TB and HIV: the deadly dual epidemic

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Global burden of TB/HIV

• In 2008:
  
  • One third of the 33.3 million people living with HIV co-infected with TB
  
  • 1.4 million people HIV positive TB patients
    – 500,000 people died of HIV associated TB
  
  • 1.4 million TB patients tested for HIV
    – Of those HIV positive; 200,000 given CPT and 100,000 ART
  
  • 1.4 million PLHIV screened for TB
    – Only 48,000 given IPT
# WHO TB/HIV Collaborative Activities Policy

## A. Establish the mechanism for collaboration
1. TB/HIV coordinating bodies
2. HIV surveillance among TB patient
3. TB/HIV planning
4. TB/HIV monitoring and evaluation

**Joint HIV and TB**

## B. To decrease the burden of TB in PLHIV
5. Intensified TB case finding
6. Isoniazid preventive therapy
7. TB infection control in health care and other settings

**HIV programme**

## C. To decrease the burden of HIV in TB patients
8. HIV testing and counselling
9. HIV preventive methods
10. Co-trimoxazole preventive therapy
11. HIV/AIDS care and support
12. Antiretroviral therapy to TB patients.

**TB programme**
1.3 Target audience

This document is intended for decision-makers in the field of health, for tuberculosis and HIV/AIDS programme managers working at all levels in the health sector, as well as donors, development agencies and nongovernmental organizations supporting tuberculosis and HIV/AIDS programmes. The recommendations made in this document also have important implications for the strategic directions and activities of other ministries.
TB/HIV Response to PPM

- WHO TB/HIV collaborative activities policy also targets NGOs and other line ministries.

- Advocacy strategy: target HIV/AIDS NGOs not working on TB, particularly in Africa.
  - Any AIDS NGO which does not work on TB is providing substandard care
  - (key message of Africa Road Map that led to the regional declaration of TB emergency in 2005)

- NGOs conduit to implementation
  - TB/HIV Working Group engaged with key activists in HIV arena
  - Conducted workshops to build their capacity to engage in TB/HIV

- Activists generate demand
Intensified engagement with PEPFAR

Our strategy: engage PEPFAR and Track 1.0 Partners

- Track 1.0 Partners (funded since 2004)
  - AIDSRelief
  - Catholic Relief Services Consortium
  - Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)
  - Harvard School of Public Health
  - Mailman School of Public Health of Columbia University

PEPFAR Track 1.0 (Treatment) Partners receive the bulk of funding each year – these 4 partners have received $1.6 billion USD since 2004
Intensified engagement with PEPFAR

- Revised TB/HIV Working Group ToR to include institutional members, donors and program managers
  - PEPFAR/OGAC became an institutional member
- Catalyzed opportunity of HIV Implementers Conferences held by PEPFAR each year
- Held side meetings and sessions at the conferences with Track 1.0 partners and key PEPFAR decision-makers
- Lobbied to participate in the Track 1.0 partners' meeting and was invited to attend

RESULT

- TB screening made a mandatory part of all HIV proposals to PEPFAR
Joint ILO-WHO Survey

• 57% of workplaces do not address TB through their HIV programs

• 95% of Governments responded that they would like TB to be included in HIV workplace programs
WHO Response

• WHO responded to calls for guidance on how to engage all partners in TB/HIV response
  – Protocol Promoting the implementation of collaborative TB/HIV activities through public–private mix and partnerships developed in 2008

• Pilot projects currently being conducted in Namibia and India to garner evidence

• Encourage documentation – implementation occurring but needs to be published in peer reviewed journals
WHO Response

- Protocol outlines the guiding principles for scaling up involvement of public & private providers in TB/HIV collaborative activities
- Defines the task mix according to local policies & context
Box 2. Guiding principles for commencing and scaling-up the involvement of public and private providers in collaborative TB/HIV activities

