We can prevent people living with HIV from dying of tuberculosis

Joint Action for Results

UNAIDS Outcome Framework:
Business Case 2009–2011

UNAIDS
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Uniting the world against AIDS

UNAIDS Joint Action for Results

In *The Joint Action for Results: UNAIDS Outcome Framework, 2009–2011*, UNAIDS Executive Director, Michel Sidibé, called for a new and more focused commitment to the HIV response. The Outcome Framework committed the UNAIDS Secretariat and cosponsors to leverage their respective organizational mandates and resources to work collectively with national and global partners to deliver results for people at country level. It outlined 10, interconnected priority areas, each representing a pivotal component of the AIDS response. all of which are reflected in the UNAIDS 2010-2011Unified Budget and Workplan. It opened each of the ten areas with an affirmative challenge (see inside back cover).

For each priority area, a business case was developed by a global UNAIDS interagency working group, building upon and complementing action on the ground. Each business case is different, due to differences in the scope, knowledge base and stage of development of the policies and programmes involved. However, each business case succinctly explains the rationale for the priority area and outlines why success in this area will dramatically decrease new HIV infections and improve the lives of people living with and affected by HIV. The business cases delineate what is currently working and what needs to change in order to make headway in the 10 areas. They are intended to guide future investment and to hold UNAIDS accountable for its role in achieving tangible results. Each priority area business case presents three results to be achieved globally by 2011, which mark important progress towards our shared 2015 goals. These business cases informed both the UNAIDS 2011-2015 Strategy and the development of the 2012-2015 Unified Budget, Results and Workplan.

In 2009, UNAIDS' Executive Director asked each country Joint United Nations Team on AIDS, in consultation with their national AIDS programme, to identify three to five of the priority areas for intensified, unified United Nations (UN) support in 2009–2011. The global priority area working groups also proposed strategies to maximize UNAIDS' impact – some focusing on countries with the largest disease burden, and others on phasing waves of research or technical support according to learning opportunities and demand from local stakeholders. The work at country, regional and global levels has strengthened the foundations and baselines for action toward the ten goals of UNAIDS' 2011-2015 Strategy, Getting to Zero.

Focused, concrete and synergistic actions in the ten areas have the potential to change the trajectory of the epidemic. They will help to achieve universal access to HIV prevention, treatment, care and support, and contribute to achieving the Millennium Development Goals. Optimizing partnerships between national governments, communities, the UN, development partners and other stakeholders, the business cases recommend ways forward that build on decades of research and experience, and focus our work, hearts and minds on a unified and strategic vision.

We can prevent people living with HIV from dying of tuberculosis

1. WHY IS THIS A PRIORITY AREA?

Tuberculosis (TB) is a leading cause of serious illness and death among people living with HIV, despite being curable and preventable. The need for an integrated approach to addressing HIV and TB (HIV/TB), as intersecting epidemics, is extremely urgent and increasing.

Almost one in four of the world's 2 million AIDS-related deaths each year is caused by TB. The majority (83%) of these deaths occur in Africa, where the mortality rate from HIV-related TB is more than 20 times higher than elsewhere in the world. Even for people living with HIV who survive TB, the disease can take an enormous toll, requiring months of treatment and large financial costs. The rapid growth of multidrug-resistant and extensively drug-resistant TB poses an even greater threat to people living with HIV, due to alarmingly high mortality rates and the severe side-effects that can result from HIV treatment and second-line TB drugs.

TB mycobacteria live in a dormant state in about one third of the world's population, and HIV is the single greatest risk factor for causing this latent TB infection to progress to active TB disease. This is why preventing new HIV infections and ensuring universal access to antiretroviral therapy for people living with HIV are of vital importance. Reducing the transmission of TB through the 'three Is'—infection control, intensified early case detection and treatment, and isoniazid preventive therapy—is also critical.

Proactive strategies for addressing HIV and TB together are mutually beneficial:

- **Offering universal and voluntary HIV testing and counselling to all TB patients and TB suspects** is an important way to reduce the HIV burden among people with TB, by delivering appropriate advice and services for HIV prevention (such as condoms, circumcision, prevention of mother-to-child transmission and harm reduction) to populations at higher risk and by making sure that those who need it get access to life-saving antiretroviral therapy.
- **Ensuring universal access to TB screening, diagnosis and treatment for people living with HIV can prevent people living with HIV from dying of TB.**

The world cannot afford to delay action on HIV/TB—together we need to accelerate joint action by national TB and HIV programmes, their partners and other stakeholders, including the private sector and affected communities. The UNAIDS cosponsors have an essential role to play in coordinating and implementing the comprehensive, multisectoral, life-saving approaches described in this business case.

