

draft 28 April 2005

TWO DISEASES, ONE PATIENT

TB/HIV control strategy towards 2015

The TB/HIV Working Group (WG) strategic plan 2006-2015 reviews progress in the control of HIV related TB made since the launch of the 1st Global Plan to Stop TB (GPSTB). This strategic plan analyzes current challenges and opportunities and outlines the strategic vision of the WG 2006-2015 and beyond, while keeping in mind the long term goal to eliminate TB as a global public health problem by 2050.

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

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

Conversely, TB is among the most important causes of morbidity and mortality among people living with HIV/AIDS (PLWHA). Around 13 million PLWHA worldwide are also infected with TB and thus at increased risk of developing active TB. In 2003, there were an estimated 674 000 new cases of TB in PLWHA (8% of all new TB cases) and 229 000 deaths from TB in PLWHA (13% of all TB deaths). Global tuberculosis incidence continues to rise by 1% per year, despite incidence remaining stable or falling in five out of the six WHO regions (Global TB Report 2005). The continued rise of TB incidence in the WHO region for Africa is sufficient to offset the stable or falling TB incidence in the rest of the world. Of the 15 countries in the world with the highest rates of TB per capita, 13 are in Africa. With 28% of TB in the African Region attributable to HIV, HIV clearly presents one of the greatest challenges to achieving the global TB control targets. If it were not for the effect of the HIV epidemic, global TB incidence would be falling. HIV is changing the face of TB in other ways. HIV prevalence is often highest among young people and especially young (15-24 years) women, consequently TB incidence 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 global TB control and so the scope of collaborative TB/HIV activities should remain global. Unless the continued global spread of HIV can be halted and reversed the global TB control targets will become increasingly difficult to reach. UNAIDS predict that the global total of PLWHA is unlikely to fall before 2010.

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 prime objective of the WG is to provide guidance on how to address the dual epidemic. The basis for TB/HIV collaboration is laid out in the 'Interim policy on collaborative TB/HIV activities' which clearly defines the collaborative activities that should be undertaken under three objectives (see box 1).

Box 1

Establish the mechanisms for collaboration
<ul style="list-style-type: none">• Set up a coordinating body for TB/HIV activities effective at all levels• Conduct surveillance of HIV prevalence among tuberculosis patients• Carry out joint TB/HIV planning• Conduct monitoring and evaluation
Decrease the burden of tuberculosis in people living with HIV/AIDS
<ul style="list-style-type: none">• Establish intensified tuberculosis case-finding• Introduce isoniazid preventive therapy• Ensure tuberculosis infection control in health care and congregate settings
Decrease the burden of HIV in tuberculosis patients
<ul style="list-style-type: none">• Provide HIV testing and counselling• Introduce HIV prevention methods• Introduce co-trimoxazole preventive therapy• Ensure HIV/AIDS care and support• Introduce antiretroviral therapy

2. TB/HIV WG Achievements 2000-2005

The first Global Plan recommended that the TB/HIV WG:

- develop a technical framework to guide country strategies to better control TB among HIV infected people;
- promote integration of 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.

Since these recommendations, the WG has published a core essential set of guidance documents which define the policy on collaborative TB/HIV activities, what countries should do, how they can do it, and how they can monitor results¹. Together, they provide a clear evidence based technical framework for reducing the impact of HIV related TB through collaboration between TB and HIV/AIDS programmes and their partners. Human resource

¹ 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/)

capacity in collaborative TB/HIV activities has been strengthened through development of training materials and national-level consultant training courses.

It is now accepted that collaborative TB/HIV activities should be an integral component of DOTS expansion activities in high HIV prevalence settings, building on DOTS and HIV/AIDS programmes to improve prevention, treatment and care of HIV related TB. TB programmes have become an important entry point in the HIV/AIDS continuum of care. The DOTS model for TB control has provided the HIV community with a strong basis on which to develop strategies for the delivery of antiretroviral therapy in resource limited settings. HIV/AIDS programmes are an important partner in TB control, increasing TB case detection through TB screening and providing TB preventive therapy. Lessons from HIV/AIDS activism and advocacy have revitalised the TB community and engaged a broader spectrum of partners in TB control.

