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From Rhetoric to Reality:

AN ANALYSIS OF DONOR AND IMPLEMENTING COUNTRY
EFFORTS TO SCALE UP THE TB-HIV RESPONSE

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People living with HIV are especially vulnerable to tuberculosis (TB), which is currently the leading cause of HIV-related deaths. TB is preventable and treatable, yet the airborne disease caused 320,000 deaths among HIV-positive people in 2012. Recognizing the urgency of this co-epidemic, the World Health Organization (WHO) put forward guidelines outlining 12 key collaborative activities to fight TB and HIV together.

This report analyzes the extent to which donor programs and national health policies include the 12 collaborative activities in countries where at least 20% of people with TB are co-infected with HIV.

Donors and implementing countries must increase investments and scale up key TB-HIV interventions – both through policies and practice. A failure to do so will further hinder efforts to end both epidemics and cause needless deaths from preventable and treatable illnesses.

Summary of Recommendations

- The **Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)** should require country leadership to comply with new TB-HIV guidelines and ensure a significantly increased portion of HIV grant funding in high burden countries goes toward implementing TB-HIV activities.
- The **President's Emergency Plan For AIDS Relief (PEPFAR)** should review TB-HIV funding levels in all high burden countries and increase funding allocation to TB-HIV.
- The **UK Department for International Development** should conduct a thorough review of health programs in countries with high TB-HIV burdens, and ensure TB-HIV collaborative activities are being systematically financed, implemented, monitored, and evaluated.
- The **World Bank** should increase funding for TB and HIV within its health portfolio, and ensure TB-HIV activities are being systematically implemented, monitored, and evaluated.
- **National HIV Programs** should require health facilities to screen all people living with HIV for TB and ensure access to proper TB testing, treatment, and care. When services are not located at the same clinic, incentives should be provided for affected communities to complete referrals.
- **National TB Programs** should reduce out-of-pocket costs for diagnostic tests such as x-rays, and work with National HIV Programs to provide psychosocial and nutrition support to people diagnosed with TB-HIV.

Data reviewed showed that WHO recommendations on TB-HIV collaborative activities have not been embraced equally across donors and implementing countries, and that those interventions are under-resourced and under-prioritized, especially by HIV programs.

A Deadly Duo: TB + HIV

TB is currently the leading killer of people living with HIV/AIDS, causing 20% of AIDS-related deaths. Although curable, only a fraction of people with TB-HIV co-infection are treated for TB. In 2011, the WHO estimated 1.1 million people living with HIV became sick with TB but only 280,000 – approximately 25% – successfully completed TB treatment.¹ The other 820,000 either did not access care at all, accessed health services but were not

diagnosed and treated, or were diagnosed and treated but not documented by country reporting systems. Without proper treatment, an estimated 90% of people living with HIV will die within months of contracting TB.²

These two diseases form a lethal combination, each speeding the others' deadly progress. Most healthy people exposed to TB – an airborne disease that often attacks the lungs – are able to fight off the bacteria, and do not get sick. Due to their weakened immune system, however, people with HIV are up to 30 times more likely to develop active TB than people who don't have HIV.³ To further complicate the issue, the most common TB test used in low and middle income countries often fails to diagnose TB in people living with HIV. **It is estimated that only half of all people with TB-HIV co-infection are reported to the World Health Organization (WHO).**⁴

Only 25% of the 1.1 million people living with TB-HIV successfully completed TB treatment.¹



Photo Credit: World Lung Foundation Image Library

History of Integrating TB and HIV Health Services

The emergence of HIV over the last three decades has led to skyrocketing rates of TB, which in turn accelerated the progression of HIV. New TB infections tripled in high-HIV areas, especially in sub-Saharan Africa, which now carries 75% of the global burden of TB-HIV.^{5,6} African Ministers of Health responded to the growing threat, declaring TB a public health emergency in Africa in 2005.⁷

To combat increasing rates of co-infection, the WHO put forward interim guidelines to address TB-HIV in 2004. This policy emphasized the need to integrate HIV and TB services, as the two diseases often affect the same person.⁸ Four years later, the policy was updated to include three key strategies to address co-infection. Often referred to as the 'Three I's', the report highlighted the need to scale up efforts to detect TB among people living with HIV (**intensified case finding**), thwart new infections with preventive antibiotics (**Isoniazid Preventive Therapy**), and stop TB from spreading in health clinics with measures like increased ventilation and providing protective masks (**infection control**).⁹

Over time, the definition of integration began to change. Initially, there was a push for HIV programs to refer clients to TB clinics and vice versa. However, now there is a greater push for 'one-stop shops' where HIV services are provided alongside TB services.¹⁰ As best practices were identified, the WHO updated its TB-HIV policy recommendations

in 2012. These recommendations outline 12 TB-HIV collaborative activities to improve health services and health outcomes for people with and at risk of TB-HIV co-infection. Failure to implement these activities will lead to more unnecessary deaths and reverse the fragile progress made on TB-HIV.

