JOINT TB AND HIV PROGRAMME MANAGERS MEETING

12–14 March 2019
Manila, Philippines
WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

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MEETING REPORT

JOINT TB AND HIV PROGRAMME MANAGERS MEETING IN THE WESTERN PACIFIC REGION “BUILDING BRIDGES TO STRENGTHEN OUR RESPONSES”

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Manila, Philippines
12-14 March 2019

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NOTE

The views expressed in this report are those of the participants of the Joint TB and HIV Programme Managers Meeting in the Western Pacific Region and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the Joint TB and HIV Programme Managers Meeting in the Western Pacific Region “Building Bridges to Strengthen Our Responses” in Manila, Philippines from 12 to 14 March 2019.
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<th>HIV infections - prevention and control</th>
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<td>Regional health planning</td>
<td>Program evaluation</td>
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### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AMR</td>
<td>antimicrobial resistance</td>
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<tr>
<td>APCASO</td>
<td>Asia Pacific Council of AIDS Service Organizations</td>
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<td>ART</td>
<td>antiretroviral therapy</td>
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<tr>
<td>ARV</td>
<td>antiretroviral</td>
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<td>DR-TB</td>
<td>drug-resistant tuberculosis</td>
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<tr>
<td>DTG</td>
<td>dolutegravir</td>
</tr>
<tr>
<td>EMTCT</td>
<td>elimination of mother-to-child transmission</td>
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<tr>
<td>DOTS</td>
<td>directly observed treatment, short-course</td>
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<tr>
<td>GASP</td>
<td>Gonococcal Antimicrobial Surveillance Programme</td>
</tr>
<tr>
<td>Global Fund</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>IGRA</td>
<td>interferon-gamma release assay</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
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<tr>
<td>IPT</td>
<td>isoniazid preventive therapy</td>
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<tr>
<td>KNCV</td>
<td>KNCV Tuberculosis Foundation</td>
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<tr>
<td>LF-LAM</td>
<td>lateral flow lipoarabinomannan assay</td>
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<tr>
<td>LTBI</td>
<td>latent tuberculosis infection</td>
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<tr>
<td>MDR-TB</td>
<td>multidrug-resistant tuberculosis</td>
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<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<td>NAAT</td>
<td>nucleic-acid amplification test</td>
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<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>PITC</td>
<td>provider-initiated HIV testing and counselling</td>
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<td>PLHIV</td>
<td>people living with HIV</td>
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<td>PPM</td>
<td>public–private mix</td>
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<tr>
<td>PrEP</td>
<td>pre-exposure prophylaxis</td>
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<tr>
<td>QMRL</td>
<td>Queensland Mycobacterium Reference Laboratory</td>
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<tr>
<td>RR-TB</td>
<td>rifampicin-resistant tuberculosis</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<tr>
<td>SHI</td>
<td>social health insurance</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TST</td>
<td>tuberculin skin test</td>
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<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>VCT</td>
<td>voluntary counselling and testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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SUMMARY

Tuberculosis (TB) and HIV remain the leading cause of death from infectious diseases globally. People living with HIV (PLHIV) are 16–27 times more likely to develop TB than those without HIV. In 2017, an estimated 1.8 million people fell ill with TB and 100 000 new HIV infections occurred in the Western Pacific Region, with an estimated 30 000 TB/HIV co-infected cases. The overall goal of TB/HIV collaborative activities is to decrease the burden of TB and HIV in people at risk of or affected by both diseases. Steady progress has been made in the scale-up of TB/HIV collaborative activities; however, this progress has not been sufficient to achieve the Sustainable Development Goal (SDG) targets in the Region. In 2017, 50% of TB patients received HIV testing and 55% of TB/HIV co-infected patients received antiretroviral therapy (ART). Isoniazid preventive therapy (IPT) coverage remains very low. In the context of scarce domestic resources and decreased donor funding, collaborative efforts help the efficient use of resources. Broader collaboration of TB and HIV programmes contributes to improved health system action domains and paves the way towards universal health coverage (UHC).

Inspired by the United Nations (UN) high-level meeting on TB and in response to the availability of new drugs and guidelines, digital technology and a changing financial landscape, the WHO Regional Office of the Western Pacific Region organized the Joint TB and HIV Programme Managers Meeting in Manila, Philippines on 12–14 March 2019. The theme was “Building bridges to strengthen our responses”. The meeting reviewed the current status and shared the best practices of TB/HIV collaboration at the country level. The meeting was attended by around 90 participants including representatives from Member States, WHO collaborating centres, representatives of civil society organizations and affected populations, donors and key technical partners.