Collaborative TB/HIV activities are now being 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 2003. However, only 3% of the 4.4 million notified TB cases in 2003 were tested for HIV. Implementation of collaborative TB/HIV activities remains slow for the reasons discussed below, but there is considerable urgency to accelerate access to comprehensive TB/HIV prevention and care.

The WG now has over 230 registered members and has held annual meetings since its creation. The 2004 WG meeting in Addis Ababa², was attended by almost 200 participants from 38 countries, and provides a forum for stakeholders while the Core Group of the WG with 25 members guides the development of products, strategies and policies. The WG has drawn on the support and experience of HIV activists and advocacy efforts to raise the global profile of TB/HIV.

3. The vision for 2005-2015

The vision for collaborative TB/HIV activities and the TB/HIV WG towards 2015 has been informed by global epidemiological and cost analyses with input from WG members.

The **strategic vision** of the TB/HIV WG for 2005-2015 is to reduce the global and individual burden of HIV related TB by scaling up implementation

² 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".

'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

of collaborative TB/HIV activities in countries with a high burden of TB/HIV³; consolidating global TB/HIV policy and adapting it to special situations; engaging all health providers in delivering TB and HIV services; mobilising affected communities and promoting research and development.

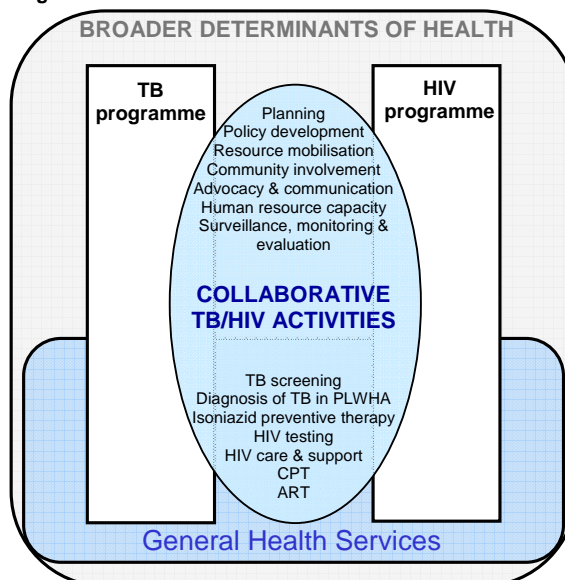
The **mission** of the TB/HIV WG is to build collaboration between TB and HIV/AIDS programmes and communities in order to more effectively address and understand the epidemic of HIV related TB. Collaborative TB/HIV activities are not a replacement for strong DOTS based TB programmes and comprehensive HIV/AIDS prevention and care programmes, instead they build on existing programmes, exploiting the synergies and commonalities between these disease focused programmes to deliver accessible, comprehensive and high quality prevention, care and support services to people affected by TB and HIV - two diseases which frequently occur in the same community, the same patient.

The **goal** of the TB/HIV WG is to develop effective policy to reduce the impact of HIV related TB and to promote, monitor and evaluate the global implementation of this policy.

4. The context

Collaborative TB/HIV activities are planned and governed by existing TB and HIV programmes but TB/HIV interventions will usually be delivered in the context of the general health services, under the influence of the broader determinants of health, such as poverty, the social environment and education. As such, implementation of collaborative TB/HIV activities will be limited by the constraints of existing programmes and health services and the extent to which the broader determinants of health can be influenced (see figure 1).

Figure 1: Context in which collaborative TB/HIV activities



1. Establishing effective collaboration between TB and HIV programmes

Global policy on collaborative TB/HIV activities has been developed that builds on established DOTS TB programmes and comprehensive HIV/AIDS programmes to provide comprehensive, high-quality and patient-centred TB and HIV prevention, care and support services that will reduce the impact of

³ The Interim policy on collaborative TB/HIV activities defines the collaborative TB/HIV activities that countries should undertake based on the status of the HIV epidemic.