Despite awareness of the 12 collaborative TB-HIV activities, little research is available about the extent to which WHO recommendations were being implemented in the most affected countries. A review of existing literature showed this analysis was carried out in specific countries or among specific donors, but little data existed across multiple countries and donors. Two reports provided insight on the global status of integration. In 2009, ACTION published a report, *Living with HIV, Dying of TB*, which provided a critique of the TB-HIV response of major international donors.¹¹ In 2011, the WHO analyzed the inclusion of TB-HIV Collaborative Activities in proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) from rounds 8, 9, and 10.¹² However, the WHO recommendations on TB-HIV have progressed since these reviews were completed. Furthermore, these reviews only focused on proposals rather than active grants and did not include budget details for TB-HIV activities.

2004

WHO put forward interim guidelines to address TB-HIV.

2008

The policy was updated to include three key strategies to address co-infection.

2012

WHO updates policy as best practices are identified.

Methodology

To better understand how the updated WHO recommendations on TB-HIV were being put into practice, ACTION carried out a mixed methods study analyzing efforts by donors and implementing countries to include TB-HIV collaborative activities in their policies and programs. The research focused on 32 countries where 20% or more of people with TB were co-infected with HIV.^{13*} This list is solely based on percentage of new TB cases that are co-infected with HIV, not absolute number of people living with the diseases. As a result, it does not include a number of Asian and European countries.

Four donor agencies were chosen for review: The Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States President's Emergency Plan for AIDS Relief (PEPFAR), the United Kingdom Department for International Development (DFID), and the World Bank. The analysis, which took place during March and April 2014, focused on these donors because they are large financiers of TB and HIV programs and relevant data was publicly

available. The Global Fund, for example, provides approximately 75% of external financing for TB control globally.¹⁴ While not exhaustive, this analysis serves as an initial look into major donors' response to WHO recommendations on TB-HIV collaborative activities. Available national strategic plans on TB and HIV in the 32 most affected countries were evaluated as well. All documents were analyzed to capture any mention of WHO recommendations, and assessed to determine if budget was allocated to carry out the TB-HIV activities.

To complement the quantitative analysis, ACTION carried out 35 in-depth interviews with stakeholders in three countries with high TB-HIV burdens: Kenya (Nairobi and Kisumu), Zambia (Lusaka), and South Africa (Cape Town and Pretoria). The locations were chosen based on TB-HIV co-infection rates and presence of ACTION partners or allies. Interviewees included government officials, donor representatives, civil society, care providers, and people affected by TB-HIV.



Students take part in World TB Day activities in Khayelitsha, South Africa, an area where 70% of people with TB are co-infected with HIV.

*Lesotho, Swaziland, Zimbabwe, South Africa, Botswana, Malawi, Mozambique, Zambia, Uganda, Namibia, Tanzania, Antigua and Barbuda, Guinea-Bissau, Kenya, Cameroon, Saint Vincent and the Grenadines, Barbados, Central African Republic, Rwanda, Gabon, Cote D'Ivoire, Trinidad and Tobago, Nigeria, Togo, Bahamas, Guyana, Chad, Congo, Jamaica, Suriname, Belize, Haiti

Finding 1: WHO recommendations on TB-HIV collaborative activities have not been embraced equally across donors and implementing countries.

PEPFAR and the Global Fund were quick to update their policies to reflect the new WHO guidelines.

TB-HIV collaborative activities received prominent attention in PEPFAR policies including the *2012 PEPFAR Blueprint: Creating an AIDS-free Generation*, which featured seven of the 12 recommendations.¹⁵ PEPFAR has made efforts to put these policies into practice. A review of most recent Country Operational Plans (COPs) from FY2013 showed country programs in high TB-HIV burden countries included a 54% increase in mention of TB-HIV collaborative activities than COPs from those same countries in FY2008.

