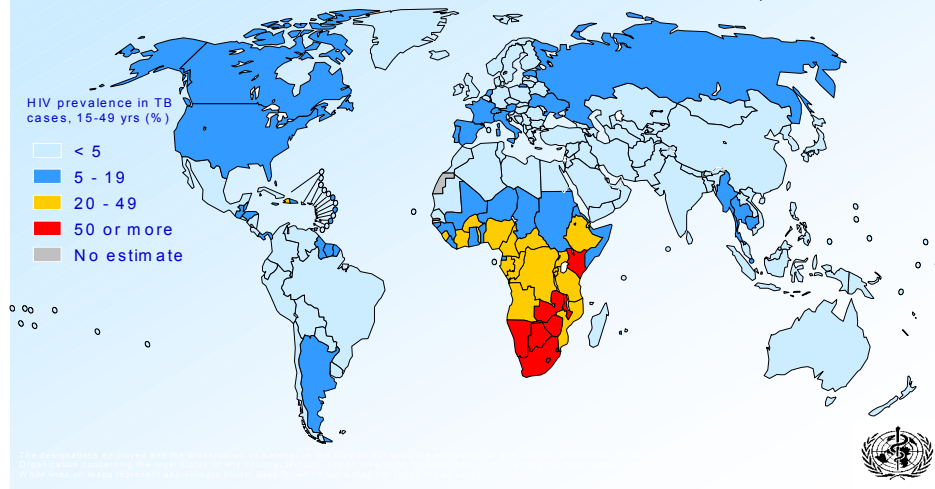


TB/HIV Control Strategy For The African Region

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Estimated HIV Prevalence in TB cases, 2002



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Foreword

The HIV/AIDS epidemic has become the single most important cause of rapid increase in the incidence of Tuberculosis in the African Region. With only 10% of the world population, the African Region contributes at least one fifth and a quarter of total and new smear positive global TB notifications respectively every year since the late nineties. The increase in incidence generally corresponds to the distribution of HIV prevalence in the general population and underlines the cause and effect relationship between HIV and TB.

Even though the close interaction between the two epidemics has been recognized, programmes for their control have often been implemented independent of each other. Further, until lately when the Global Fund Against AIDS, TB and Malaria (GFATM) and other recent initiatives have substantially increased available financial resources for TB and HIV/AIDS control, the two programmes have been operating against a background of limited and diminishing resources due to overall worsening economic conditions in most countries. Notwithstanding, between 1998 to 2001, WHO successfully led an initiative to evaluate the feasibility and cost-effectiveness of collaborative activities in Malawi, South Africa and Zambia. The experiences from these countries have mostly demonstrated that collaborative activities are feasible and logical integral parts of comprehensive care for the dually infected. The experiences were seminal to the development of global Strategic Frameworks and Guidelines for implementation of collaborative TB/HIV activities.

WHO is now promoting the approach as part comprehensive TB and HIV prevention and care. This includes TB preventive therapy, other Opportunistic Infections prophylactic therapy, promotion of condoms, management of sexually transmitted infections and anti-retroviral therapy, using Voluntary Counseling and Testing (VCT) as an entry point. For the medium to long term, this will be promoted in all member states with significant or rising TB/HIV dual epidemics.

This Regional Framework has been developed to reflect the global strategies and guidelines in the context of our unique Regional context. It is meant to provide member states with sufficiently specific strategic directions for planning and implementing interventions to address the TB/HIV dual epidemic. This is timely, considering the 2005 WHA TB Control targets, the 3 by 5 Initiative and the 2015 TB and HIV/AIDS Millennium Development Goals (MDGs). At the same time, we have new opportunities to do more and better. In addition to whatever else has been available for this fight, the GFATM and other international partnerships and Initiatives have led to increased availability of ARVs and other supplies hitherto not easily and widely available.

It is my strong conviction that this is a battle we can and must win. With available tools, it is possible to effectively diagnose and successfully treat tuberculosis cases. ARVs, hitherto not available to the majority in need on account of high cost are now becoming more and more available and affordable. WHO and her partners have recently declared lack of ARVs a Global emergency and collaborative TB/HIV prevention and care must of necessity constitute part of a standard basic package of care for all dually infected. We have a duty to ensure that those in need are facilitated to access these life saving services or else history will judge us harshly indeed.

