

US President's Emergency Plan for AIDS Relief

KEY FINDINGS

- ▶ The United States President's Emergency Plan for AIDS Relief (PEPFAR) has strong policy guidance on TB-HIV, including program-wide goals to achieve, as part of a global effort, universal access to core TB-HIV services. While PEPFAR country teams set annual targets for TB-HIV service implementation, the program does not set aggregate targets.
- ▶ Strong guidance backed with significant funding has contributed to several important "success stories" in TB-HIV programming that now must be taken to scale across all supported programs.
- ▶ Since 2004, PEPFAR Country Operational Plans (COPs) have shown an increasing number of PEPFAR project components planning to implement at least one TB-HIV activity. Despite progress, in FY08 COPs, just 23.1 percent of project components reported plans to implement at least one TB-HIV activity.
- ▶ PEPFAR has had some success scaling up HIV testing in TB settings, but has largely missed leveraging the program's comparative advantage to scale up TB services in HIV settings.
- ▶ Country teams are encouraged to screen all PLWHA for TB as a priority, and anecdotal reports suggest that implementing partners are increasingly providing screening. However, PEPFAR does not routinely monitor TB screening for PLWHA and does not know how many PLWHA in its programs have been screened for TB. New "next generation" indicators, if adopted as planned, will make TB screening a standard part of PEPFAR's M&E framework.

BACKGROUND

Administered by the federal Office of the Global AIDS Coordinator (OGAC), the United States (US) President's Emergency Plan for AIDS Relief (PEPFAR) is the US' primary vehicle for combating the global HIV/AIDS epidemic. Authorized by Congress in 2003, PEPFAR provided \$18.8 billion from FY04¹ to FY08 to support HIV/AIDS prevention, treatment, and care services, mostly within 15 focus countries.² In 2008, Congress reauthorized PEPFAR for an additional five years, permitting the US government to provide at least \$48 billion for global HIV/AIDS, TB, and malaria programs from FY09 through FY13.³

1. The fiscal year for the United States Government runs from October 1 through September 31.

2. Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.

3. The Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008 authorized \$4 billion for TB and \$5 billion for malaria, included within the \$48 billion total. The congressional appropriations process will annually determine the exact levels of funding devoted to these three diseases. Because the bill authorized \$2 billion in FY09 for the Global Fund to Fight AIDS, Tuberculosis and Malaria and "such sums as necessary" thereafter, it is difficult to identify an exact authorized funding level for HIV/AIDS programs.

In PEPFAR's first year, TB-HIV received little attention and almost no funding. Since then, however, the initiative has increased support for TB-HIV activities each year, from \$25.5 million in FY05 (2 percent of its program budget) to over \$169 million in FY08 (4.3 percent of its program budget).⁴ In FY07, PEPFAR identified TB-HIV as one of the initiative's three "priority program areas" (PEPFAR 2006d).

As a result of increased funding and more focused policy, PEPFAR has scaled up delivery of some TB-HIV services — notably the provision of HIV counseling and testing to TB patients and others at high risk for TB infection. But overall, PEPFAR's TB-HIV programming remains modest in light of both the need and the initiative's goals. PEPFAR does not know how many PLWHA have been screened for TB in its programs, and anecdotal evidence suggests minimal progress in this area over five years. Furthermore, FY08 Country Operational Plans (COPs) for the 12 focus countries in sub-Saharan Africa show that only 23.1 percent of all project components include at least one TB-HIV activity.⁵ OGAC must collaborate with host governments and implementing partners to fill these program gaps, ensuring that all patients receiving support from PEPFAR have access to the full range of appropriate TB-HIV interventions.

POLICIES

US government teams working at the country level are instructed to "seek all opportunities to improve coordination of TB and HIV/AIDS interventions" and to allocate resources so as to achieve the following objectives:

- ▶ Diagnose, care, and treat all PLWHA with active TB disease;
- ▶ Provide HIV counseling and testing for all patients who are seeking care in TB programs; and
- ▶ Provide preventive TB care for PLWHA who are not diagnosed with active TB (consistent with local guidelines) and ensure that all eligible co-infected PLWHA receive antiretroviral therapy (ART) (PEPFAR 2006b).