The Global Fund's HIV grants have limited mention of necessary TB-HIV collaborative activities. On a policy level, however, the Global Fund has taken recent measures to correct this. In November 2013, the Board of the Global Fund decided to require countries with high burdens of co-infection to submit a joint concept note for TB and HIV when applying for grant funding.^{16,17} Developing joint concept notes has the potential to improve collaboration between National TB and HIV programs and ensure Global Fund proposals better reflect the priority of TB-HIV activities. This is especially important, as ACTION's review of these program's policies showed National TB and National HIV programs were often poorly aligned.

While it is too soon to determine the impact of the Global Fund board decision on joint concept notes, it appears that efforts are challenged by lack of aggressive uptake and some resistance at the country level.¹⁹ This sentiment was echoed in interviews for this report, which indicated a history of poor coordination between national TB and national HIV programs. "There are territorial battles" between government agencies, explained a member of Kenyan civil society.²⁰

Other donors, including the UK Department for International Development (DFID) and the World Bank, have been slow to implement WHO recommendations.

Despite strong rhetoric on the need to integrate TB and HIV services in its policy documents, it is unclear to what extent DFID are integrating TB and HIV services in their bilateral programs. There are ten high TB-HIV burden countries in which DFID operates. Eight of these countries have active health projects that mention HIV, yet none include a single TB-HIV collaborative activity. Recent communication with DFID has indicated that data on their bilateral TB-HIV work may be captured in partner documentation but at present this is not publicly available on their development tracker website. While UK Secretary of State for International Development Justine Greening told the House of Commons in March 2014 that DFID will "make sure over time we integrate those guidelines into our program," DFID has given no indication of when or how this will take place.²²

The World Bank's response to TB-HIV co-infection has also been inadequate in practice. While 63% of the 16 active health projects with HIV and/or TB listed as a project theme included at least one TB-HIV collaborative activity, five TB-HIV collaborative activities, including antiretroviral treatment and Isoniazid Preventive Therapy, had no mention at all. Furthermore, the World Bank provides a minuscule amount of funding for TB and HIV. Currently, the World Bank has only 13 active projects with a TB theme for a total investment of \$180.8 million and 49 active projects with an HIV theme for a total investment of \$966.4 million – a mere 5% of the current \$22.9 billion approved for health projects.²³

Main Findings

Analysis of Donor Documents

Includes active projects and policies from the 32 countries with TB-HIV burdens of 20% or higher

	PEPFAR FY 2013 Country Operational Plans (19 total)	World Bank active health projects that include TB & HIV (16 total)	Active Global Fund TB grants (26 total)	Active Global Fund HIV grants (51 total)	DFID health projects with HIV focus (16 total)
A1 Set up and strengthen a coordination body for collaborative TB/HIV activities functional at all levels.	95%	13%	54%	10%	0%
A2 Determine HIV prevalence among TB patients and TB prevalence among people living with HIV.	26%	0%	70%	16%	0%
A3 Carry out joint TB/HIV planning to integrate the delivery of TB and HIV services.	95%	56%	88%	33%	0%
A4 Monitor and evaluate collaborative TB/HIV activities.	89%	19%	100%	24%	0%
B1 Intensify TB case-finding and ensure high quality anti-tuberculosis treatment.	95%	41%	100%	20%	0%
B2 Initiate TB prevention with Isoniazid preventive therapy and early antiretroviral therapy.	84%	0%	31%	6%	0%
B3 Ensure control of TB infection in health care facilities and congregate settings.	89%	6%	12%	0%	0%
C1 Provide HIV testing and counseling to patients with presumptive and diagnosed TB.	89%	6%	62%	20%	0%
C2 Provide HIV prevention interventions for patients with presumptive and diagnosed TB.	58%	6%	8%	8%	0%
C3 Provide cotrimoxazole preventive therapy for TB patients living with HIV.	84%	0%	42%	6%	0%
C4 Ensure HIV prevention interventions, treatment and care for TB patients living with HIV.	79%	0%	12%	8%	0%
C5 Provide antiretroviral therapy for TB patients living with HIV.	84%	0%	58%	8%	0%

Main Findings

Analysis of National Strategic Plans

Includes latest publicly available National Strategic Plans written in English or French from the 32 countries with TB-HIV burdens of 20% or higher