Most countries in the Region have some form of collaboration between TB and HIV programmes in line with WHO guidelines. Major components of the collaboration lie in governance, cross-screening, treatment among co-infected persons and monitoring and evaluation of joint TB/HIV activities. Although there has been significant progress in the last decade, startling gaps still remain. At this joint TB and HIV meeting, Member States shared their experiences and best practices, identified major challenges faced while implementing interventions on the patient pathways from TB and HIV entry points and agreed on a concrete way forward for addressing these challenges.

The following specific recommendations were developed for Member States and the WHO.

Member States are invited to consider the following:

1. Set country-specific targets and accelerate implementation plans for TB detection and prevention in line with the political declaration signed by countries at the first UN high-level meeting on TB in September 2018.
2. Improve access to screening, diagnosis and treatment for both diseases through review and revision of existing policies that may include:
   a. Co-location of services and/or efficient referral mechanisms to ensure that all TB patients receive HIV screening and all people living with HIV (PLHIV) are screened for TB disease.
3. Address stigma, financial barriers and awareness among patients and the community for TB and HIV and co-infection.
4. Maximize opportunities to improve coverage of TB preventive therapy among PLHIV through:
   a. simplifying the screening algorithm (symptom screening is sufficient to rule out active TB before initiating latent TB infection (LTBI) treatment);
   b. adopting shorter rifamycin-based regimens;
c. using digital technologies for adherence;
d. improving surveillance; and
e. engaging communities and the private sector to improve uptake.

5. Ensure an uninterrupted supply of commodities for diagnosis and treatment of TB (infection and disease) and HIV that may include:
   a. centralized procurement;
   b. pooled procurement to address high prices, specifically in countries which are not in the preferential pricing list; and
   c. integrated supply mechanisms.

6. Develop and/or strengthen an integrated electronic surveillance system that provides complete, consistent and credible information on TB/HIV care and prevention.

7. Leverage high-level and multisectoral commitments for both TB and HIV through wider stakeholder engagement and ensuring accountability at all levels.

8. Strengthen domestic health financing models and provider payment mechanisms for TB and HIV care and prevention especially in the wake of increasing need and diminishing external funding.

WHO is requested to consider the following:

1. Provide high-level advocacy and technical support to Member States for translating political commitments into concrete planning and implementation.
2. Support Member States in reviewing existing policies and planning for improving access for both TB and HIV care and prevention.
3. Provide support for adoption and adaptation as well implementation of the updated guidelines on latent TB infection and newer ART regimens.
4. Continue to coordinate/negotiate with global commodity service suppliers for uninterrupted supplies of commodities and preferential pricing.
5. Support Member States in strengthening integrated surveillance systems and using data for improving programme performance.
6. Continue to collaborate with stakeholders at regional and country levels to provide coordinated support to Member States for implementation of TB and HIV care and prevention within the wider health system and Sustainable Development Agenda.
7. Support Member States in establishing and/or strengthening multisectoral bodies and frameworks and their accountability.
8. Continue to support Member States in mobilizing resources and planning for transition to domestic financing for TB and HIV programmes.
1. INTRODUCTION

1.1 Meeting organization
The Joint TB and HIV Programme Managers Meeting was held from 12 to 14 March 2019 in Manila, Philippines. The theme was “Building bridges to strengthen our responses”. The meeting was attended by around 90 participants including representatives from Member States, World Health Organization (WHO) collaborating centres, civil society organizations, donors, key technical partners and affected populations.

1.2 Meeting objectives
The objectives of the meeting were:

1) to review the status and share the best practices of the current TB/HIV collaboration at the country level;

2) to identify major challenges and to agree on the way forward for addressing identified challenges as well as potential WHO and partner support to strengthen TB/HIV collaborative activities in the Region; and

3) to provide updates to all participants on changes to the WHO global policy and guidelines on TB and HIV.

2. PROCEEDINGS

2.1 Opening session
Dr Liu Yunguo, Director, Division of Programme Management, opened the joint meeting on behalf of Dr Takeshi Kasai, WHO Regional Director for the Western Pacific, and announced the co-chairs. Opening remarks were delivered by Dr Tereza Kasaeva, Director, Global TB Programme; Dr Gottfried Hirnschall, Director, HIV/AIDS Department, WHO headquarters; and Dr Eamonn Murphy, Director, Regional Support Team for Asia and Pacific, Joint United Nations Programme on HIV/AIDS (UNAIDS). A person living with TB and HIV shared a testimony that set the tone for the meeting. The meeting objectives were introduced by Dr Naoko Ishikawa, Coordinator, HIV, Hepatitis and Sexually Transmitted Infections, and Dr Tauhid Islam, Coordinator, End TB and Leprosy, both from the WHO Regional Office for the Western Pacific.