Dr Ebrahim Malik Samba
Regional Director, WHO Office for the African Region

List of abbreviations

AIDS	-Acquired Immunodeficiency Syndrome
ARV	-Anti-retroviral drugs
ART	- Antiretroviral Therapy
CBO	-Community-based Organization
CPT	-Cotrimoxazole preventive therapy
CHBC	-Community and Home-based Care
DOT	-Directly Observed Therapy
DOTS	-Directly Observed Therapy Short Course
GDF	-Global Drug Facility
GFATM	-Global Fund Against AIDS, Tuberculosis and Malaria
HBC	-Home-based Care
HIV	-Human Immunodeficiency Virus
HSR	-Health Sector Reforms
IEC	-Information Education and Communication
IPT	-Isoniazid Preventive Therapy
IUATLD	-International Union Against Tuberculosis and Lung Diseases
MDGs	-Millennium Development Goals
MDR-TB	- Multi-Drug Resistant TB
MoH	-Ministry of Health
NACP	-National AIDS Control Programme
NGOs	- Non-Governmental Organizations
NTP	-National Tuberculosis Control Programme
PLWHA	-People Living with HIV/AIDS
PMTCT	-Prevention of Mother to Child HIV Transmission
PPs	- Private providers
ProTest	-WHO coordinated initiative to PRO mote TEST ing for HIV using VCT as entering point to access a range of TB/HIV prevention and care interventions.
TB	- Tuberculosis
TUB	-Tuberculosis Unit, WHO/AFRO
TB/HIV	- HIV related Tuberculosis
UNAIDS	-United Nations Joint Programme on HIV/AIDS
RPA	-Regional Programme on AIDS
STIs	-Sexually Transmitted Infections
VCT	-Voluntary Counseling and Testing
WHA	-World Health Assembly
WHO	-World Health Organization

1. Introduction

Tuberculosis remains an important but neglected cause of adult and childhood morbidity and mortality in the African region. With an estimated 1.6 million new infectious cases and 600,000 deaths annually, tuberculosis is one of the commonest preventable causes of premature death from a single infectious agent in the region. Recent notification data¹ indicates that at least 20% and 24% of the total and new smear positive cases respectively were reported from the region. Furthermore, nine (9) of the twenty-two (22) global TB high burden countries are in the African Region.

At the same time, as at the end of 2002, an estimated 42 million people were living with HIV² globally. With an estimated 29.4million people living with HIV/AIDS, sub-Saharan Africa remains the worst affected region. Approximately 3.5 million new infections occurred during the year and an estimated 2.4 million Africans died from HIV/AIDS related causes. Furthermore, ten million young people aged 15-24 and almost 3 million children under 15 years of age are living with HIV/AIDS.

While the African Region has always had a huge TB burden, the region has experienced a huge upsurge in the incidence of tuberculosis cases and deaths especially in the past decade, largely due to the direct impact of the HIV/AIDS pandemic currently affecting many countries in the region. The HIV epidemic is now considered the most important factor driving the TB epidemic that is threatening to overwhelm even effective TB Control Programmes in the region. It is estimated that between 30-50% of all newly diagnosed TB cases are also infected with HIV and that about 40% of all AIDS deaths in the region are due to TB.

Recent evidence from the implementation of collaborative TB/HIV intervention projects in some countries in the region have show that effective TB control leads to improved HIV/AIDS care, and that effective HIV prevention strategies lead to reduced TB transmission and disease. Based on these experiences, WHO and UNAIDS developed a global “Strategic Framework to Decrease the Burden of TB/HIV”³ which represents a strengthened unified health sector strategy to control HIV related tuberculosis as an integral part of the strategy for HIV/AIDS. The framework outlines the need and modalities for forging close partnerships between National TB and AIDS Control Programmes in order to control the dual epidemic.

The aim of this Regional strategy document is to provide a generic approach to a comprehensive and coordinated regional response to the dual TB/HIV epidemic in order to lessen the social and economic impact of HIV related tuberculosis on the individual, family, community and nations. Each country is expected to tailor implementation of the suggested interventions according to prevailing country specific situations.

¹ World Health Organization. Global Tuberculosis Control. WHO Report 2001. Geneva.

² UNAIDS/WHO: AIDS epidemic update. December 2002. UNAIDS/WHO 2002.

³ World Health Organization. Strategic Framework to Decrease the Burden of TB/HIV. WHO/CDS/TB/2002.296 WHO/HIV_AIDS/2002.2

2. Justification for collaborative TB/HIV activities

TB Control programmes in the African Region were the first to implement the internationally recommended DOTS Strategy for TB. To date, the majority of countries in the Region have successfully adopted the strategy. Despite this development, many countries in sub-Saharan Africa are experiencing unprecedented rises in the incidence of tuberculosis. This is most acute in countries where HIV prevalence is high. In many such countries, annual TB notification rates have risen several fold reaching peaks of more than 500 total cases/100,000 population⁴. Evidence indicates that these escalations are largely attributable to the HIV epidemic⁵. The annual risk of developing tuberculosis in a PLWHA who is co-infected with *M. tuberculosis* ranges from 5-15%⁶ compared to 10% lifetime risk in those without HIV/AIDS.