	TB National Strategic Plans (12 total)	HIV National Strategic Plans (28 total)
A1 Set up and strengthen a coordination body for collaborative TV/HIV activities functional at all levels.	92%	57%
A2 Determine HIV prevalence among TB patients and TB prevalence among people living with HIV.	75%	25%
A3 Carry out joint TB/HIV planning to integrate the delivery of TB and HIV services.	100%	64%
A4 Monitor and evaluate collaborative TB/HIV activities.	92%	71%
B1 Intensify TB case-finding and ensure high quality anti-tuberculosis treatment.	100%	57%
B2 Initiate TB prevention with isoniazid preventive therapy and early antiretroviral therapy.	83%	18%
B3 Ensure control of TB infection in health care facilities and congregate settings.	83%	25%
C1 Provide HIV testing and counseling to patients with presumptive and diagnosed TB.	100%	50%
C2 Provide HIV prevention interventions for patients with presumptive and diagnosed TB.	67%	11%
C3 Provide cotrimoxazole preventive therapy for TB patients living with HIV.	92%	32%
C4 Ensure HIV prevention interventions, treatment and care for TB patients living with HIV.	75%	14%
C5 Provide antiretroviral therapy for TB patients living with HIV.	100%	46%



COUNTRY SUCCESS: SOUTH AFRICA

Even before the WHO guidelines were released in 2012, South Africa was already demonstrating leadership in its approach to tackle the TB-HIV co-epidemic. With the highest burden of HIV of any country in the world and the second highest rate of TB globally, South Africa took ambitious steps to integrate TB and HIV into a single National Strategic Plan that included all 12 TB-HIV collaborative activities.²⁴ Many interviewees described the situation in the mid-2000s as being dire, with virtually no integration of services. “When I was diagnosed with HIV and TB in 2005, it was not easy,” explained a former patient from Khayelitsha, an informal settlement outside Cape Town. “I had to go for TB meds from one clinic and then for HIV to the other clinic.”²⁵

Today, health care providers say HIV counselling and testing rates for people with TB have increased to 95%.²⁶ Studies show similar progress. Since integrating services, there has been a 60% increase in access to antiretroviral therapy (ART) for people co-infected with TB.²⁷ There have also been improvements in the relationship between the government and civil society, with civil society now playing a more active role in national planning. One South African civil society member explained, “A number of people from different civil society organizations were part of writing [the strategic plan], not just rubber stamping it.”²⁸



Main Findings

Finding 2: Despite having fewer resources, TB programs carry out the majority of joint TB-HIV efforts, while TB-HIV interventions are often neglected by HIV programs.

Overall, TB programs have done a much stronger job than HIV programs of including collaborative TB-HIV activities in their grants, projects, and policies. A review of TB National Strategic Plans showed 100% included at least seven TB-HIV collaborative activities. All of the Global Fund TB grants reviewed addressed TB-HIV in some way, although there is still room for improvement as only 62% of TB grants ensured that TB patients received HIV counseling and testing.

On average, HIV programs were alarmingly weak in addressing TB-HIV, as compared to their TB counterparts. A review of HIV National Strategic Plans showed only 25% made any mention of infection control to stop the spread of TB in HIV clinics. Global Fund HIV grants (prior to the new

requirement of joint concept notes) also did a poor job including TB-HIV collaborative activities. Despite its strong recommendation from WHO, only 8% of HIV grants included ART for patients with TB-HIV co-infection – an intervention proven to cut deaths in people with co-infection by as much as 95%.^{29,30} PEPFAR was an exception to the trend, where 18 of the 19 COPs reviewed included nine or more TB-HIV collaborative activities. All COPs reviewed included an emphasis on increasing TB case-finding for people living with HIV and 84% included a specific focus on ART for patients with TB-HIV co-infection.

Globally, the lackluster effort of HIV programs to carry out TB-HIV collaborative activities has produced grim results. Of the 569,000 people living with HIV who were diagnosed with TB in 2012, only 57% were provided HIV treatment (antiretroviral therapy, or ART) – a far cry from the 100% target.³¹ While an improvement from previous years, screening for TB remains deficient. In 2012, 4.1 million people living with HIV were screened for TB – approximately 42% of people enrolled on ART (9.7 million), but only 12% of the estimated people living with HIV in the world (35.3 million).^{32,33,34} There are no data on how many of these people completed the referral – this lack of tracking and reporting is a problem in itself and indicates that systems are not prioritizing this critical step.