These are ambitious goals to which PEPFAR expects to contribute as part of a global effort. They are not, however, specific project outcomes that PEPFAR plans to achieve on its own. PEPFAR has no aggregate five-year targets for TB-HIV services, as it does for HIV/AIDS prevention, treatment, and care. Instead, PEPFAR sets annual targets for TB-HIV activities for each focus country. COP Guidance notes, however, that these annual targets are "motivational targets" only, intended to serve as points of reference rather than hard targets for which country teams will be held accountable (PEPFAR 2005c).

4. Total funding for the TB-HIV program area includes programmatic funding, as well as expenses associated with central procurement, supply chain, technical leadership and support, strategic information, management and staffing, policy analysis, systems strengthening activities, and other administrative or indirect costs that are attributed to the TB-HIV program area at the aggregate level.

5. OGAC requires each PEPFAR focus country team to submit its annual HIV/AIDS program plan, known as a Country Operational Plan. Country teams develop COPs based on initial country budgets and technical guidance provided by OGAC. Technical guidance is provided in the form of a Country Operational Plan Guidance document, which outlines COP requirements, priority interventions, limitations on PEPFAR support, and other guidelines. While COPs are not exhaustive planning documents, they do provide a picture of country priorities from year to year that generally track with PEPFAR's reported annual TB-HIV outputs. In instances where COPs described an increase over the previous year in project components implementing at least one TB-HIV activity, PEPFAR reported an increase in patients reached with TB-HIV services during that year. In instances where COPs described a decrease, PEPFAR reported a decrease in patients reached. An analysis of COPs is limited, however. In this case, while 23.1 percent of program components reported plans to implement at least one TB-HIV activity, there is no objective way to determine exactly what percent of project components should include at least one TB-HIV activity. In the absence of more detailed, publicly available programming data, however, the analysis of COPs provides a useful, if limited, method for evaluating country-level plans.

FY08 Country Operational Plan (COP) Guidance described previous years' efforts to scale-up of TB-HIV activities as "slow" and referred to "broad gaps" in TB-HIV programming in all PEPFAR focus countries (PEPFAR 2007b). To speed progress in scaling up TB-HIV service delivery, the guidance requested that PEPFAR country teams "significantly increase Emergency Plan resources and attention dedicated to this priority area" (PEPFAR 2007b). In FY09, OGAC officials report that further steps have been taken to improve TB-HIV service scale-up, specifically that requirements for TB screening and TB infection control have been established for PEPFAR's second phase (FY09-13) and that all care and treatment programs will be expected to have a TB-HIV strategy in place and a system to monitor its implementation (OGAC, personal communication 2009).

PROGRAMMING

PEPFAR publishes few outcome data describing its delivery of TB-HIV services. PEPFAR's annual reports to Congress provide data regarding its efforts to treat HIV/AIDS patients for TB (Table 4), but little other data are available regarding the extent to which PEPFAR has impacted the burden of TB among PLWHA.

Table 4. Number of PLWHA receiving TB care and treatment⁶ services at USG-funded health centers in PEPFAR Focus Countries