In spite of the known close interaction between the two diseases, HIV/AIDS and Tuberculosis Control Programmes have largely pursued individual courses. Tuberculosis Control Programmes have focused on implementing the Directly Observed Treatment Short-course (DOTS) Strategy for TB that emphasizes case finding and cure⁷, with little or no attention to HIV/AIDS prevention, care and support for tuberculosis patients dually infected with the HIV virus. Similarly, HIV/AIDS Control Programmes have largely concentrated on HIV prevention with little attention to the care of PLWHA co-infected with TB.

It is now clear that collaborative effort to control the dual epidemic, as an integral part of both TB and HIV Control Programme activities, is imperative. Respective Control Programmes need to take-on relevant interventions necessary for continuum of care for the dually infected patients.

The atmosphere for this collaboration is now ripe. Political commitment at both national and international levels has increased tremendously. Establishment of the Stop TB Partnership in 1998 and Global TB Drug Facility (GDF) in 2001 as well as the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in 2002 have all opened up unprecedented opportunities for countries to access significant additional resources for scaling up implementation of control strategies. If well coordinated, this increased interest to control the dual epidemic has the potential to make a difference in the quality of life of the dually infected.

⁴ World Health Organization. Global Tuberculosis Control. WHO Report 2001. Geneva.

⁵ Bleed D, Dye C, Raviglione M. Dynamics and control of the global tuberculosis epidemic. *Current Opinion in Pulmonary Medicine* 2000; 6: 174-179

⁶ Raviglione MC, Harries AD, Msiska R, Wilkinson D, Nunn P. Tuberculosis and HIV: current status in Africa. *AIDS* 1997; 11 (suppl B): S115-S123.

⁷ World Health Organization. *Treatment of Tuberculosis: Guidelines for National Programmes*. 2nd edition, 1997. WHO Geneva.

3: Goals, objectives and targets

3.1 Goal

The goal of the strategy is to contribute to the reduction of HIV/AIDS and tuberculosis related morbidity and mortality as part of overall efforts to reduce the health and economic impacts of the dual TB/HIV epidemic on individuals, families and communities in the region.

3.2 Objectives

3.2.1: Overall Objective:

To ensure a comprehensive and coordinated health sector response to the dual TB and HIV/AIDS epidemics through the implementation of collaborative TB/HIV activities as part of a standard package of care and support for the dually infected.

3.2.2: Specific objectives:

- 3.2.2.1: To provide a framework for the planning, organization, implementation, monitoring and evaluation of collaborative TB/HIV activities.
- 3.2.2.2: To promote the provision of TB and HIV/AIDS prevention, care and support services as an integral part of a comprehensive minimum package of care for People Living with HIV/AIDS.

3.3 Targets

Key control targets for both TB and HIV/AIDS are stated in various United Nations' documents^{8 9}. At the Regional level, the Abuja Heads of State and Government Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases adopted these targets in a Declaration (April 2001). Collaborative TB/HIV activities seek to contribute to these overall targets.

3.3.1: TB Control

- 3.3.1.1: To detect 70% of new smear positive TB cases and to cure at least 85% of these by the year 2005.
- 3.3.1.2: To have halted and begun to reverse the incidence of, and deaths from, Tuberculosis by 2015

3.3.2: HIV/AIDS

- 3.3.2.1: To achieve a 25% reduction in the prevalence of HIV/AIDS among young men and women in the most affected countries by 2005;
- 3.3.2.2: To have halted and begun to reverse the spread of HIV/AIDS by 2015

⁸ World Health Assembly. Forty-fourth World Health Assembly. WHA44/1991/REC/1.1991.

⁹ United Nations General Assembly. Special Session of the General Assembly on HIV/AIDS. Fifty-fifth session (July 2001).

4: Guiding Principles

The following guiding principles should govern implementation of collaborative TB/HIV activities:

4.1 Country programme ownership.

The national teams must take full responsibility for programme planning, implementation, monitoring and evaluation, regardless of the funding source. The Ministry of Health and the other sectors concerned should plan resources for TB and HIV/AIDS control (prevention, care and support) in their respective national budgets.

4.2 Focusing of efforts

It is important that all players in the national response focus their efforts to areas of greatest need and impact according to respective comparative advantages. The Ministry of Health should focus its efforts and resources on specific health interventions for which it is most competent such as treatment of tuberculosis, STD case management; blood safety, prevention of mother to child HIV transmission, epidemiological surveillance etc. The other sectors should be fully responsible for the non-health interventions, according to their areas of competence. In order to consolidate the national response, however, a strong coordination mechanism is indispensable.

