

## ***The Terms of Reference for the TB Infection Control Subgroup***

### **Background and rationale**

The association of TB and HIV/AIDS, the lack of concern paid to TB transmission in health care and congregate settings, and the absence of a global TB infection control strategy have created a suitable environment for an efficient transmission and spread of TB and MDR- and XDR-TB, among patients, health care workers, and the community.

Weak health systems in general and TB control programs in particular, have caused MDR-TB to emerge in countries where TB short-course chemotherapy was introduced in the absence of a strong (public health) DOTS program. High default rates and poor clinical practice have resulted in increasing MDR-TB rates in new and previously treated patients. Inadequate treatment of these patients with second-line TB drugs has resulted in extensively drug resistant TB (XDR-TB). The recent outbreak of XDR-TB in a hospital in Kwazulu Natal in South Africa illustrated the impact of TB transmission among patients and health care workers in the presence of HIV infected and immune-compromised patients and the absence of proper infection control policy and practice. The potential implications of TB transmission in health care and congregate settings on global TB morbidity and mortality have highlighted the urgent need to refocus attention on TB infection control, with a clear vision of phased expansion of successful activities to provide national coverage, incorporating and building on the lessons learned from successful infection control models. This process requires commitment of all implementing partners to common goals and co-ordination of stakeholder actions.

### **Mission of the TB Infection Control Subgroup**

To reduce the transmission of TB in health care and congregate settings, e.g., prisons, nursing homes, military compounds, refugee settlements with special attention to HIV prevalent settings and the emerging MDR and XDR TB context through the development, implementation, and evaluation of TB infection control policies and strategies.

### **The Goal of the TB Infection Control Subgroup**

To develop, test, monitor, evaluate, advocate and support implementation of tools, procedures and policy to promote effective TB infection control in health care and congregate settings.

### **Terms of Reference**

1. To advise WHO on the **development of policies, strategies, research priorities, and guidelines** for implementing effective tuberculosis infection control practices with emphasis on MDR- TB, XDR-TB, and TB/HIV, based on available knowledge, latest evidence, and practical field experience.
2. To **build strategic partnerships for effective TB infection control** including with other Stop TB Partnership working groups, WHO HIV Department, Epidemic and Pandemic Alert and Response, occupational health groups,

scientific communities, health care providers, and representatives of workers, patients, visitors, and others in the community directly and indirectly affected by TB transmission in congregate settings.

3. To build capacity at the country level for infection control implementation, including advocating for and facilitating the **training of international and national technical consultants** in TB infection control, and facilitating their availability to provide technical assistance to countries for the implementation of TB infection control activities.
4. To prioritize **the protection of health care and other workers, particularly HIV+ individuals** by linking with global occupational safety and health programs. To work to create a demand for safe conditions in the workplace and empower workers with the knowledge and tools to protect themselves.
5. To assist WHO and partners to **develop and implement ways to monitor the implementation of infection control measures at the country level**, including the development and testing of performance indicators to identify implementation and efficacy problems that require additional attention. These infection control performance indicators would become part of routine reporting along with TB and HIV treatment and control indicators and would become part of WHO TB and HIV program reviews, whenever possible.
6. To assess the costs of implementing infection control activities and **advocate for resource mobilization**, working with GFATM, PEPFAR, DFID, Bill and Melinda Gates Foundation, and other funding agencies, and monitoring the **inclusion of specific funding for infection control in project proposals and funding opportunities**.
7. To seek, strengthen, and **coordinate working relationships on TB infection control** with the scientific community, health care providers, and representatives of workers, patients, visitors, and other stakeholders in airborne infection control in health care and congregate settings, e.g., agencies dealing with refugees, internally displaced persons, prisons, nursing homes, and military barracks.

## **Mode of Operation**

### **The form of the TB Infection Control Subgroup**

#### **Governance**

The TB-IC SG is a subgroup of the Global TB/HIV Working Group of the Stop TB Partnership, housed in WHO.