HIV related TB. The current global policy, supporting documents and training materials⁴ are clear about the precise nature of the recommended collaborative TB/HIV activities. The international standards for TB/HIV collaboration have been established. It is now important to deliver and maintain those standards. The current policy is being implemented in many high burden settings but the data from the 2005 Global TB Control report demonstrate that implementation is slow and must be accelerated if we are to reach the MDG targets. Implementation of these basic recommendations in all high burden settings will be at the core of the TB/HIV strategic plan for 2005-2015. However, no policy is static and the policy will be refined on the basis of experience from countries implementing the policy and the results of new research as it arises. The generic policy will also have to be adapted to respond to the needs of specific populations not currently addressed by existing policy e.g. injecting drug users and children.

2. Strengthening health services

National health policy is primarily implemented through the formal health sector, and as such is limited by the capacity of the health service to deliver. In most low income countries, particularly in sub-Saharan Africa (sSA) where disease burden is greatest, health services are weakest, with limited capacity to implement existing health policies. Strengthening health systems and the health workforce to deliver TB and HIV care and prevention will be vital to attaining the MDGs. In low income settings, 80% of all consultations in the primary health care setting are related to TB, HIV/AIDS, malaria, or maternal & child health. Thus strengthening accessibility, affordability and availability of these four 'MDG programmes' will go a long way to strengthening the health service and reaching the MDGs. But strengthening primary care will also require strengthening of related referral facilities, laboratories and hospitals as well as strengthening the supportive role of communities and the private sector. Investing in disease focused programmes such as TB and HIV can rapidly reduce disease impacts and with a broader approach such as TB/HIV can also contribute to the longer term goal of strengthening health services as a whole.

Involving partners outside of the traditional health sector will 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 collaborative TB/HIV activities. It should aim to include all HIV providers in TB and TB/HIV control activities. It must also be expanded to promote greater community involvement in provision of prevention and care

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/)

services, which will increase access to services and support health services while they are strengthened.

3. Multisectoral approach

The powerful influence of the broader determinants of health on HIV/AIDS encouraged the adoption of a multisectoral approach from early in the course of the epidemic. In comparison the TB community have been relatively slow to adopt the multisectoral approach and engage partners outside of the health sector in TB control, and as such TB has fallen off the development agenda in many settings. TB, like HIV/AIDS, is strongly influenced by poverty, gender inequality, human rights, living conditions, and other socio-political factors and will not be adequately addressed unless these issues are tackled through the involvement of the non-health sectors, such as education, justice, employment, and the environment. TB needs to be mainstreamed into the development agenda and included in the broader strategic planning approaches and financial frameworks aiming to tackle poverty, such as the PRSPs (Poverty Reduction Strategy Papers), HIPC (Highly Indebted Poor Country) strategies, and MTEF (Medium Term Expenditure Frameworks) and SWAps (Sector Wide Approaches) which hold the potential for addressing constraints in the health sector and place financing for TB control in a sustainable and flexible long term strategic plan. Better connections between anti-poverty initiatives and health system strengthening must be forged.

5. OBJECTIVES:

The TB/HIV WG strategy for 2006-2015 is to enhance interventions to reduce the impact of HIV related TB through the following objectives:

1. Consolidate collaborative TB/HIV activities
2. Adapt collaborative TB/HIV activities
3. Engage all providers and partners in collaborative TB/HIV activities
4. Involve communities in collaborative TB/HIV activities
5. Promote research and development in collaborative TB/HIV activities

Objective 1 - Consolidate collaborative TB/HIV activities

Scale-up, optimise, sustain and measure implementation of collaborative TB/HIV activities, focusing on quality and a patient-centred approach. This will be achieved by advocating for the collaborative approach amongst all stakeholders in TB and HIV, building capacity and mobilising sustained human and financial resources to support collaborative TB/HIV activities within strengthened health systems. Effective surveillance, monitoring and evaluation systems will be established. Collaborative TB/HIV activities cannot be developed in a vacuum and rely on the availability of a strong DOTS TB programme to detect and manage all TB cases which will reduce TB transmission in the community in HIV negative people (an important source of infectious TB), as well as HIV positive people. Effective HIV/AIDS prevention and care services will reduce transmission of HIV and through

effective antiretroviral therapy will reduce the incidence of TB among PLWHA.