Despite high performance including TB-HIV collaborative activities, TB programs are consistently undercut by low funding.

The burden to carry out TB-HIV collaborative activities falls primarily on TB programs. Of the Global Fund grants reviewed, **TB grants had a**

HIV Programs/Policies Compared to TB Programs/Policies:

How many included at least 1 TB-HIV collaborative activity?

HIV Programs & Policies

56%

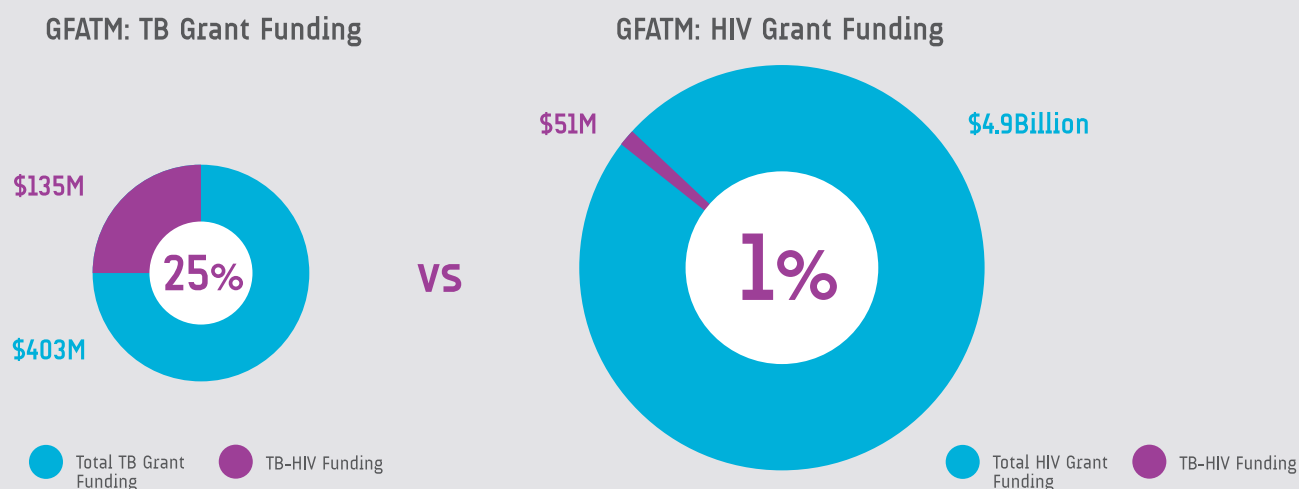
TB Programs & Policies

100%

*TB programs/policies include 26 active Global Fund TB grants and 12 TB National Strategic Plans

**HIV programs/policies include 51 active Global Fund HIV grants, 28 HIV National Strategic Plans, 19 COPs, and 16 DFID health projects with HIV focus.

Percentage of grant funding spent on TB-HIV collaborative activities



budget one-eighth the size of HIV grants, yet allocated nearly three times the amount of TB-HIV funding. TB-HIV specific funding made up 25% of Global Fund TB funding but only 1% of HIV funding – resulting in \$135 million from TB grants, and only \$51 million from HIV. This finding was echoed by stakeholders interviewed. One government official explained, “The financial burden and human resources burden of carrying out these activities such as isoniazid, infection control, intensified case finding, falls on the TB program, and not so much on the HIV program.”³⁵

Although TB-HIV collaborative activities are reflected in the COPs reviewed, PEPFAR only allocated 4% (\$125 million) of COP budgets reviewed to TB-HIV – one-third of which went to South Africa. These funding levels are far from sufficient to bring PEPFAR’s excellent model of addressing TB-HIV to needed scale. Increased funding for the diseases would allow more people with TB-HIV to access ART and would accelerate the development of more one-stop shops where people are able to access services for both HIV and TB.

Finding 3: Failure to integrate TB and HIV programs creates barriers to TB diagnosis and treatment for people living with HIV/AIDS.

One essential first step in integrating TB and HIV services is to ensure that all people living with HIV/AIDS are screened for TB and then referred for diagnosis and treatment. Screening includes asking

a series of questions about symptoms such as cough, fever, night sweats, and unexplained weight loss. When someone’s symptoms indicate TB, the referral system must ensure that he/she is then

Main Findings

actually tested for TB. Lack of screening for TB by HIV programs is a first major barrier, followed by large gaps between screening positive for TB and confirming diagnosis with a TB test.