4.3 Efficiency and effectiveness

Stringent, efficient and effective management will sustain the focusing of efforts and resources. To enhance this, programming and budgeting should be results-oriented. A rigorous continuous monitoring and evaluation system is to be set up at all levels and within all relevant sectors. For any resources invested, there must be corresponding concrete and quantifiable results.

4.4: Promoting equity

The Ministry of Health should strengthen its efforts to improve access to health services paying particular attention to the needs of the vulnerable and disadvantaged groups.

4.5 Quality of services

Mechanisms for improving the quality of services should be strengthened through development of standards, strengthening of skills of service providers and improvement of systems for supervision.

5 Strategies and major interventions:

- The expanded scope of the new strategy for TB control in high HIV prevalence populations comprises strategies directed at controlling TB (through intensified case finding, improved cure rates and TB preventive therapy) and those directed against HIV/AIDS (condom promotion and distribution, voluntary counseling and testing programmes, prevention of mother-to-child transmission, management of opportunistic infections, preventive therapy for other bacterial infections, treatment of sexually transmitted infections and use of ARVs).

In order to implement the new strategy, Ministries of Health need to develop practical implementation plans according to local priorities and available resources.

The priority strategic directions and major interventions include:

5.1 *Creating enabling environment (strengthening the health system).*

This encompasses the following major interventions:

- Advocacy for political and financial commitment.
- Partnerships building.
- Decentralization of services
- Integration of services
- Developing capacity for programme implementation [including management systems].
- Involving private health providers.
- Resource mobilization.
- Operational research.

5.1.1 Advocacy for political commitment

Effective prevention and control of TB/HIV demands strong and dedicated leadership able to sustain political and financial commitment and mobilization of additional human and financial resources.

Availability of a national strategic document is a strong and useful advocacy tool. Advocacy to key stakeholders would result in appropriate policies and legal framework for recognizing the rights of PLWHA and TB patients to care and support.

It is also important to promote the rights of women and youth by developing a supportive legal and political environment. Legal structures against discrimination and stigma should also be facilitated. National Governments should review importation laws, where necessary, in order to reduce or remove importation barriers to treatment supplies and commodities such as taxation, import duties, cumbersome importation and clearing procedures.

5.1.2 Partnership building

The TB/HIV problem goes beyond the health sector. It demands a multi-sectoral and multidisciplinary approach. Particular efforts are needed to foster strategic partnerships between public, private, communities and civil organizations at all levels. The UNAIDS WHO and other multilateral and bilateral donors / partners at national, regional and lower levels are all veritable partners in the implementation of the TB/HIV collaborative activities. All partners should participate in the planning, implementation, monitoring and evaluation of programme activities. The responsibilities of each player must be clearly defined.

5.1.3 Decentralization of services

Decentralization is designed to develop systems and mechanisms to overcome institutional, physical and administrative constraints to cost-effective delivery of services. As much as possible, TB and HIV/AIDS Control Programmes should seek to exploit the opportunities presented by decentralization of services.

Collaboration between National TB and HIV/AIDS programmes and planning units in Ministries of Health during the planning and implementation process can ensure that the fundamentals of TB and HIV/AIDS control are maintained in the context of health system development so that the control of both diseases is strengthened rather than threatened in the process. Indicators for a successful TB programme, such as treatment success and case detection rates, may be included among indicators of a successful health system development.

The aim should be to develop a national TB/HIV control plan that is synchronized with the country's overall health development plan and policy. The roles and responsibilities of various service delivery levels should be clarified and complemented with allocation of adequate resources and management capacity.

5.1.4 Integration of services

The common aim of integration should be to increase efficiency and cost-effectiveness, and to coordinate the participation of partners in the delivery of services. Integration can be achieved in various ways but to avoid loss of visibility and expertise of the two control programmes, it is best to have strong specialized management units at Central and intermediate levels (responsible for policy guidance, training, supervision and monitoring of control activities) and integrated delivery of services through the general primary health care system at the operational level. The reasons for NTP/NACP programme integration needs to be clear in order for functional programme collaboration to occur. Suggested areas of TB/HIV integrated activities may include:

- Development of integrated strategic and work plans;
- Integrating a service into another that is already being offered on a large scale such as introducing VCT in public and private health facilities;
- Offering VCT services where TB services are being offered and offering TB screening where VCT services are being offered;
- Integrated community and home based care initiatives;
- Development of integrated pre-service and in-service curriculum for the training of health workers;
- Development of joint funding proposals; and
- Development of joint monitoring and evaluation systems.