- Existence of national TB and AIDS control programmes and implementation of basic DOTS strategy and basic services for HIV prevention and treatment
- An environment conducive to national policy, and capacity to support PPM TB/HIV activities
- Coordination between the national AIDS and TB control programmes at all levels (state, regional, provincial, district) and among all private and public stakeholders involved in the initiatives
- Strategic and regular advocacy to involve all providers and ensure buy-in of all relevant TB and HIV stakeholders in PPM TB/HIV activities
- Medicines and consumables supplied free of charge to providers extended free of charge to patients
- Diagnostic tests widely accessible and affordable
- Capacity building (including training and supervision) in accordance with national policies and standards
- Strengthen existing collaborative mechanisms and/or emerging opportunities between private and public sector and national TB and AIDS control programmes optimized to ensure sustainability and avoid duplication of structures
- Provision of technical assistance (internal and/or external) ensured
- Ensured continuity of services to end users in cases of provider decisions to opt out of PPM scheme.
<table>
<thead>
<tr>
<th>Collaborative TB/HIV activities</th>
<th>Rationale</th>
<th>Distribution of task or involved stakeholders</th>
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<tbody>
<tr>
<td><strong>A. Establish the mechanisms for collaboration</strong></td>
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<tr>
<td>A.1 Set up a coordinating body for TB/HIV activities effective at all levels</td>
<td>Coordinating body is needed (at all levels) to ensure more effective collaboration between the two programme efforts and the private and public service providers.</td>
<td>National, TB and AIDS Control Programmes and their system at regional, state, provincial or district levels. Professional Associations, Service provider interest groups, other line ministries such as Ministry of Justice</td>
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<tr>
<td>A.2 Conduct surveillance of HIV prevalence among tuberculosis patients</td>
<td>Surveillance is essential to inform programme planning and implementation. The method chosen will depend on the national TB and HIV situation, and the availability of resources and expertise.</td>
<td>National TB and HIV/AIDS Control Programmes</td>
</tr>
<tr>
<td>A.3 Carry out joint TB/HIV planning</td>
<td>Roles and responsibilities of two programmes have to be clearly defined, and should focus on all collaborative TB/HIV activities, capacity building, training, resource mobilization and advocacy, communication and social mobilization.</td>
<td>National TB and HIV/AIDS Control Programmes and their system at regional, state, provincial or district levels. Professional Associations, service provider interest groups, line ministries</td>
</tr>
<tr>
<td>A.4 Conduct monitoring and evaluation</td>
<td>M&amp;E helps ensure continuous improvement of programmes’ performances. It involves collaboration and referral linkages between different services and organizations.</td>
<td>National TB and HIV/AIDS Control Programmes and their system at regional, state, provincial or district levels.</td>
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<td><strong>B. Decrease the burden of tuberculosis in people living with HIV/AIDS (the Three I’s)</strong></td>
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<td>B.1 Establish intensified TB case-finding</td>
<td>Screening for early signs and symptoms of TB among PLHIV increases the chance of survival, improves quality of life, and reduces the transmission of tuberculosis in the community. Involves suspect identification, referral or patient or family education</td>
<td>All HIV treatment and care providers involved in the PPM initiative. Informal providers for patient referral.</td>
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<tr>
<td>B.2 Introduce isoniazid preventive therapy (IPT)</td>
<td>Six to nine months of IPT prevents the progress of latent TB infection into TB disease in PLHIV.</td>
<td>All HIV care providers to be involved in the PPM initiative. Pharmacists and informal providers to assist adherence for IPT</td>
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<td>B.3 Ensure TB infection control in health care and congregate settings</td>
<td>Health care workers and their patients are at risk of being infected by TB (especially in congregate settings) if infection control is not properly maintained.</td>
<td>All TB and HIV treatment and care providers involved in the PPM initiative.</td>
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<td><strong>C. Decrease the burden of HIV in tuberculosis patients</strong></td>
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<tr>
<td>C.1 Provide HIV testing and counselling</td>
<td>Testing should be offered to all TB suspects and patients as it offers an entry point of prevention, care, support and treatment of HIV/AIDS and TB.</td>
<td>All TB diagnosis and treatment service providers involved in the PPM initiative.</td>
</tr>
<tr>
<td>C.2 Introduce HIV prevention methods</td>
<td>Providing or referring for HIV prevention services. Choice of method will depend on the type of transmission: sexual, parental, and/or vertical.</td>
<td>All TB diagnosis and treatment service providers involved in the PPM initiative. Informal providers included.</td>
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<tr>
<td>C.3 Introduce cotrimoxazole preventive therapy (CPT).</td>
<td>CPT is useful to prevent several secondary bacterial and parasitic infections in adults and children with HIV/AIDS and improves mortality and morbidity in HIV positive TB patients.</td>
<td>All TB and HIV treatment and care providers involved in the PPM initiative.</td>
</tr>
<tr>
<td>C.4 Ensure HIV/AIDS care and support</td>
<td>Providing or referring for comprehensive AIDS care and support services (clinical management, nursing care, palliative care, home care, counselling and social support).</td>
<td>All TB diagnosis and treatment service providers involved in the PPM initiative.</td>
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<tr>
<td>C.5 Introduce antiretroviral therapy (ART)</td>
<td>ART improves the quality of life and greatly improves survival for PLHIV. It transforms HIV infection into a chronic condition with improved life expectancy. ART also reduces the incidence of TB in HIV positives.</td>
<td>All TB and HIV treatment and care providers involved in the PPM initiative.</td>
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</tbody>
</table>
Steps for promoting scale-up TB/HIV