The referral system presents barriers for people living with HIV to get diagnosed with and treated for TB.

Interviews indicated that distance, time, and transportation were major barriers to completing a referral. One client in Zambia explained, “If you say you have to come to one day for HIV and another day for TB, you won’t do it. You won’t have the time, money.”³⁷

Even when referrals are completed and a TB test is performed, many people living with HIV have fewer bacteria in their sputum samples, rendering the TB test inconclusive. Additionally, traditional TB tests don’t detect TB outside the lungs, which is more common in people living with HIV.³⁸ In situations where test results are inconclusive or TB outside the lungs is suspected, clients are referred to get an x-ray. Few clinics perform x-rays and patients are often referred to provincial hospitals. In addition to being located far away, the hospitals usually charge for x-rays, as opposed to the standard microscopy TB test which is free. In Kisumu, Kenya x-rays cost 600 Kenyan Shillings, approximately US\$7 – more than many Kenyans make in a week.

A new TB diagnostic, GeneXpert, is helping address many of these issues. GeneXpert delivers results in less than two hours and is more effective in detecting TB among people living with HIV. South Africa has pioneered the rollout of this new tool, ordering over 4,000 new machines in the last two years.³⁹ However, the higher effectiveness of GeneXpert comes at a price. It is relatively expensive compared to a

microscope and slides, and requires electricity and a trained lab technician. This means coverage is still limited and its use is more difficult in rural settings. “It is by chance and luck that you end up in the right clinic,” explained a South African interviewee about the availability of GeneXpert.⁴⁰

Once diagnosed, many people with TB-HIV co-infection face structural challenges to being cured of TB.

As part of their TB treatment, many people living with HIV are required to visit the TB clinic every day to have a nurse observe them taking the medication, a practice known as DOTS (Directly Observed Therapy Short-Course). Finding transportation to and from the clinic each day is difficult. Additionally, most people interviewed said lack of nutrition and psychosocial support made it difficult to complete treatment.

To reduce barriers to TB diagnosis and treatment, people interviewed suggested increasing support for community health workers to screen for TB and deliver integrated care. Community Health Workers reach people who don’t always have regular access to health care through clinics and hospitals and could serve an important role for finding the more than half a million people with TB-HIV co-infection who go unreported each year. The untapped potential of Community Health Workers was raised several times in interviews with stakeholders. In the three countries, interviewees often remarked that Community Health Workers were underpaid, undervalued, or only trained in one health area such as HIV and that TB-HIV integration efforts suffered as a result. “By the amount we pay them, we instantly disrespect what they do,” explained a TB doctor in South Africa.⁴¹

“TB and HIV have been managed separately...national plans are separate. So when you get down to the clinics, TB corner and ART corner are still separate.”³⁶



Demonstrators at the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA 2013) call for increased attention to TB-HIV integration. Photo Credit: Arne Von Delft, TBProof.org



START

You are a person living with HIV/AIDS who is feeling generally ill with a fever, night sweats, and a cough.

DO YOU RECOGNIZE THESE ARE SYMPTOMS OF TB?

REQUIRED:



You take the day off work and head to your local HIV clinic to find out what is causing these symptoms.

ARE YOU SCREENED FOR TB?

REQUIRED:



The TB screening reveals you may have TB. You are referred to a laboratory in another community for a TB test.

ARE YOU TESTED FOR TB?

REQUIRED:



You are **NOT** successfully cured of tuberculosis, the leading killer of people living with HIV.

In 2011, **75%** of people with HIV and TB co-infection were not successfully treated for TB. One of the main barriers to TB care is getting properly diagnosed. Integrating TB screening and testing into HIV clinics is the most effective way to ensure people living with HIV are properly diagnosed with TB, but support should not stop at diagnosis. **Community-based treatment programs** where health workers provide medicine, food, and psychosocial support are essential to ensuring all people living with HIV and TB co-infection have access to care and treatment.

You are one of the fortunate people with HIV to be cured of TB.

In 2011, only **25%** of people with HIV and TB co-infection were cured of TB. More people can be cured of TB if we remove barriers to care such as lack of transportation, time, and nutritional support.

THE PURSUIT OF A TB CURE

FOR PEOPLE LIVING WITH

HIV

THE LONG AND WINDING ROAD

Like many people living with HIV, you have fewer bacteria in your cough sample, so the TB test is inconclusive. You are referred to a hospital for a chest x-ray.