5.1.5: Developing capacity for programme implementation [including management systems].

Skilled human resources are deficient at district and provincial levels within countries in the region. In addition, health sector reforms often call for additional training of multipurpose staff. The capacity to respond to the increasing health care needs of the people therefore need to be strengthened. This will include building capacity for human and infrastructure (including laboratory network) resource needs. On the job training should be planned and conducted for all cadres of staff and community members involved in service delivery.

In order to ensure the standardization of the quality of training, existing training materials need to be adapted or new ones developed. Training of undergraduates and postgraduates needs to be covered by adjusting the traditional curriculum in medical, nursing and laboratory schools to accommodate the current acceptable practices to control TB and HIV/AIDS. It is essential to put in place a functional evaluation system for maintaining and improving quality of training.

Building management capacity, particularly in the management of drugs and other treatment supplies (e.g. anti-tb drugs, antiretroviral drugs, condoms, IEC materials etc), is crucial. Capacity has to be developed for estimation, procurement, storage, record keeping and distribution of drugs and materials at all levels.

Prominence should also be given to human and infrastructural capacity for microscopy services, as this is essential to bring diagnostic services closer to patients and communities.

5.1.6: Involving the private sector.

Both formal and informal health sector comprising private practitioners, voluntary and for profit organizations, professional societies, private hospitals, corporate health providers as well as community and traditional healing homes is fast growing. Mechanisms for collaboration between the public and private health sectors should be established. In order to promote compliance with treatment guidelines, private care providers should be involved in their development. They should also be empowered to facilitate training within the sector. Improved programme coverage, patient access to diagnostic and treatment services, increased case detection and treatment outcomes, and improved overall quality of care are some of the potential benefits of involving private health providers in delivery of services.^{10, 11}

¹⁰ Uplekar MW, Shepard DS. Treatment of tuberculosis by private general practitioners in India. *Tubercle* 1991; 72: 695-702

¹¹ Pathania V, Almeida J, Kochi A. TB patients and for profit health care providers in India WHO/TB/97.223. 1997. Geneva

5.1.7 Resource Mobilization

A meaningful response to the TB/HIV epidemics requires a massively increased level of resources managed coherently on a sustainable basis. Priority should be given to those interventions that can make critical contributions to reduce the spread of the epidemics and increase the quality of life of those affected. Resources may be mobilized both locally and externally. External sources include bilateral and multilateral agencies such as the Global Fund to fight AIDS, TB and Malaria. Costed Programme implementation plans should be integrated into the National Health Sector Plans to enhance sustainability.

5.1.8 Operational research

Delivery of specific interventions in low resource settings can pose significant challenges. Operational research can help to identify problems and reasons for weak performance and determine most appropriate solutions. Workable alliances with research institutions and bodies should be established to develop capacity to perform relevant operational research.

5.2 Prevention of TB, HIV and STIs.

5.2.1 Information Education and communication (IEC) to promote behavioural change.

A strong focus on prevention is essential in order to reduce significantly the spread of the epidemics and their impact. Development of an IEC strategy designed to effect behavioural change, especially in young people, highly mobile populations (drivers, refugees, police and military personnel), commercial sex workers and ultimately the general population is key. The Strategy should also help to reduce stigma attached to HIV/AIDS and TB.

5.2.2 Voluntary counseling and testing

Voluntary counseling and testing is an essential service for both prevention and treatment. Studies have shown that irrespective of the result, VCT influences individuals to change their risky sexual behavior to protect themselves or their partners in ways that lead to reduction in transmission rates of HIV¹². Individuals attending a center for VCT can benefit from TB screening. Those found to be both HIV positive and with active TB should be referred for TB treatment while those without active TB should be offered TB preventive treatment with Isoniazid. Similarly, TB patients taking up VCT can benefit through appropriate referral for clinical care and support if they test HIV positive. High utilization rates of VCT services usually indicate low levels of stigma and discrimination with regard to HIV/AIDS.

¹² Merson MH, Dayton GM, O'Reilly K. Effectiveness of HIV prevention interventions in developing countries. AIDS 2000; 14 (Suppl 2): S68-84

5.2.3 Management of STIs, condom promotion and distribution

The most efficient way to curtail the spread of HIV in the general population is to target those most likely to have a high transmission rate such as those with the most sexual partners.¹³ The immediate proximate interventions of proven efficacy in decreasing HIV transmission are condom use¹⁴ and the treatment of STIs¹⁵. Efforts should be made to strengthen services providing syndromic management of STIs. Referral system should also be strengthened where necessary.

