIV Working Group

- The Chair will oversee the functions of the TB/HIV WG and of its associated bodies and will ensure monitoring of the implementation of recommendations of the WG.
- The Chair of the TB/HIV WG will chair the WG meeting and Core Group meetings.
- The Chair will represent the WG on the Coordinating Board of the Stop TB Partnership, and act as the chief link between the Partnership and the WG, in close collaboration with the Secretariat
- The Chair will serve a term of three years, and will be eligible for re-election for a second consecutive term only once.

The Vice-Chair of the TB/HIV Working Group

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- The Chair will be assisted in all its normative functions by the Vice-Chair. The Vice-Chair will assist the Chair during meetings of the WG and its associated bodies, and the Coordinating Board of the Stop TB Partnership.
- The Vice-Chair will be a current member of the Core Group and will be nominated, reflecting gender, TB or HIV expertise and geographic representation, by the Chair in consultation with the Secretariat. The Chair and Vice-Chair will both reflect TB and HIV expertise.
- The Chair will present the nominee(s) to all members of the Core Group who will approve the Vice-Chair by majority vote. The candidate will recuse herself/himself from the voting. In the unlikely event of equally distributed votes, the vote of the Chair will be a binding vote.
- The Vice-Chair will serve a term of three years. In the event the Vice-Chair is selected during the term the Chair is serving, this period will be shorter in order to coincide with the end of the Chair's term. The Vice-Chair will be eligible for re-selection for a second consecutive term as a vice-Chair.

Selection process for the Chair of the TB/HIV Working Group

- Two standing members of the CG will be asked by the Secretariat to form a search committee panel (hereafter referred to as the panel) together with one secretariat staff;
- Members of this panel will not be eligible to take the position of Chair;
- The panel will prepare a profile of the desired qualifications and characteristics of the Chair, according to the terms of the reference available in this document, which will be approved by the Core Group;
- The panel will identify, through discussion with members of the WG, directly or by electronic communication, suitable candidates from amongst the WG and the larger public health community;
- The panel will seek the availability of candidates and provide the CG with a confidential shortlist of not more than three candidates in a ranked order for approval;
- If any member of the Core Group is a candidate they will recuse themselves from the debate on the selection and from the voting;
- Working group members who have been registered as member for at least 3 months will confidentially vote on the shortlist through electronic media and select the preferred candidate;
- The panel will then once again contact the candidate with the most votes and seek her/his availability. Should the incumbent decline the invitation to become Chair, the second candidate will be contacted;
- Should the shortlist be insufficient to appoint the Chair, the panel starts the selection process again.