Activity areas:

Implementing current policy on collaborative TB/HIV activities

The recommendations on collaborative TB/HIV activities in the Interim policy are far from fully implemented in the highest TB/HIV countries. A major short term focus for the WG is to support the implementation of the basic package of activities in all high burden settings. To achieve the TB focused MDGs a particular focus should be placed on reducing transmission of TB to PLWHA by rapidly identifying and successfully treating all TB cases and improved environmental controls to reduce transmission in high HIV prevalence settings. Reducing recurrence of TB among PLWHA through use of rifampicin-containing regimens throughout treatment and ART, reducing TB mortality among PLWHA through co-trimoxazole and ART. For the HIV focused MDGs it will be important to promote HIV prevention among TB patients and provide comprehensive care, including ART to HIV positive TB patients.

Advocacy and Communication

International advocacy and communication (A&C) efforts need to be directed at technical and donor agencies to place TB and TB/HIV near the top of the health and development agendas, alongside HIV/AIDS. The TB and HIV communities need to advocate strongly for comprehensive health sector strengthening to reverse the chronic underinvestment in health services. Intensifying A&C for collaborative TB/HIV activities at community, district, and country level, as well as internationally, will increase commitment and resources for collaborative TB/HIV activities as an adjunct to DOTS and comprehensive HIV/AIDS prevention and care. Grassroots TB and HIV activists can work together to considerably enhance impact. Messaging should be sustained, directed and tailored to specific audiences.

Mobilising resources - including technical assistance

Supporting countries to enhance collaboration between the TB and HIV/AIDS communities to provide comprehensive TB and HIV prevention, care and support services will remain key to the TB/HIV WG and its partners. National policy makers and health professionals need to be encouraged to take the lead, define country priorities and allocate available national financial resources for comprehensive TB and HIV prevention and care that can be supplemented as necessary by external funds. The TB/HIV WG will help countries to mobilise additional resources for TB/HIV control if necessary from bilateral and multilateral donors (e.g. USAID, DFID, CIDA, European Union, World Bank) as well as non-governmental organisations, other international and philanthropic funding initiatives (e.g. GFATM, and Bill and Melinda Gates Foundation). The major technical agencies in TB/HIV such as CDC, IUATLD, KNCV and WHO can provide ongoing technical assistance to plan, implement, monitor and evaluate collaborative TB/HIV

activities. Funding for such technical assistance will need to be found either at country level or from external sources.

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 collaborative approach to human resource capacity development by advocating for more staff, more attractive salaries, better working conditions, improved pre-service and in-service training, more efficient working practices, and making use of alternative cadres of staff will have benefits to both programmes. TB/HIV training should be integrated into TB and HIV training strategies and should be coordinated with other disease specific programmes, e.g. through the IMAI (integrated management of adult and adolescent illness) approach.

Quality improvement through surveillance, monitoring and evaluation

As the coverage of collaborative TB/HIV activities is expanded it is important to ensure that the quality of service delivery is maintained. Well designed surveillance, monitoring and evaluation will provide the information required to measure coverage of activities, identify problems in the implementation of collaborative TB/HIV activities and to constantly improve programme performance. TB and HIV/AIDS programmes should have a specific budget line for M&E, which includes TB/HIV and where possible TB/HIV should be incorporated into existing TB and HIV M&E systems. The results of M&E must feed into the TB and HIV planning cycles, turning results into best practice, quality improvement and strong advocacy messages to support investment in TB/HIV activities. The ability to chart the impact of interventions will be key. 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 - Adapt collaborative TB/HIV activities

Continuous improvement of the collaborative approach to TB/HIV prevention and care by incorporating new interventions and tailoring activities to specific situations, such as TB/HIV in children, injecting drug users, prisons and migrant populations and the needs of other special groups.