#### **The Secretariat**

The Secretariat, hosted by WHO, is answerable to the TB/HIV WG, and operates under the WHO system within the TB/HIV and Drug Resistance unit of the Stop TB Department. The Secretariat is responsible for organizing the TB-IC SG and Core Team meetings, to prepare the agenda and relevant documents, in consultation with

the Chair and members of the Core Team, to prepare and distribute the reports of the meetings, to monitor implementation of the recommendations of the Core Team and SG and to manage resources provided for the functioning of the Group.

### **Composition**

The subgroup will be composed of members with broad representation of institutions, professions and countries with experience and/or interest in tuberculosis infection control. This includes representatives with expertise in clinical practice, both physicians and infection control nurses, infectious disease control experts, hospital managers working in TB and HIV and resource-constrained settings, infection control, building and ventilation engineers, worker safety, and international public health program, quality control, and field representation. Representatives of national disease control programmes, Ministries of Health, non-governmental organizations (NGOs), bilateral and multilateral aid agencies, and research institutions will also be invited to participate. Membership is open to any institution or agency which supports the goals of the SG. Additional members may be invited based on their potential contribution to the activities of the TB-IC SG. Membership will be open to interested persons with a rolling enrolment. A core team will be established to expedite the work of the subgroup.

### **Ways of working**

#### **The Meeting of the TB Infection Control Subgroup**

- The TB-IC SG will meet once per year, pending availability of resources
- The site of the meeting is not fixed: rotation between high burden countries and industrialized countries is desirable. Members are requested to consider hosting meetings;
- The annual meeting will be a forum with the overall goal to expand TB infection control;
- The annual meeting will serve to support activities aimed at expanding TB infection control nationally, and as a venue to share experiences and build linkages with other infection control institutions and stakeholders.

#### **The Chair**

- The Chair of the subgroup will be responsible for chairing the meetings of the subgroup and Core Team. The Chair will be assisted by a vice-chair for this function.
- The Chair will represent the SG in the Core Group of the Global TB/HIV Working group, and act as the chief link between the SG and the WG. He/she will be represented by the vice-Chair when not able to attend in person.
- The Chair will have overview of the functions of the TB-IC SG and of its associated bodies and will ensure monitoring of the implementation of recommendations of the SG.
- The Chair will serve a term of two years, and will be eligible for re-election for a second consecutive term only once.
- The Chair will liaise with the overall Chair of the TB/HIV WG on strategic issues in order to ensure the engagement of more HIV and TB stakeholders for TB infection control.

### **The Vice-Chair**

- The Chair will be assisted in all normative functions by the vice-Chair. The vice-Chair will also assist the Chair during meetings of the SG and its associated bodies, and the Global TB/HIV WG
- The vice-Chair will be a current member of the Core Team and will be selected, reflecting geographic and gender equity, by the Chair in consultation with the secretariat.
- Members of the Core Team will vote by majority vote on the candidate selected by the Chair in consultation with the Secretariat. The candidate will recuse herself/himself from the voting.
- The vice-Chair will serve a term of two years. In the event the vice-Chair is selected during the term the Chair is serving, this period will be shorter (until the end of the term the Chair is serving). The vice-Chair will be eligible for re-election for a second consecutive term as a vice-Chair or for selection as the Chair at the end of his/her term as a vice-Chair.

### **Selection process for the Chair**

- Nominations for Chair will be solicited from the infection control subgroup
- Candidates will be reviewed by a panel convened by the subgroup secretariat and selected against a set of established criteria.
- Members of the Core Team vote by elimination voting on the shortlist and select the preferred candidate;
- The panel will then 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

### **The Core Team**

The Core Team (CT) aims to facilitate and accelerate decision making and guide the strategic direction of the SG. The CT will have a membership of not more than ten members. Members will be requested to allocate time for their function in the Core Team at their discretion, and expected to serve as spokespersons for the work of the SG 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.

All individual members will be invited to join the Core Team based on their individual capacity, outstanding skills and contribution they will bring to the mission of the Subgroup. They will have a two year membership into the Core Team. The Chair and Secretariat will select all individual members based on their application with due consideration of their expertise, geographical representation and outstanding contribution.

The Core Team will meet physically twice per year, depending on availability of resources. Moreover, the CT will meet by telephone or by video conference as required by the SG Chair or Secretariat.