GLOBAL CONSULTATION TO DRAW LESSONS FROM DEVELOPMENT OF SINGLE TB AND HIV CONCEPT NOTES AND DEFINING THE WAY FORWARD FOR JOINT TB AND HIV PROGRAMMING

Date: 18 to 20 November 2015, Venue: Elilly International Hotel, Addis Ababa, Ethiopia

OVERVIEW AND CONTEXT OF JOINT TB AND HIV PROGRAMMING

Haileyesus Getahun
Global TB Programme, WHO.
TB and HIV programme managers modus operandi

"If a virus and a bacteria can work together, why don’t we"

F. Adatu former NTP Manager, Uganda

"The Lion and the Tiger never talked to each other"

M. Chhi Vun NAP Manager, Cambodia
Some equates it to a wishful marriage

Courteously. S. Lawn, 2008

Modus operandi between TB and HIV programmes
Global Fund and TB/HIV response

“GFATM’s guidelines for proposal should stress the importance of including TB interventions in HIV proposals, and vice versa, as a requirement for successful applications from high-burden TB/HIV countries.”

Recommendation of the Global TB/HIV Working Group, September 2004
3. The Board recognizes that the slow progress in implementing core TB-HIV collaborative services is a risk to achieving successful outcomes under current and future Global Fund tuberculosis and HIV grants. Given the large gap in tuberculosis screening in HIV settings and vice versa, the Board emphasizes that all applicants should include and implement significant, robust tuberculosis interventions in their HIV/AIDS proposals and HIV/AIDS interventions in their tuberculosis proposals. The Board requests the Secretariat to review the guidelines for phase 2 requests to require that, in respect of continued funding for tuberculosis or HIV grants, CCMs explain their plans for scale up to universal TB-HIV collaborative services and explicitly articulate what TB-HIV activities, funding, and indicators will be included in each proposal.
High level TB/HIV meeting, July 21, 2012 Washington DC.

Transforming the HIV/TB Response: Defining the next 10 years

21 July, 2012 | Washington DC, USA
The World Health Organization, in collaboration with Georgetown University, organized a high level international consultation on behalf of the TB/HIV Working Group of the Stop TB Partnership, in conjunction with the AIDS 2012 conference in Washington.
Joint meeting of Global Fund Committees on TB and, HIV and AIDS

22nd October 2012; 14:00 – 15:30 – Geneva

1. How to better program TB/HIV collaborative activities in Global Fund grants

This joint meeting was organized as suggested by the two Disease Committees on TB and on HIV and AIDS. The intended outcomes were to better understand the key challenges for TB/HIV programming; to agree on how to develop operational guidance to support CCMs and the Global Fund Secretariat; and to establish a short term working group to coordinate this joint work.

Dr Haileyesus Getahun of WHO presented the attached slides and highlighted key issues and bottlenecks in integration and implementation of TB/HIV activities as follows:
Discussion points proposed:

- The Three I’s and the earlier ART require urgent attention
- Models of integration of TB and HIV services as a minimum requirement in funding requests for either TB or HIV.
- Focus on countries with higher TB/HIV burden to achieve greater impact.

Suggestions proposed by Disease Committee:

- Using grant renewals and the NFM to scale up
- Integration beyond the two diseases including HSS and CSS elements
- Besides high burden countries, attention should also be paid to countries with a concentrated epidemic and especially to MARPs
Thirtieth Board Meeting
Geneva, Switzerland, 7-8 November 2013

GF/B30/11

Board Information

STRATEGY, INVESTMENT, AND IMPACT COMMITTEE DECISIONS AND RECOMMENDATIONS TO THE BOARD
Implementing TB-HIV Collaboration Services

2.10 During a discussion at the October SIIC Meeting on lessons learned from the transition to the new funding model, the Secretariat informed the SIIC that in many cases, countries with a heavy HIV and TB burden were not linking these together through joint proposals, despite previous explicit encouragement of this by the Board and the Committee. It was therefore proposed that SIIC approve a decision expressing the need for collaboration between HIV and TB services in countries with high co-morbidity through a requirement that they submit a single joint Concept Note for the two diseases, while granting the Secretariat discretion to make exceptions when warranted. The following decision was approved by consensus:

Decision Point GF/SIIC09/DP5:

In accordance with the Board’s prior decisions recognizing the importance of core TB-HIV collaboration services, the Strategy, Investment and Impact Committee decides:

1. Countries with high co-infection rates of TB and HIV shall submit a single concept note that presents integrated and joint programming for the two diseases, unless the Secretariat determines that extraordinary circumstances warrant separate concept-note submissions; and

2. The Secretariat should facilitate the development of such TB-HIV concept notes through the country dialogue process to present integrated programs to the Board for approval.
JOINT TUBERCULOSIS AND HIV PROGRAMMING INFORMATION NOTE

April 2014

INSTRUCTIONS: SINGLE TB AND HIV CONCEPT NOTE

Investing for impact against tuberculosis and HIV

This document has been prepared by the Global Fund Interagency Working Group on TB/HIV. Member organizations of the Working Group include the Global Fund, PEPFAR, the Stop TB Partnership, UNAIDS, UNICEF and the WHO. It is intended to support countries and other applicants in the preparation of a single concept note for tuberculosis and HIV under the Global Fund’s new funding model.
Annex 1: List of 38 high TB/HIV burden countries to which the Global Fund Board decision regarding the single concept note for TB and HIV applies

<table>
<thead>
<tr>
<th>High TB/HIV Burden Countries</th>
<th>Estimated TB/HIV incidence, 2012</th>
<th>HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>330,000</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>130,000</td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>83,000</td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>55,000</td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>46,000</td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>45,000</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>35,000</td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td>35,000</td>
<td></td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>32,000</td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>23,000</td>
<td></td>
</tr>
<tr>
<td>Cameroon</td>
<td>19,000</td>
<td></td>
</tr>
<tr>
<td>Myanmar</td>
<td>19,000</td>
<td></td>
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<tr>
<td>Democratic Republic of the Congo</td>
<td>16,000</td>
<td></td>
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<tr>
<td>Malawi</td>
<td>16,000</td>
<td></td>
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<tr>
<td>Swaziland</td>
<td>13,000</td>
<td></td>
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<tr>
<td>Thailand</td>
<td>12,000</td>
<td></td>
</tr>
<tr>
<td>Lesotho</td>
<td>9,900</td>
<td></td>
</tr>
<tr>
<td>Viet Nam</td>
<td>9,300</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>High TB/HIV Burden Countries</th>
<th>Estimated TB/HIV incidence, 2012</th>
<th>HIV Positive Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Côte d'Ivoire</td>
<td>8,000</td>
<td>27%</td>
</tr>
<tr>
<td>Indonesia</td>
<td>7,500</td>
<td>28%</td>
</tr>
<tr>
<td>Namibia</td>
<td>7,300</td>
<td>47%</td>
</tr>
<tr>
<td>Angola</td>
<td>5,500</td>
<td>9.6%</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>5,300</td>
<td>39%</td>
</tr>
<tr>
<td>Botswana</td>
<td>5,100</td>
<td>63%</td>
</tr>
<tr>
<td>Ukraine</td>
<td>4,800</td>
<td>14%</td>
</tr>
<tr>
<td>Haiti</td>
<td>4,300</td>
<td>20%</td>
</tr>
<tr>
<td>Sudan</td>
<td>4,300</td>
<td>7.50%</td>
</tr>
<tr>
<td>Chad</td>
<td>4,100</td>
<td>20%</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>3,900</td>
<td>19%</td>
</tr>
<tr>
<td>Congo</td>
<td>3,600</td>
<td>33%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>2,900</td>
<td>26%</td>
</tr>
<tr>
<td>Ghana</td>
<td>2,800</td>
<td>24%</td>
</tr>
<tr>
<td>Cambodia</td>
<td>2,700</td>
<td>4.40%</td>
</tr>
<tr>
<td>Burundi</td>
<td>2,500</td>
<td>19%</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>1,600</td>
<td>15%</td>
</tr>
<tr>
<td>Mali</td>
<td>1,200</td>
<td>28%</td>
</tr>
<tr>
<td>Togo</td>
<td>1,200</td>
<td>24%</td>
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<tr>
<td>Djibouti</td>
<td>540</td>
<td>10%</td>
</tr>
</tbody>
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Rationale of joint TB and HIV programming