Activity areas:

Broaden the scope of existing TB/HIV policy

The existing policy on collaborative TB/HIV activities should be refined and adapted using all available knowledge and evidence. Strategies to improve the management of smear negative TB, including improved access to rapid culture techniques, need to be developed urgently. Introduction of daily rifampicin-containing regimens throughout the full course of TB treatment will reduce the recurrence rate of TB and should be widely introduced. Use of four drug fixed dose combination antituberculous drugs is important to

reduce pill burden and promote adherence especially in PLWHA who may also be on ART. Taking a broader approach to attaining the MDGs and reducing TB mortality we may have to address the other causes of mortality in HIV positive TB patients in certain situations, e.g. preventing malaria through the distribution of insecticide-treated bed nets in malaria endemic areas, promoting methadone replacement therapy for injecting drug users.

Adapt policy on collaborative TB/HIV activities for special situations and vulnerable groups

Existing policy needs to be adapted to certain situations not covered by the existing policy including intravenous drug users (IDU), prisoners, children, mobile or remote populations. IDUs are an important risk group in the European region and in parts of Asia. They are at increased risk of both diseases and may have more difficulties in accessing services and adhering to therapy, in addition methadone replacement therapy may interact with TB and HIV medications. Prisoners have a higher prevalence of both disease and prisons can act as amplifiers of TB and HIV transmission. Establishing collaborative TB/HIV activities in prisons may help to break this transmission cycle and target some of the most marginalised members of society. In many settings, migrant and remote populations have difficulty in accessing health care services and adhering to long term therapy. Special collaborative approaches may help to improve their care. The complexity of diagnosis and treatment of TB and HIV in children will require special attention.

Objective 3 - Engage all providers and partners in collaborative TB/HIV activities

The factors that influence TB and HIV are broad and extend far beyond the scope of the public health sector. The impact of both diseases will be most effectively reduced when a broad range of partners and stakeholders beyond the health sector are engaged in impact reduction through the public private mix (PPM) and multisectoral approaches.

Activity areas:

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 PPM 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.

Develop a multisectoral approach to collaborative TB/HIV activities

Many of the factors which influence TB and HIV are outside the control of the health sector but need to be addressed if TB and HIV are likely to be effectively prevented. Most of these social, cultural, environmental and political factors are common to both TB and HIV and could be addressed

jointly. The multisectoral approach to HIV/AIDS prevention and care should be adapted to include TB and TB/HIV on the agendas of the main sectors that have an influence on health e.g. economy, education, employment, justice. TB/HIV is a development issue contributing to the cycle of poverty in many countries. Advocacy efforts are needed to place TB and TB/HIV high on the development agenda and included in broad strategic planning frameworks such as the PRSPs.

Objective 4 - Involve communities

Promote community participation and engage societies to increase demand for, and contribute to the provision of comprehensive care

Activity areas:

Engage communities in advocating for collaborative TB/HIV activities

As the HIV community has demonstrated community activism is a powerful tool in increasing access to effective prevention and care services for PLWHA. This community mobilisation approach needs to be adapted to increase political commitment to collaborative TB/HIV activities. 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.

Engage communities in planning, delivering and monitoring collaborative TB/HIV activities

Communities affected by TB and HIV should play a central role in planning, delivering and monitoring collaborative TB/HIV activities. It is important that communities feel a sense of ownership over their valuable health resources and are empowered to take responsibility for supporting the health services where possible. Community involvement in planning and monitoring services will ensure that the service responds to the communities needs. In low resource settings, especially where human resource capacity is limited, communities can play an important role in supporting delivery of collaborative TB/HIV activities.

Objective 5 - Promote research and development:

The WG needs to continue to work with policy makers and researchers to identify the most important research questions surrounding TB/HIV, mobilise the resources needed to conduct the research and translate the research results into improved policy on collaborative TB/HIV activities. The WG should support the efforts of public and private enterprises to develop better tools for TB diagnosis, treatment and prevention in the context of HIV.