2. WHAT NEEDS TO BE DONE?

Intensified action is required from national TB and HIV programmes to work towards universal access to timely, comprehensive and integrated HIV and TB services. Action also is needed to work towards reducing many factors that put individuals at risk of HIV-related TB, such as poor housing and work conditions, drug use and malnutrition.

A strategic, multisectoral approach can reduce the human and economic costs of the dual epidemic to individuals, communities, businesses and governments and can contribute to achieving the Millennium Development Goals through coordinated efforts that span the health and humanitarian sectors, the private sector and the workplace, as well as harm reduction and correctional services.

Goal and bold results

UNAIDS's **goal** for this priority area is a 50% reduction in TB deaths among people living with HIV in all settings by 2015. This would mean saving the lives of about a quarter of a million people living with HIV per year, and putting countries on track to eliminating TB deaths by 2050.

Halving the number of TB deaths among people living with HIV by 2015 will require **strengthening systems to support HIV/TB collaborative activities, decreasing the burden of TB for people living with HIV and decreasing the burden of HIV for people with TB.**

In order to achieve the overall goal for 2015, the following bold results need to be reached by the end of 2011 in at least 10 of the plan's 21 most affected countries:

- **Reduce TB deaths by 20% among people living with HIV.**
- **Treat 50% of HIV-positive incident TB cases for both TB and HIV.**
- **Ensure that 80% of TB patients know their HIV status.**

Universal access to integrated HIV and TB prevention, treatment and care services will accomplish several important aims. As well as preventing new TB and HIV infections and reducing the number of HIV/TB cases and deaths, it will have a positive impact on most other UNAIDS priority areas and cross-cutting strategies.

Experience from countries that have successfully expanded their HIV/TB activities shows that targeted, well-supported and orderly efforts are essential to progress. The following are **best practices** learned from countries that have had success with such expansions:

- Setting national targets for the expansion of collaborative HIV/TB activities helps their implementation and the mobilization of political commitment and support from stakeholders.
- National policy and operational guidelines, training manuals and protocols should all be developed in line with international guidelines.

- Well-designed recording and reporting formats for collaborative HIV/TB activities are essential for documenting progress and for providing information on programme performance.
- TB components should be included in HIV registers, and HIV components should be included in TB registers.
- TB and HIV services should be integrated and delivered through primary health-care facilities and occupational health services.

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- Workplace structures should be used to emphasize the importance of preventing TB and HIV transmission to workers, their families and communities.
- For those affected by TB and/or HIV, nutritional support has been shown to be highly beneficial to case detection and to improving treatment uptake and adherence. HIV infection and malnutrition are risk factors for reactivating latent TB, and HIV infection and TB disease have a negative impact on nutritional status. Treatment outcomes for TB and HIV can be improved significantly by integrating nutritional support with antiretroviral therapy and/or TB treatment.
- Advocacy on HIV and TB issues has helped to increase investment and interest from stakeholders and to guide country-level implementation in many countries.
- Building the capacity of civil society and the private sector to advocate for better, more integrated services and more ambitious plans is critical to improving implementation.

Most progress to date has been seen in the uptake of HIV counselling and testing of TB patients by TB programmes, especially in Africa.

Despite the many lessons we have learned about how best to expand HIV/TB activities, we are still failing in many ways to comprehensively and effectively address these intersecting epidemics.

We are failing to prevent, diagnose and treat TB among people living with HIV and are not doing enough to prevent, diagnose and treat HIV among TB patients. We are also failing to address the many risk factors contributing to both conditions. Furthermore, we are not reaching out into communities to diagnose both conditions early enough to minimize their impact, and we are failing to provide adequate education and essential services to populations that need them.

The following are **critical issues** that have been identified for action by UNAIDS under the leadership of the World Health Organization (WHO), the UNAIDS convening agency for this priority area:

- TB still has not been sufficiently integrated into existing HIV workplace programmes and policies at the national level.
- In too many settings, people who cannot afford nutritious food during treatment are not receiving nutrition assessments, education, counselling or food assistance.

- Fewer than one third of HIV-positive TB patients were being provided with both antiretroviral therapy and TB treatment at the end of 2008. The greatest unmet need is in sub-Saharan Africa, where more than 400 000 people in 2007 needed, but did not receive, treatment for both conditions.
- We are failing to target services to those most in need and most at risk, who often have the least access to services. These populations include drug users, workers in specific sectors (such as mining and construction), prisoners, migrants and populations in humanitarian crisis situations.
- In many of the most affected countries in the world, prison authorities have yet to introduce any TB or HIV services.
- Communities affected by HIV are seldom aware of their risks of TB and of what they can do (and demand) in order to reduce these risks.
- Stigmatization, discrimination and punitive laws increase the barriers to effective prevention, treatment and care. We need a strong human rights framework to ensure that services are accessible to those most in need and to reach the most underserved population groups.
- Significant gaps remain in reducing the burden of TB among people living with HIV. In 2008, screening for TB was provided to only 4% of the 33.4 million people estimated to be living with HIV worldwide.
- Weak health systems pose important obstacles to reducing the burden of HIV among TB patients, and the burden of TB among people living with HIV, especially in the areas of service delivery (including drug supply and laboratories), workforces, strategic information and financing.