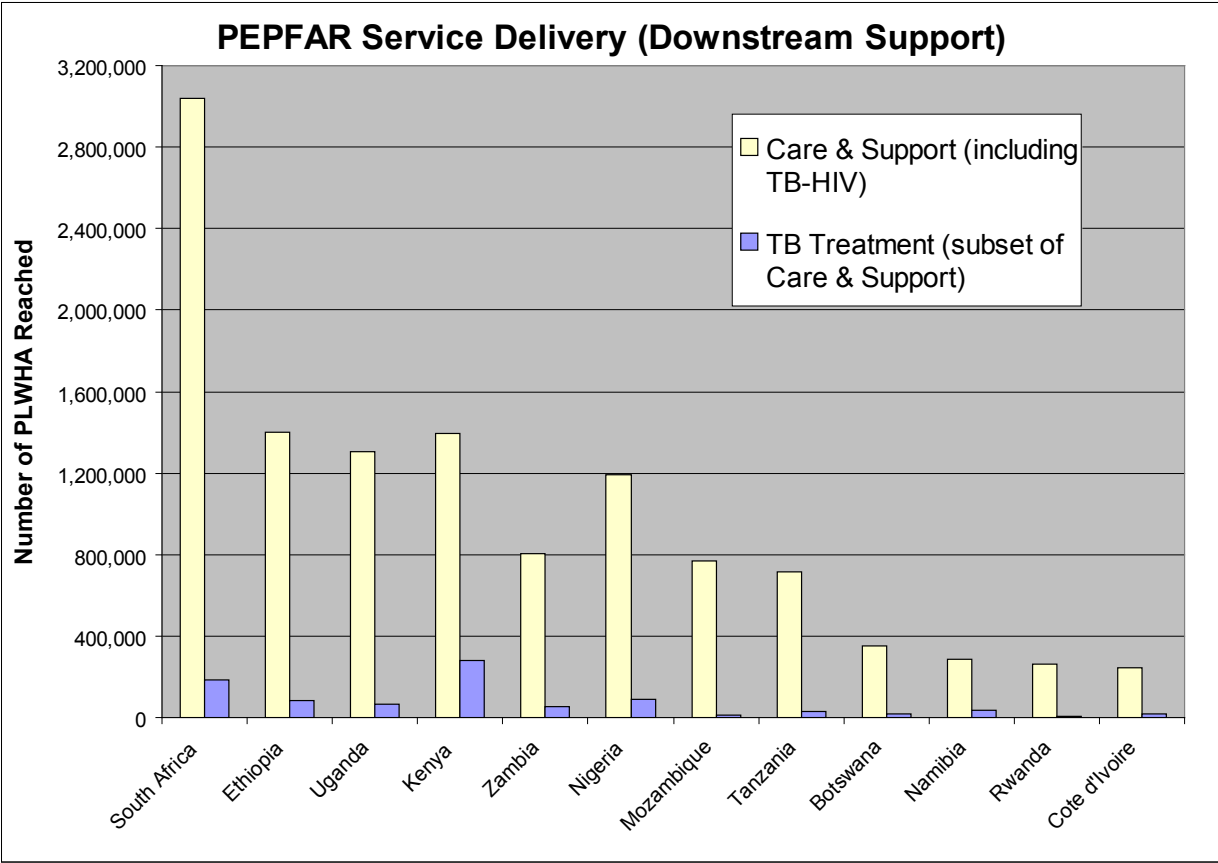
Country	FY04	FY05	FY06	FY07	FY08	Total FY2004–2007
Botswana ^a	1,100	200	5,900	6,300	2,900	16,400
Cote d'Ivoire	7,500	1,400	1,500	2,700	3,900	17,000
Ethiopia	1,000	33,000	11,000	11,600	26,900	83,500
Guyana	15	200	300	200	200	915
Haiti	300	1,800	1,000	1,600	1,600	6,300
Kenya	59,700	63,200	59,800	57,900	40,000	280,600
Mozambique	0	0	1,700	5,900	7,000	14,600
Namibia	1,700	14,300	3,000	10,900	7,600	37,500
Nigeria	0	33,200	6,200	18,500	32,200	90,100
Rwanda	1,500	400	600	1,600	1,400	5,500
South Africa	3,300	14,100	28,800	54,600	81,200	182,000
Tanzania	200	400	6,200	8,100	15,400	30,300
Uganda	10,300	14,300	14,600	11,600	12,800	63,600
Vietnam	33	300	1,600	2,500	4,200	8,633
Zambia	15,100	2,600	2,700	12,000	22,500	54,900
Total	101,748	179,400	144,900	206,000	259,800	891,848

^aTreatment numbers for Botswana for FY06 through FY08 incorporate both patients directly reached with TB-HIV services as well as patients reached with TB-HIV services through PEPFAR's support for health system strengthening. Only a single indicator incorporating both upstream and downstream treatment outcomes has been reported since FY06, following an agreement reached between the USG and the Government of Botswana.

6. For FY05 and FY06, PEPFAR reported on the number of HIV-positive patients receiving "TB care and treatment." Beginning with FY07, PEPFAR began to report on the number of HIV-positive patients receiving "treatment for TB disease."