2.2 Setting the scene

2.2.1 Plenary presentations: Ending TB and AIDS – leaving no one behind
In 2017, an estimated 1.8 million people fell ill with TB, and around 90 000 people died from the disease in the Western Pacific Region. An estimated 114 231 incident cases of multidrug-resistant TB (MDR-TB) were also recorded. Five countries (Cambodia, China, Papua New Guinea, Philippines and Viet Nam) are on the WHO global list of 30 high-TB burden countries and account for 93% of TB cases in the Region. Two additional countries (Lao People’s Democratic Republic and Mongolia) are considered to be regional TB priority countries because of the rate and burden of TB. HIV prevalence among TB patients in the Region was estimated at 1.8%. About 5000 patients with TB/HIV co-infections died in 2017.
In 2017, 1.5 million people were living with HIV in the Western Pacific Region, and about 100,000 people were newly infected with HIV. Six countries (Cambodia, China, Malaysia, Papua New Guinea, Philippines, and Viet Nam) account for over 90% of the HIV burden.

The Sustainable Development Goals (SDGs) call for an end to the epidemics of TB and AIDS by 2030. Achieving this target will depend on high-level political commitment (e.g. UN high-level meetings), new drugs, updated WHO guidelines, digital technology, multisectoral response and changed financial landscape. The TB/HIV system was founded on the six key components of a well-functioning health system (governance, financing, information and research, service delivery, health workforce and medicine and technology) and the five action domains of universal health coverage (UHC) (quality, efficacy, equity, accountability and sustainability).

2.2.2 Patient-centred simulation and Regional TB and HIV summary

Dr Ishikawa and Dr Islam from the WHO Regional Office involved participants in a patient-centred simulation exercise that aimed to identify gaps and challenges encountered along the patient pathway from TB and HIV service entry points to treatment. Meeting participants, especially those from high-priority countries, agreed with the issues raised and discussed possible solutions to bridge those gaps.

2.2.3 Poster marketplace

The poster marketplace provided an opportunity for countries to present country information on governance, financing, service delivery (detection, screening, treatment, TB prevention, treatment outcomes) for TB/HIV coinfection, preventive treatment for latent TB infection (LTBI) in HIV patients, laboratory services, commodity management, monitoring and evaluation for TB/HIV collaborative activities and patient support and community engagement in TB/HIV collaborative activities.

2.3 Thematic area 1: Find and treat

2.3.1 What is new in screening and treatment?

Dr Shalala Ahmadova, End TB and Leprosy, and Dr Donghyok Kwon, HIV, Hepatitis and Sexually Transmitted Infections, presented WHO recommendations for screening and treatment. To diagnose TB among PLHIV, WHO recommends using Xpert® MTB/RIF Ultra and lateral flow lipoarabinomannan assay (LF-LAM). The Ultra cartridge shows significantly better performance (increased sensitivity) compared to the current Xpert® MTB/RIF cartridge for the detection of Mycobacterium tuberculosis in paediatric and extrapulmonary specimens. It also detects TB in specimens with low numbers of bacilli, especially in smear-negative, culture-positive specimens such as those from persons with TB/HIV co-infection. LF-LAM is also very important for the rapid diagnosis of TB among PLHIV. In addition, in settings where laboratory testing has been traditionally organized by disease programme, the introduction of multi-disease testing devices can bring new opportunities for collaboration and integration, which can provide significant system efficiencies, cost savings, and increase patient access to care. WHO recently released new recommendations on the treatment of multidrug- and rifampicin-resistant TB (MDR/RR-TB) and guidance on regimens suitable for treatment of patients co-infected with HIV. WHO recommends a regimen containing dolutegravir (DTG) as a preferred first-line regimen for PLHIV initiating antiretroviral therapy (ART). The data on the efficacy and safety of DTG co-administered with rifampicin among people co-infected with HIV and TB shows that the dose of DTG needs to be increased to 50 mg twice daily because of drug–drug interactions with rifampicin.

2.3.2 Digital health

Dr Kitty van Weezenbeek, Executive Director, KNCV Tuberculosis Foundation, presented on digital health. There are several digital solutions that can help to improve the performance of TB programmes, including
diagnostic connectivity solutions and digital adherence tools. WHO advises that all sites that use WHO-recommended rapid diagnostic tests should be transmitting results electronically to clinicians and to information management systems using data connectivity solutions by 2020.

The 2017 update of the WHO Guidelines for Treatment of Drug-susceptible Tuberculosis and Patient Care identified three digital technologies – short message service (SMS), digital medication monitoring systems and video observation of treatment (VOT) – to support daily TB treatment on a large scale. Digital health has the potential to improve data-driven TB programme management (surveillance, stock management and procurement, monitoring performance), patient management and prioritization of patients who need intensified support, efficiency along the patient pathway and integration of TB data within the broader health system. At the same time, digital health solutions must respect the privacy and (other) rights of patients and must not replace personal care. They also should meet quality data requirements to prevent “fake news” and wrong decisions and be affordable and sustainable (local production, free access platforms, flexible, etc.).