5.2.4 Prevention of mother to child infection (PMTCT)

Prevention of mother to child HIV transmission should aim at reducing the number of new pediatric HIV infections while also reducing the risk to orphanhood. Most women who become pregnant or lactate remain unaware of options for preventing vertical HIV transmission. Use of anti retroviral drugs and counseling on infant feeding should be promoted. Guidelines on breast-feeding in the context of high HIV prevalence should be strengthened while affordable alternatives to infant feeding are vigorously pursued.

5.3 Care and support for PLWHA and TB

Preventive interventions delivered through the health sector such as VCT, PMTCT, antibiotic preventive therapy (e.g. Cotrimoxazole) etc are inextricably associated with care and support. This synergy of action is essential in halting the spread of the dual epidemic.

5.3.1: Expanding and strengthening the DOTS strategy.

HIV/AIDS and TB are closely linked. Individuals with weakened immune systems are more likely to develop active TB compared to those without HIV. These additional tuberculosis cases increase the transmission of tuberculosis to other people with or without HIV infection. The DOTS strategy has been proven to be the most effective strategy for controlling the tuberculosis epidemic. Countrywide implementation of the DOTS strategy is therefore the basic minimum for TB control. National Governments should renew their efforts to improve DOTS coverage so that treatment for TB would be accessible to those requiring it. Case finding must be intensified among individuals presenting with respiratory symptoms in public, private and NGO health services. Particular attention should be given to those attending centers for voluntary counseling and testing (VCT) for HIV. It is of utmost importance to motivate patients to complete their treatment in order to ensure effective cure. New approaches emphasizing the role of communities in tuberculosis treatment (community based DOTS) have been shown to be more cost

¹³ Laga M, Alary M., Nzila N et al, Condom promotion, sexually transmitted disease treatment, and declining incidence of HIV-1 infection in female Zairian sex workers. *Lancet* 1994; 344: 246-48

¹⁴ Rojanapithayakorn W, Hanenberg R. The 100% Condom Programme in Thailand. *AIDS* 1996; 10: 1-7.

¹⁵ Grosskurth H, Mosha F, Todd J, et al. Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: a randomised controlled trial. *Lancet* 1995; 346: 530-36.

effective with satisfactory treatment success rates.¹⁶ The opportunities available through the promotion of community based DOTS must be fully optimized.

5.3.2: Preventive treatment against tuberculosis

PLWHA are at high risk of developing tuberculosis. Evidence from studies in high HIV prevalence countries indicated that Isoniazid Preventive Therapy (IPT) reduces the short term risk of developing TB to about 40% of what it would have been without such treatment¹⁷. Preventive tuberculosis treatment decreases the risk of developing a first ever episode or recurrent episode of tuberculosis in seropositive individuals. It is therefore logical to offer IPT to eligible seropositive individuals.

Screening for tuberculosis should be done in line with the NTP guidelines. Exclusion of active tuberculosis in HIV positive clients should be an indication for IPT. Those screened and found to have active disease (tuberculosis) should benefit from short course chemotherapy in accordance with the internationally recommended DOTS strategy.

5.3.3: Prevention and management of other opportunistic infections

The main burden of disease in PLWHA is related to a number of common infections that cause considerable morbidity and contribute to high case fatality rates¹⁸. Prevention against bacterial causes of pneumonia and diarrhea and their complications using Cotrimoxazole has been shown to be beneficial.^{19 20} The use of Cotrimoxazole prophylaxis in HIV infected individuals with or without active Tuberculosis should be promoted as part of a minimum package of care for PLWHA. Provision of cotrimoxazole at affordable costs at treatment points should be facilitated and sustained.

5.3.4: Improving access to anti-retroviral therapy

Although antiretroviral therapy (ART) is not a cure, it improves the immune status of the patient leading to a delay in onset of AIDS. Widespread use of antiretroviral drugs (ARV) has been associated with a considerable reduction in morbidity and mortality from AIDS with improvement in the quality of life of PLWA.^{21 22} Access to ARV drugs is an

¹⁶ Maher D, Van Gorkom JLC, Gondrie P, Raviglione M. Community contribution to tuberculosis care in countries with high tuberculosis prevalence: past, present and future. *Int J Tuberc Lung Dis* 1999; 3 (9): 762-768.

¹⁷ World Health Organisation. Preventive therapy against tuberculosis in people living with HIV. *Weekly Epidemiological Record* 1999; 74: 385-398.

¹⁸ Mukadi YD, Maher D, Harries AD. Tuberculosis case fatality rates in high HIV prevalence populations in sub Saharan Africa. *AIDS* 2001; 15: 143-152.