From FY04 to FY08, PEPFAR reports that it reached approximately 891,848 HIV-positive patients with TB care and treatment in United States Government (USG)-supported health care service centers.⁷ Though a considerable number, PEPFAR has significant ground to cover before it is providing TB-HIV services to all PLWHA receiving care and support in health care facilities that receive PEPFAR funding. Figure 1 compares the number of PLWHA being treated for TB in PEPFAR-support facilities against the total number of PLWHA receiving care and support services in those facilities. As this graph shows, there is a pronounced gap between the total number of PLWHA receiving care and support services and those PLWHA who are being treated for active TB disease as part of their care package.⁸

Figure 1. PLWHA Directly Reached with Care and Support and TB Treatment in PEPFAR Focus Countries in SSA, FY05–FY08



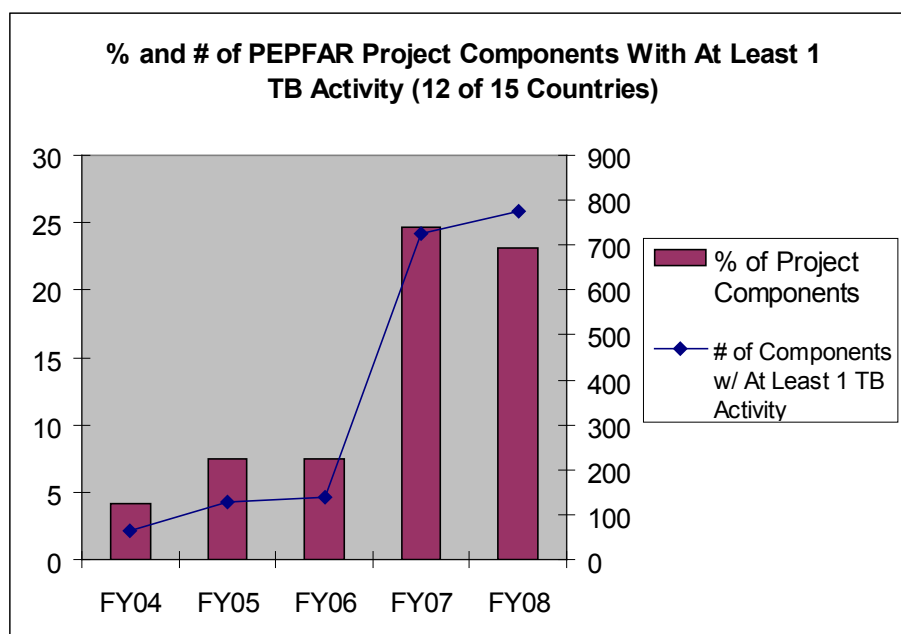
7. This number accounts for HIV-positive patients receiving treatment for TB disease in PEPFAR’s 15 focus countries only. PEPFAR reports that an additional 658,200 HIV-positive patients were reached in its focus countries through “upstream” systems strengthening, which contributed to the provision of treatment for TB disease in settings not directly supported with PEPFAR funding. Annual reports do not provide the methodology used to quantify the numbers reached through upstream support.

8. Along with gaps in service delivery, Figure Y reveals a data gap, as the “treatment for TB disease” figures that are reported do not paint the whole picture. A more informative analysis would be possible if total care figures could be compared with the number of TB screenings in HIV settings, as well as with the number of PLWHA reached with other TB-HIV services, such as spell this out since it’s the first mention of it (IPT).

To determine how the scale-up of TB-HIV activities has been reflected in country program planning, the ACTION project analyzed COPs for the 12 PEPFAR focus countries in sub-Saharan Africa for FY04-08. ACTION reviewed individual project components and identified those describing at least one TB-HIV activity.

In terms of the percent of project components that include at least one TB-HIV activity, our analysis showed that support for TB-HIV services increased from 4.1 percent in FY04 to 23.1 percent in FY08 (Figure 2). From FY06 to FY07 alone, the percentage of project components including at least one TB-HIV activity tripled from 7.5 percent to 24.6 percent. Though the number of project components including at least one TB-HIV activity increased from the previous year, the percentage dropped slightly to 23.1 percent in FY08. Through five years, while there was a substantial increase over the FY04 baseline, less than one quarter of project components included at least one TB-HIV activity in FY08.

Figure 2. Project Components in PEPFAR Focus Countries in Sub-Saharan Africa (SSA) That Include At Least One TB-HIV Activity, FY04–FY08



The publicly available data present an incomplete picture of TB-HIV services supported by PEPFAR in its focus countries. The data that are available, however, show a substantial increase in the expansion of HIV/AIDS services into TB settings. For example, in Rwanda PEPFAR has contributed to 89 percent of TB patients being tested for HIV, with 61 percent of those found to be co-infected provided with cotrimoxazole preventive therapy (CPT) and 39 percent put on ART (Dybul, 2008). In Mozambique, 74 percent of patients in TB clinics have been tested for HIV as part of a PEPFAR-supported program implemented by the International Center for AIDS Care and Treatment Programs (ICAP) (Ryan, 2008). Of those found to be co-infected, 89 percent were given CPT and 95 percent were referred to ART services (Ryan, 2008). In Tanzania, the percentage of TB patients tested for HIV in a TB-HIV pilot site in Tanzania’s Kilimanjaro region increased from 50 percent to 83 percent between 2006 and the second quarter of 2008. Of those TB patients found to be HIV-positive in 2008, 98 percent were referred to HIV clinics, and 98 percent were provided with CPT (Ryan, 2008).