Countries with high TB and HIV burdens require resources and political will to mobilize high-quality, integrated TB and HIV services. They should be setting ambitious targets on HIV/TB and should be supported as they implement appropriate programmes. Such programmes should include globally developed, evidence-informed policies and guidelines and should be sophisticated enough to specifically target vulnerable populations and populations at higher risk.

Resources and support for collaborative HIV/TB activities in countries with the highest TB burden are currently inadequate. According to WHO, only 3% of the estimated TB control costs in these countries are allocated to collaborative HIV/TB activities.(1) These monies include national TB programme budgets and the costs associated with using general health service staff resources and infrastructure for TB control. Further analysis is needed to determine whether health systems have sufficient capacity to treat a growing number of patients.

Effective responses to HIV/TB also require better organization and greater support from stakeholders. National governments should provide political leadership and take the lead in developing and implementing policy. With its human resources and infrastructure, civil society can play a major role in implementing policies in tandem with governments and can help in model development. Bilateral and multilateral agencies and foundations can provide funding, technical support and the promotion of good practices, while research agencies can inform policies and programmes, assess present trends and predict future trends.

3. MOVING FORWARD

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The majority of UNAIDS's global support for activities on HIV/TB will focus on the 21 countries that together account for 85% of the global burden of TB cases among people living with HIV (see box). However, the UNAIDS Secretariat and cosponsors can (and should) also address HIV/TB among specific vulnerable populations and populations at higher risk in other countries, based on their field presence and comparative advantage. The key stakeholders in the response to HIV/TB include national governments, the private sector, civil society, bilateral and multilateral agencies, foundations, humanitarian actors and research agencies.

Although the national disease burden among the general population has been used as one criterion in selecting priority countries, a high prevalence of TB and/or HIV may exist within specific at-risk and vulnerable populations in countries other than those most affected by HIV/TB. Such populations include people who use drugs, prisoners, refugees and internally displaced people, and workers in certain occupations (including health workers). Priority programmes should explicitly target these key population groups.

By 2011, significant progress will be made in the following three areas:

- **Strengthen systems to support HIV/TB collaborative activities.** Cosponsor activities will strengthen advocacy and partnerships, planning and coordination, financing, strategic information, procurement and supply, and infrastructure, while promoting human rights and gender equality, including respect for sexual diversity, in HIV and TB programmes.
- **Decrease the burden of TB for people living with HIV.** Cosponsor activities will intensify TB case finding, expand the use of isoniazid preventive therapy, strengthen infection control for TB, and improve TB treatment, care and support, including nutrition, for people living with HIV.
- **Decrease the burden of HIV for people with TB.** Cosponsor activities will expand HIV testing and counselling for TB patients, expand HIV prevention services provided by TB programmes, put more HIV-positive TB patients on antiretroviral therapy and co-trimoxazole preventive therapy, and improve HIV care and support, including nutrition, for TB patients living with HIV.

Countries accounting for 85% of the global burden of HIV/TB (see Annex) Brazil, Cameroon, China, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Malawi, Mozambique, Myanmar, Nigeria, Rwanda, South Africa, Swaziland, Thailand, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

The role of UNAIDS

The mandate, political voice, reach and presence of UNAIDS (cosponsors and the Secretariat) at the global, regional and national levels position it to play a distinct role in supporting countries to achieve results in this priority area. To improve HIV/TB services and integration, while addressing vulnerability factors beyond the traditional purview of the health sector, each cosponsor will leverage its comparative advantage as part of a comprehensive, multisectoral approach. Individual cosponsors have unique comparative advantages and will take the lead in the areas in which they have the greatest expertise. Working together, they will develop country-specific frameworks to streamline the delivery of coordinated HIV/TB activities and to achieve synergies with work in other priority areas.

Treatment of TB patients with HIV infection (with or without supporting antiretroviral therapy) typically costs less than US$ 1 per day of healthy life gained, which is less than the average economic productivity of workers in the least developed countries. In a lead or convening capacity, UNAIDS cosponsors can have an enormous impact on the prevention of TB deaths among people living with HIV.