DO YOU RECEIVE A CHEST X-RAY?

REQUIRED:



Your x-ray shows you have TB. You are directed to a TB clinic to start treatment, commonly referred to as DOTS (Directly Observed Therapy Short-course).

ARE YOU STARTED ON TREATMENT?

REQUIRED:



You are placed on treatment for six months. As part of DOTS, you are required to visit the TB clinic every day to have a nurse observe you taking your medication.

DO YOU COMPLETE TB TREATMENT?

REQUIRED:



REQUIRED ICON KEY:



HEALTH EDUCATION



MONEY



TRANSPORTATION



TIME



TRAINED CLINIC STAFF



NUTRITIONAL SUPPORT

Recommendations

A lack of investment in TB-HIV interventions results in unnecessary suffering and death among people living with HIV. It is time for donors and implementing countries to increase investments and intensify efforts to address TB-HIV co-infection, especially within HIV programs, whose adoption of TB-HIV collaborative activities has been alarmingly low. Additionally, donors and implementing countries should monitor and evaluate in real time the implementation of TB-HIV collaborative activities and make all findings publicly available at least annually.

The Global Fund

The inclusion of TB-HIV collaborative activities in active Global Fund HIV grants (through 2013) is poor; none of the HIV grants addressed infection control in health facilities and only 1% of HIV grant funding was dedicated to TB-HIV. However, the Global Fund's decision to require the submission of a joint TB and HIV concept note has the ability to improve the inclusion of TB-HIV collaborative activities in Global Fund grants, and to push national programs to work together more closely and effectively.

- **The Global Fund should require country leadership to comply with the new guidelines, and ensure that a significantly increased proportion of HIV grant funding in high burden countries goes toward implementing TB-HIV activities.**
- **The Global Fund should collect best practices for developing a joint TB and HIV concept note and share them with National TB and National HIV programs.**

PEPFAR

PEPFAR has ensured TB-HIV interventions were reflected in its policies and programs; 18 of the 19 COPs reviewed included nine or more WHO recommendations. However, too little money is allocated to carry out these policies – only 4% of total spending in high burden countries.

- **PEPFAR should review TB-HIV funding levels in all high burden TB-HIV countries and increase funding allocation to TB-HIV.** This financing would allow scale-up of TB case finding, expanded rollout of GeneXpert, and development of more 'one-stop shops' where clients can access both HIV and TB services.

DFID

Despite strong rhetoric on the need to integrate TB and HIV services in its policy documents,²¹ it is unclear to what extent DFID are integrating TB and HIV services in their bilateral programs.

- **We recommend DFID conduct a thorough review of health programs in countries with high TB-HIV burdens, and ensure TB-HIV collaborative activities are being systematically financed, implemented, monitored, and evaluated.**

World Bank

The World Bank's response to TB-HIV co-infection has been inadequate; five of the WHO recommendations, including ART for TB patients, had no mention in any of the 16 World Bank programs reviewed. Financing for TB and HIV is exceedingly low, making up only 5% of total World Bank investments in health.

- **The World Bank should provide countries with specific guidance on TB-HIV interventions and ensure that TB-HIV activities are being systematically implemented, monitored, and evaluated.**
- **The World Bank should increase funding for TB and HIV within its health portfolio.**

National HIV Programs

Despite being the leading killer of people living with HIV, National HIV Programs have failed to prioritize TB-HIV interventions. Only 25% of HIV National Strategic Plans reviewed included infection control for TB.

- **National HIV Programs should require health facilities to screen all people living with HIV for TB and ensure access to proper TB testing, treatment, and care. These services should be monitored and reported on annually.**
- **When TB and HIV services are not located at the same clinic, incentives should be provided for affected communities to complete referrals, such as transportation and nutritional support.**

National TB Programs

National TB Programs have faced the dual burden of carrying out TB and HIV activities. However, major barriers exist to the diagnosis and treatment of TB among people living with HIV.

- **National TB Programs should reduce out-of-pocket costs for diagnostic tests such as x-rays and work with National HIV Programs to provide psychosocial and nutritional support for people diagnosed with TB-HIV co-infection.**
- **Additionally, National TB Programs should support more community-based TB programs where community health workers or family members can support patients to take their TB medication.**

End Notes

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Our partners (www.action.org/about/partners) work across five continents in both donor and high burden countries:

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