Protocol builds on basic PPM principles

• Planning
  – action steps of strategic importance that have implications at national, regional and local levels; all service providers, (NGOs, professional associations or interested groups of private professionals)

• Preparation
  – What are the tools, supplies and essential systems that are necessary to facilitate local implementation, and M&E of PPM TB/HIV activities

• Local implementation

• Monitoring and evaluation
  – Monitoring and evaluation is critical in informing further scale-up and expansion of PPM TB/HIV activities
What else needs to be done?

• MOST IMPORTANT - Generate evidence through utility of the protocol

• Documentation

• Documentation

• Documentation
What else needs to be done?

- Raise awareness among workers, families, communities
- Integrate TB and HIV activities in the workplace and community programs –
  – prevention, diagnosis, treatment, care & support
- Ensure non-discrimination and respect confidentiality
- Work with the national TB and AIDS control programs
  – M&E
Summary

• Universal access to HIV services means access also to prevention, care and treatment of TB
  – TB prevention, diagnosis and treatment should be essential component of HIV care and treatment
  – The failure to screen and provide IPT for people living with HIV for TB is sub-standard care

• All TB and HIV stakeholders including corporations & communities need to work very closely together to reduce the impact of TB on people living with HIV
Engaging civil society, particularly NGOs changes lives

International AIDS Conference, Mexico 2008
<table>
<thead>
<tr>
<th>Approach</th>
<th>Actors/Organizers</th>
<th>Target Audience</th>
<th>Objective</th>
<th>Strategies</th>
<th>Measuring Success</th>
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<tbody>
<tr>
<td>Information, Education, Communication (IEC)</td>
<td>Service providers</td>
<td>Individuals Segments of a community (women, men, youth)</td>
<td>Raise awareness and change behavior</td>
<td>Sorting by audience Mass media campaigns Community outreach Traditional media</td>
<td>Change in knowledge or skills (behavior change) Process indicators Focus groups Service statistics</td>
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<tr>
<td>Public Relations</td>
<td>Commercial institutions</td>
<td>Consumers</td>
<td>Improve the company’s image and increase sales</td>
<td>Large-scale advertising (radio, TV, print media) Public events Sponsoring a “charity”</td>
<td>Improved public perception Increased sales Increased market share</td>
</tr>
<tr>
<td>Community Mobilization</td>
<td>Community members and organizations</td>
<td>Community members and leaders</td>
<td>Build a community’s capacity to rank needs and take action</td>
<td>Door-to-door visits Village meetings Participatory Rural Appraisal (PRA)</td>
<td>Issue-specific process and outcome indicators Quality of participation</td>
</tr>
<tr>
<td>Advocacy</td>
<td>NGOs/networks Special interest groups Professional associations</td>
<td>Public institutions and policy makers, Communities/community leaders</td>
<td>Change policies, programs, and resource allocation</td>
<td>Focus on policymakers with the power to affect advocacy objective High-level meetings Public events (debates, protests, etc.)</td>
<td>Process indicators Media scans Key informant interviews Focus groups Opinion surveys</td>
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<tr>
<td>Program Year</td>
<td>Annual Funding (millions)</td>
<td>No. of Countries</td>
<td>No. of Partner Programs</td>
<td>No. of Treatment Facilities</td>
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<td>1 (2004-05)</td>
<td>$92</td>
<td>11</td>
<td>21</td>
<td>119</td>
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<tr>
<td>2 (2005-06)</td>
<td>$172</td>
<td>13</td>
<td>24</td>
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<td>3 (2006-07)</td>
<td>$206</td>
<td>13</td>
<td>24</td>
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<td>4 (2007-08)</td>
<td>$320</td>
<td>13</td>
<td>25</td>
<td>652</td>
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<td>5 (2008-09)</td>
<td>$443</td>
<td>13</td>
<td>25</td>
<td>1,030</td>
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<tr>
<td>6 (2009-10)</td>
<td>$389</td>
<td>13</td>
<td>25</td>
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Total Funding since February 2004 = $1.6 billion