¹⁹ Anglaret X, Chene G, Attia A, et al. Early chemoprophylaxis with trimethoprim-sulphamethoxazole for HIV-1-infected adults in Abidjan, Cote d'Ivoire: A Randomised Trial. *Lancet* 1999; 353: 1463-68

²⁰ Wiktor S, Sassan-Morokro M, Grant AD, et al. Efficacy of trimethoprim-sulphamethoxazole prophylaxis to decrease morbidity and mortality in HIV-1 infected patients with tuberculosis in Abidjan, Cote d'Ivoire: a randomized control study. *Lancet* 1999; 353: 1469-75.

²¹ Jones JL, Hanson DL, Dworkin MS, De Cock KM HIV-associated tuberculosis in the era of highly active antiretroviral treatment. *Int J Tuberc Lung Dis* 2000; 4 (11): 1026-1031.

important component of a strategy to support PLWHA. By reducing viral load, ARV drugs may also reduce the risk of sexual transmission. Individuals may be more willing to undergo voluntary counseling and testing if there is a possibility of getting effective treatment.

5.3.5 Community and home based care

HIV is one of the most important known risk factors for reactivation of latent TB infection to active disease. Over the last decade, countries with high prevalence of HIV infection have reported huge increases in the incidence of TB. The resultant overburdening of the health care services has necessitated the shifting of the integrated TB and HIV/AIDS activities to community and home-based care (CHBC) levels.

CHBC represents a continuum of care involving a network of affordable services that provide holistic and comprehensive support for the ill person and caregivers. The benefit is the affordable range of services in various settings, from home to community agencies and clinics, to hospitals and vice versa. Through CHBC, care providers could specifically contribute to active case finding for TB in home based care patients, supervision of TB treatment in PLWHA with active TB, tracing of TB treatment defaulters, promotion of VCT and reduction of stigma attached to TB and HIV within the community.

5.3.6 Support to those infected and affected with HIV/AIDS

Individuals and groups affected by HIV/AIDS also need care and support. It is important that AIDS orphans and family members, particularly widows, have access to education, affordable health, rights of inheritance and psychological support. The development of structures to alleviate the socioeconomic impact of HIV in these groups should be promoted through partnerships and linkages with relevant sectors within and outside the country.

Recognising the importance of the work of CHBC members (including family members) within the community and health care system is essential. A system of reward and incentives would help in retaining the services of CHBC members²³ and should be strengthened or established where it is not in place. Mechanisms to provide support and prevent burnout should be developed and sustained.

5.4 Community mobilization for sustainability

Social mobilization is a way to engage people's participation in achieving the programme goals. It involves all relevant segments of society: decision and policy makers, opinion leaders, non-governmental organizations (professional and religious), the media, the private sector, communities and individuals. It is a process of dialogue, negotiation and consensus for mobilizing action that engages a range of players in interrelated and

²² Girardi E, Antonucci G, Vanacore P, et al. Impact of combination antiretroviral therapy on the risk of tuberculosis among persons with HIV infection. *AIDS* 2000; 14: 1985-1991.

²³ World Health Organisation. Community home-based care in resource-limited settings: a framework for action. WHO 2002.

complimentary efforts, taking into consideration the felt needs of the people.²⁴ Local community response is crucial to the prevention and control of HIV/AIDS and TB. Results from pilot projects emphasizing the roles of community and primary care facilities in tuberculosis treatment show that the approach is more cost effective²⁵. It is essential to form a network of support groups at the community level involving PLWHA, youth, women and faith-based organizations to boost community participation.

6: Implementation framework

The HIV/AIDS and Tuberculosis programmes as well as the Health systems in each of the countries in the region are at different stages of development. Implementation requires careful planning taking into consideration the local conditions. In the initial stage, implementation may be phased followed by gradual expansion to cover the whole country. Favorable conditions for the effective implementation must be created.

6.1: Establishing a TB/HIV working committee within the Ministry of Health.

A management and coordinating committee within the Ministry of Health should be established to provide leadership for the health sector response. The memberships of this committee may include officers from the HIV and TB programmes as well as other relevant units in the MOH. This committee would be responsible for planning, monitoring and evaluation of implementation of activities. Responsibilities also include fostering effective partnerships among stakeholders at all levels to enhance coordination of activities, avoid duplication of efforts and maximize the use of resources within the health sector.

6.2: Preparing country specific joint TB/HIV implementation plans.

Based on a situation analysis, the two programmes should demonstrate their commitment by preparing joint country specific TB/HIV implementation plans. The strategy and the implementation plan should take cognizance of the on-going decentralization and health sector reforms. Responsibilities and linkages between the programmes, local and international NGOS and the communities as well as other stakeholders should be clearly stated.