Activity areas:

Continually develop and refine a prioritised research agenda for collaborative TB/HIV activities

The priority areas for research in collaborative TB/HIV activities have been identified but need to be continually reviewed in the context of changing knowledge. The WG should manage this process working closely with

TB/HIV policy makers, affected communities and researchers to direct the research agenda and mobilise the necessary resources. A continuous cycle of policy informing research priorities, and research informing policy must be maintained.

Support operational research at country level

Operational research should be encouraged and supported at country level to tailor collaborative TB/HIV activities to country needs and develop research capacity. The results of operational research are often less generalisable than more robust scientific methods but can provide very important lessons for feasibility and improvement of programme performance for TB/HIV activities.

6. ACTIVITIES, TIMELINES, MILESTONES

Bullet format activities, timelines and milestone will be added.

7. RESOURCE NEEDS

It must be reiterated that collaborative TB/HIV activities are additional to functional DOTS-based TB programmes and HIV/AIDS prevention and care programmes. Thus the costs for collaborative TB/HIV activities below do not include the costs for DOTS and HIV/AIDS prevention and care.

Further discussions are needed to refine the model and finalise the total costs for delivering collaborative TB/HIV activities and the likely impact we can expect. The impact in terms of lives saved and TB cases averted will be presented when the analysis has been completed.

Year	AFRhigh		AFRlow		EEUR		EMR		LAC		SEAR		WPR		Total	
	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total	% of TB/HIV total
2006	6	2	1	0	0	0	0	0	1	0	3	1	0	0	12	1
2007	15	4	2	1	1	0	0	0	2	1	8	2	1	0	30	1
2008	32	7	5	2	2	0	0	0	5	2	14	3	1	0	59	2
2009	60	11	8	4	4	1	0	0	9	4	20	3	2	1	103	4
2010	93	15	12	5	8	1	0	0	15	6	21	4	3	1	152	5
2011	128	19	15	6	9	1	0	0	19	9	20	4	4	1	196	7
2012	157	22	19	7	10	1	0	0	20	9	19	3	5	1	230	7
2013	184	25	22	9	11	1	0	0	20	10	19	4	6	2	262	8
2014	214	27	25	10	12	1	0	0	21	10	18	4	7	2	296	9
2015	233	29	28	11	12	1	0	0	21	11	18	4	7	2	319	10
total	1122	18	136	6	67	1	3	0	132	6	160	3	38	1	1659	6

Table 1: PROVISIONAL resource needs for collaborative TB/HIV activities (cost US\$ millions) and expressed as a proportion of the total cost for comprehensive TB control by region and year.

8. MONITORING AND EVALUATION

A guide to monitoring and evaluation (M&E) of collaborative TB/HIV activities has been produced which defines the core indicators that are necessary for monitoring collaborative TB/HIV activities. M&E of collaborative TB/HIV activities will be incorporated into TB and HIV M&E systems rather than through a separate system. The existing globally recommended TB and HIV/AIDS data collection tools are being adapted to be able to capture these additional TB/HIV data. Collaborative 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 collaborative TB/HIV activities will be measured in terms of existing TB and HIV impact indicators such as TB mortality, TB incidence, and HIV incidence.

9. KEY RISK FACTORS

HIV epidemic continues to spread

It will be increasingly difficult to reach the MDG 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 the gap between rich and poor is narrowed, bringing the poorest nearer to the global average. Global economic and development strategy needs to be aligned to benefit the poorest countries.

Health systems

The capacity of health services in low income countries to deliver TB/HIV control strategies will be among the greatest constraints to achieving the MDGs. 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 both be committed to and agree on the principles and methods for collaboration to be successful. Political commitment is necessary to establish collaborative TB/HIV activities and for the appropriate allocation of human and financial resources. 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 WG 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. The WG is necessary to direct new research, refine policy and monitor progress in TB/HIV. Adequate funding will be needed to maintain the WG, provide technical assistance to countries and for ongoing monitoring and evaluation of TB/HIV activities.