- Better health outcomes and enhanced impact
- Efficient resource use and gained efficiencies
- Synergised programme management and efforts
- Collaboration, coordination and communication intensified
- Integrated TB, HIV and other services

Joint TB and HIV Programming is about broader TB and HIV issues the synergies of which will benefit TB/HIV
Joint TB and HIV programming should not be

A big fish swallowing a small fish

Overloading programmes

Disruption of functional programmes
Critical areas for Joint TB and HIV programming

- Harmonisation of policy and programme management
  - Conducive policy and program environment
  - Program management for execution

- Alignment of critical components of health system
  - Health information system
  - Laboratory and diagnostic services
  - Procurement and supply management
  - Health workforce
  - Financing

- Integrated TB and HIV services
  - Provision of integrated TB and HIV services at the same place and time
  - Minimum requirement for Joint programming

- Community system strengthening
  - Integrated delivery of community based TB and HIV activities
  - Meaningful engagement of vulnerable populations is critical

World Health Organization
Principles of joint TB and HIV programming

• Country context determine the scope (no one size fits all)
  – Epidemiology of TB and HIV
  – Maturity and capacity of programmes
  – Health infrastructure organisation
  – Client needs

• Phased implementation with no disruption

• Maximising resources and reducing duplication

• Delivery of integrated TB and HIV services is hallmark
Models for integrated TB and HIV services delivery

Integrated service delivery – minimum requirement

- **TB service**
  - HIV testing
  - HIV prevention
  - CPT
  - ART

- **One-stop service**
  - HIV testing
  - ART
  - CPT
  - Condoms

- **HIV service**
  - HIV and TB Services provided together
    - ART
    - TB diagnosis and treatment
  - TB screening
    - IPT
    - TB diagnosis
    - TB treatment
  - TB contact tracing

- **Referral to HIV**: Partially integrated
- **Referral to TB**

**TB screening**

- TB diagnosis
- TB treatment
Integrated service delivery – minimum requirement

TB service | One-stop service | HIV service

**NO To Referral**

HIV testing
- ART
- CPT
- Condoms

**Partially integrated**

HIV and TB Services provided together
- ART
- TB diagnosis and treatment

**Co-located Adjacent**

TB screening
- IPT
- TB diagnosis
- TB treatment
- TB contact tracing

**NO To Referral**

Models for integrated TB and HIV services delivery
Harmonisation of TA in the context of joint programming: paradigm shift needed.
   - Strong Team approach (e.g. TB and HIV consultants)
   - Multitasking (e.g. one consultant with multiple task)
   - Local capacity building (e.g. sustainable TA)

Consistent, transparent and intense communication, collaboration and coordination among global, regional and national TA partners (e.g. TBTEAM and UNAIDS/RST)

Constant garnering of lessons and prompt actions and corrections
We concluded at the beginning (February 2014) single concept note heralds paradigm shift in TB/HIV response

Question: Is there any paradigm shift? Has it met our expectations?
We also concluded

If you can't fly, then run,
if you can't run, then walk,
if you can't walk, then crawl,
but whatever you do,
you have to **keep moving forward**.

- Martin Luther King Jr.

Question: What are we doing? Are we moving forward?
Objectives of the meeting

• Review experiences and identify best practices in single concept note development

• Identify context, opportunities, gaps and challenges in implementation, scale up and impact

• Identify specific technical assistance and policy guidance needs

• Define specific actions to address key challenges:
  – National stakeholders (CCM, NAP, NTP and Civil Society)
  – The Global Fund
  – Technical Partners