6.3: Preparing guidelines

The new approach demands that the two programmes develop joint guidelines on technical and operational issues. The guidelines should reflect clear roles and responsibilities of implementers and stakeholders at all levels. It should also contain job descriptions with tasks and management guidelines including monitoring and evaluation. Provision of manuals would promote standardization of procedures and quality of care. An appropriate dissemination strategy should be drawn to ensure that all implementers are familiar with the new approaches.

²⁴ World Health Organisation. Guidelines for Social Mobilization; A human rights approach to tuberculosis. WHO/CDS/STB/2001.9

²⁵ Floyd K, Nganda B, Okello D, et al. Providing tuberculosis treatment in sub Saharan Africa in the face of HIV/AIDS epidemic: an economic evaluation of 5 projects emphasizing increased community and primary care facility involvement in care. Abstract WePeC4428 presented at the XIII International AIDS Conference, Durban, South Africa, 2000.

6.4: Developing advocacy and social mobilization tools.

Advocacy tools targeting politicians, government officials and key opinion leaders are useful to effect policy and legislative actions and mobilize resources. Similarly, effective social mobilization approaches have to be developed in order to encourage community participation. Studies have shown that effective IEC strategy targeted at community involvement helps to reduce the stigma attached to HIV/AIDS and TB. It further promotes responsible sexual behavior, healthy life style, living positively with HIV/AIDS and health seeking behavior including VCT. Drawing from the experiences of the HIV/AIDS programmes, guidelines for advocacy and social mobilization at all levels should be developed.

7: Surveillance, monitoring and evaluation

7.1 Surveillance

The development of infrastructure and capacity for surveillance should be promoted within the context of health information systems and integrated disease surveillance. Support should be provided for the strengthening of systems for HIV/AIDS reporting and behavioral and STI surveillance. For Tuberculosis, the standard surveillance system based on a cohort analysis system should be ensured.

7.2: Monitoring and evaluation

In order to measure programme achievements, it is important to define core indicators to assess the interventions. The indicators must be sensitive, practical in terms of measuring changes attributable to interventions. Monitoring and evaluation helps managers to refocus their efforts towards achieving programme targets and objectives and should be carried out at all levels.

The Tuberculosis and HIV/AIDS Control Programmes have their individual programme specific monitoring indicators. The monitoring indicators for TB/HIV collaborative activities should therefore be limited to coverage, implementation and utility of the collaborative activities. The HMIS exists in all settings. As much as possible, the existing system should be adapted to incorporate the HIV/AIDS/TB collaborative activities. Possibilities for joint reporting and recording system should be explored. Other monitoring and evaluation modalities should be adopted as they become available.

8 Roles and responsibilities

8.1 Countries

The continued ownership of the entire process by countries is critical to successful implementation. The Ministries of Health need to play a leadership role in mobilizing both internal and external resources for implementation. Implementation plans for key interventions in line with their national strategic plans for the prevention and control of HIV and TB must be developed. The targets, the strategies and the resources needed should be indicated clearly. The contribution of the country and other existing sources

such as the GFATM, and funding gaps should be reflected. The MOH in collaboration with other stakeholders plans activities, monitors and evaluates the programmes and ensures co-ordination of different partners.

The District Health management Team plays a leading role in the implementation of TB/HIV activities. The district as the operational level should participate in the planning of these collaborative interventions at the national level. The implementation plan should also take cognizance of the activities of faith based organizations, NGOs, the private sector, PLWHA and support groups and their resource needs and facilitate the release of resources from the national level. The district will develop supervision, monitoring and evaluation tools in line with the National monitoring and evaluation tools.

The involvement of communities in planning, implementation and management of programmes is important. Its representatives should participate in planning at the National and district levels. Every community has a commitment to setup its own local institutions including administrative leadership, social groups etc available for programme benefits determines the best way to mobilize its members. Communities should monitor their activities and report regularly to the district health management teams.

8.2 WHO

The primary role of WHO is to provide technical support and normative guidance for development of plans of action, programme implementation, and monitoring and evaluation. Support should be provided to countries in resource mobilization and in strengthening government capacity to coordinate the activities of external partners. Emphasis should be laid on strengthening health systems through, among other things, the adaptation of technical guidelines and protocols to the national context. Data collection and management should be supported, and evidence on cost effective interventions gathered and disseminated.

8.3 Other partners

Partners should participate in the development of national strategic frameworks and implementation plans, monitoring and evaluation, and provide financial and technical inputs based on their areas of comparative advantage. In addition, they should support national capacity building relevant to implementation of interventions.

Suggested further reading.

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