While expanding HIV testing and services into TB settings is critical to reducing TB-HIV co-infection, screening all PLWHA for TB is equally important. Yet here PEPFAR is lagging. Country teams are encouraged to screen all PLWHA for TB, and anecdotal evidence suggests a number of implementers are providing screening (PEPFAR, personal communication 2009). However, PEPFAR does not know how many PLWHA have been screened in its programs.

In those countries for which some information on TB screening among PLWHA is available, data show that PEPFAR-supported HIV programs are nowhere near providing routine screening. For example, in Tanzania, OGAC reported in 2008 that no TB screening was being performed at HIV identification points (e.g. VCT or PMTCT sites), and that, while there was some increase in TB testing within HIV clinics between the first quarter of 2007 and July 2008, the size of this increase was not what OGAC hoped for (Ryan, 2008). As recently as 2007, only 26 percent of the HIV patients in Mozambique's PEPFAR-supported ICAP program were being screened for TB, increasing to 50 percent in 2008 following the introduction of a new algorithm for diagnosing TB. PEPFAR identifies Mozambique as a high-performing country for TB-HIV (Ryan, 2008).

PEPFAR has begun to identify obstacles to scaling up TB services in HIV settings — citing, for example, that ARV treatment sites in most supported programs have no method for recording when a TB screening takes place, that a standardized protocol for TB screening in HIV services does not exist, and that there is limited access to the necessary diagnostic tests for TB-HIV (Dybul, 2008; Ryan, 2008). Now that these obstacles have been identified, OGAC must address each one to ensure that all PLWHA receiving support are screened for TB and provided appropriate care. As evidence that this is occurring to at least some extent, OGAC reports that it is working with WHO and in-country stakeholders to develop and implement more sensitive screening tools for identifying TB in HIV/AIDS patients (PEPFAR, personal communication 2009).

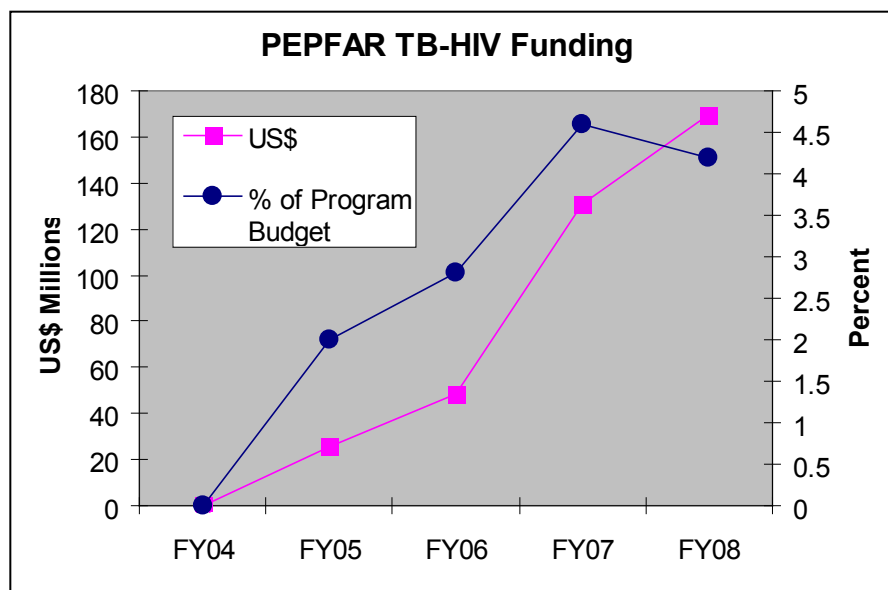
In order to contribute to the goal of reaching all PLWHA with TB services, all qualifying HIV-positive individuals in USG-supported centers should be screened and started on either TB treatment or preventive therapy in line with national guidelines. However, even accounting for the relative success that PEPFAR has achieved in some countries — notably Kenya, where PEPFAR had been reaching over 50,000 PLWHA with TB treatment annually prior to FY08 — each focus country continues to show significant gaps in TB-HIV programming.