UNAIDS has many assets that can be leveraged for joint HIV/TB programmes, including a number of existing interagency task teams—such as those for children, youth and education—that can be engaged in operationalizing this outcome area.

Both the Monitoring and Evaluation Reference Group and the Human Rights Reference Group have reviewed and incorporated relevant HIV/TB issues into their work.

The UNAIDS technical support facilities, in collaboration with WHO, function as a clearing house for technical support to countries in the multisectoral response to HIV. These technical support facilities will be encouraged to collaborate more closely with providers of TB technical support.

The joint HIV/TB programme can harness the resources of cross-cutting teams to ensure better planning, coordination, country-level implementation, and monitoring and evaluation of effort in order to reduce the burden of HIV-related TB.

The cosponsors' country teams can and should strengthen their capacity to support national partners in the implementation of collaborative HIV/TB activities. Most of this support will be needed in southern and eastern Africa, where the majority of the disease burden is located. Efforts in this region will largely be for the general population, although they will also target the needs of very high-risk populations, such as prisoners and miners, and those with the least access to services, including forcibly displaced populations and migrants. In other parts of the world, the focus may tend to be on groups at higher risk rather than the general population.

There is also a pressing need for cosponsors to engage their well-developed networks and external partners in efforts to reduce the impact of HIV-related TB.

Ensuring accountability and measuring progress

The global monitoring and evaluation framework for HIV/TB activities has recently been updated, and the indicators have been harmonized, with all major partners supporting HIV/TB activities.

Although data collected from TB programmes are generally of good quality in many countries, the data collected from HIV programmes are largely weak, and methods for collecting key indicators from HIV care and treatment registers need to be improved.

Furthermore, it is likely that existing indicators need to be adapted to the monitoring and evaluation requirements of special populations, such as migrants, drug users, prisoners, workers in particularly vulnerable sectors, and populations in humanitarian crisis situations and displacement settings. WHO and the UN World Food Programme need to continue collaborating with other partners to screen existing evidence, with the ultimate goal of setting nutritional norms for people who are infected with both HIV and TB.

Annex

Table 1. The 21 HIV/TB focus countries accounting for 85% of the global burden

	Incident TB cases in people living with HIV (2008)	Percentage of estimated global burden of HIV-related TB (2008)	95% confidence interval—lower limit	95% confidence interval—upper limit	Cumulative percentage
South Africa	340 000	24.3	280 000	410 000	24.3
India	130 000	9.3	100 000	170 000	33.6
Nigeria	120 000	8.6	93 000	160 000	42.2
Zimbabwe	65 000	4.6	53 000	79 000	46.8
Uganda	58 000	4.1	44 000	77 000	50.9
Mozambique	57 000	4.1	43 000	75 000	55.0
Kenya	57 000	4.1	43 000	76 000	59.1
Ethiopia	50 000	3.6	40 000	63 000	62.7
Zambia	40 000	2.9	30 000	54 000	65.6
United Republic of Tanzania	38 000	2.7	31 000	47 000	68.3
Malawi	30 000	2.1	23 000	40 000	70.4
Côte d'Ivoire	25 000	1.8	19 000	33 000	72.2
China	22 000	1.6	6300	75 000	73.8
Myanmar	22 000	1.6	17 000	29 000	75.4
Democratic Republic of the Congo	20 000	1.4	15 000	26 000	76.8
Brazil	19 000	1.4	14 000	25 000	78.2
Thailand	16 000	1.1	12 000	21 000	79.3
Cameroon	14 000	1.0	11 000	19 000	80.3
Rwanda	13 000	0.9	9600	17 000	81.2
Swaziland	12 000	0.9	9000	16 000	82.1
Indonesia	12 000	0.9	8700	16 000	83.0
Total global burden of HIV-related TB	**1 400 000**	**100%**	**1 300 000**	**1 500 000**	**100%**

References

1. World Health Organization. Global tuberculosis control : a short update to the 2009 report. Geneva, WHO, 2009 (WHO/HTM/TB/2009.426).
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Joint Action for Results

UNAIDS Outcome Framework:

We can reduce sexual transmission of HIV.

We can prevent mothers from dying and babies from becoming infected with HIV.

We can ensure that people living with HIV receive treatment.

We can prevent people living with HIV from dying of tuberculosis.

We can protect drug users from becoming infected with HIV.

We can meet the HIV needs of women and girls and can stop sexual and gender-based violence.

We can remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS.

We can support the ability of men who have sex with men, sex workers and transgender people to protect themselves from HIV infection, achieve full health, and realise their human rights.

We can empower young people to protect themselves from HIV.

We can enhance social protection for people affected by HIV.

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