FUNDING

Though its funding levels remain modest relative to the need, PEPFAR has substantially increased resources for TB-HIV activities since its first year of operation. From FY05 to FY08, PEPFAR increased funding for TB-HIV activities from 2 percent to 4.2 percent of its total annual program budget — an increase of more than \$140 million in annual spending — and total support for TB-HIV activities during its initial five-year period exceeded \$374 million (Figure 3).

All PLWHA receiving treatment, care, or support from USG-supported centers should be screened and started on either TB treatment or isoniazid preventive therapy in line with international guidance.

Figure 3: PEPFAR Funding for TB-HIV Activities, FY04 to FY08



According to WHO calculations, however, a minimum investment of \$536 million in collaborative TB-HIV activities was needed in 2008 alone in order to contribute to reducing TB deaths among PLWHA by 80 percent by 2015. By this metric, PEPFAR's TB-HIV spending has been significant, but continued scale-up is still needed.

WHO projects that the annual minimum investment required for collaborative TB-HIV activities will rise each year. Moreover, as it moves into its second phase, PEPFAR must expand services to harder-to-reach communities and will engage with potentially many more countries as it moves beyond the focus country model. PEPFAR's support for TB-HIV must increase in line with both challenges.

MONITORING & EVALUATION

For FY08, PEPFAR country teams were required to set annual targets and to report on four TB- and TB-HIV-related indicators (PEPFAR 2007b):

- ▶ Service outlets providing clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) in a palliative care setting;
- ▶ HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease;
- ▶ Individuals trained to provide clinical treatment for TB to HIV-infected individuals (diagnosed or presumed); and
- ▶ Registered TB patients who received counseling and testing for HIV and received their test results at a USG-supported TB service outlet.

In FY08, two changes were made to previous years' TB-HIV reporting requirements. First, PEPFAR added the indicator to track voluntary counseling and testing (VCT) for TB patients. Second, because there was little effective adoption of international recommendations around IPT in its focus countries, PEPFAR removed an

indicator to track the number of HIV-positive clients provided with TB preventive therapy (PEPFAR, personal communication 2009). Eliminating this indicator reduced PEPFAR's capacity to evaluate the delivery of a critical service to co-infected patients, but the indicator could be re-instated for FY10, as described below.

As part of its effort to improve the M&E framework in its second phase, PEPFAR is revising its TB-HIV indicators. In addition to an indicator to track the percent of eligible HIV-positive patients who start IPT, other TB-HIV indicators under consideration include: the percent of HIV-positive patients who were screened for TB; the percent of HIV-positive patients diagnosed with TB who start TB treatment, and the percent of TB patients who had an HIV test result recorded in the TB register. Adopting these new indicators would improve PEPFAR's capacity to evaluate its TB-HIV programming and track progress toward its goals.⁹ Further, PEPFAR is considering these new indicators in coordination with WHO, UNAIDS, and GFATM, and this collaborative effort should contribute to a harmonization of TB-HIV activities across donors through uniform data collection and the application of compatible evaluation criteria (PEPFAR, personal communication 2009).

RECOMMENDATIONS

As gaps persist in all focus countries, OGAC should work more proactively with country teams to expand and improve implementation of TB-HIV activities. In order to address these gaps, OGAC must continue to scale up resources for TB-HIV in order to meet the demand for services. Programming must be broadened to ensure that patients have access to the full range of TB-HIV interventions. Toward these ends, ACTION recommends the following:

- ▶ The same energy and focus with which HIV testing has been pursued in TB settings in some countries must be extended to ensure that every person receiving HIV services is routinely screened for TB.
- ▶ The implementation of the Three I's — intensified case finding, isoniazid preventive therapy, and infection control — should be a core element of all HIV/AIDS service scale-up in settings with high rates of co-infection.
- ▶ PEPFAR should set aggregate 5-year TB-HIV goals that will guide annual target-setting for individual countries.
- ▶ To continue expanding TB-HIV programming, PEPFAR should at minimum double TB-HIV expenditures to over \$300 million in FY09.

9. At the time this report was written, OGAC was planning to soon finalize the new M&E framework.