2.3.3 Panel discussion

Dr Mean Chhivun, Adviser to the Ministry of Health, Cambodia, University of Health Science, moderated the panel discussion.

A representative of the Philippines shared the country’s experience with systematic symptom screening for TB infection among PLHIV and revealed the enabling factors that are contributing to timely screening. These include the development of algorithm, policy changes, advocacy with the private sector, capacity-building activities, inclusion of TB/HIV collaborative activities in annual national HIV treatment conferences, facility-level TB/HIV coordination to strengthen cross-referrals and the presence of a TB/HIV nurse coordinator in facilities.

The Cambodia representative shared the country’s efforts to increase HIV testing coverage for diagnosed TB patients. Several TB/HIV collaborative activities related to governance and policy guidance have contributed to the success, including establishment of a TB/HIV subcommittee, development of the Framework for TB/HIV in Cambodia, issuance by the TB and HIV programmes of a joint statement on roles and responsibilities, and various standard operating procedures (SOPs) for testing TB/HIV.

Dr Christopher Coulter, Queensland Mycobacterium Reference Laboratory (QMRL), Australia reiterated that in settings where laboratory testing has been traditionally organized by disease programme, the introduction of multi-disease testing devices brings new opportunities for collaboration and integration, which can provide significant system efficiencies, cost savings, and increased patient access to care. He shared key issues that need to be considered for quick adoption and implementation of a common laboratory platform – GeneXpert for detection of MTB/RIF, HIV and viral hepatitis. Key issues include coordinated planning led by the Ministry of Health, regulatory approval and validation, project and site selection, integrated specimen referral systems and SOPs and training for end users. Other factors include inventory management, procurement, quality management systems, monitoring and evaluation and data management and integration.

A representative of Viet Nam shared the country’s experience in organizing TB and HIV treatment for co-infected patients and achieving high coverage for dual treatment. The key factors contributing to high coverage for ART and TB treatment included political commitment and leadership, strong TB/HIV coordination guidance from the Ministry of Health, comprehensive TB/HIV technical guidance, availability of the TB/HIV management guidelines, as well as the new model for TB/HIV integrated service at the grassroots level. A one-stop-shop model was applied at commune and district levels with positive results documented so far: it has reduced the loss-to-follow-up rate; reduced human resources needed for TB and HIV; increased the adherence rate of 12 months of treatment to 92–100%; and reduced the time for diagnosis of TB for HIV
patients from 8 days to 5 days. Elements of the new model are: (1) provider-initiated HIV testing and
counselling (PITC) for TB patients and voluntary counselling and testing (VCT) for people at risk with HIV;
(2) diagnosis, care and treatment for PLHIV, TB patients and patients with TB/HIV co-infections; and
(3) management, monitoring and evaluation, recording and reporting for TB, HIV and TB/HIV.

Mongolia shared its views on closing the gap between estimated TB/HIV cases and notified TB/HIV
co-infected cases. Mongolia highlighted six actions that can increase access to and use of health services,
namely: (1) early screening for TB infection among PLHIV, (2) early screening for HIV infection among TB
patients, (3) detecting TB among high-risk groups, (4) improving capacity of primary- and secondary-level
laboratories, (5) improving supply of essential kits and reagents, and (6) ensuring continuous education,
capacity-building and specialized training for health-care workers at primary and secondary levels.

A representative of APN Plus Positive Change (APN+) shared recommendations on overcoming challenges of
TB/HIV co-treatment, including: increase access to appropriate drugs including bedaquiline and delamanid;
ensure training and refresher training for health-care workers on complex treatment issues; educate patients
and family members; provide peer support by playing the roles of local PLHIV networks; ensure treatment
literacy through peers especially PLHIV networks; and provide TB and HIV treatment through community-
Based organizations such as local PLHIV networks.

During the discussion, participants asked about quality assurance and costs associated with multiple-disease
testing devices, as well as the one-stop-shop model for integrated TB/HIV care and treatment services.

2.3.4 Group work and plenary feedback

Four group work sessions were held for participants to discuss screening and detection, a common laboratory
platform, access to treatment and patient-centred approach. A summary of key messages, barriers and action
points are listed below:

**Key messages/best practices:**

1. Countries are making steady progress in uptake of diagnostic tools relevant for TB and HIV,
including a common laboratory platform.
2. A one-stop-shop mechanism offers unique opportunities to provide integrated patient-centred support.
3. Empowering patients so that they are well educated and informed about the disease, treatment options
and side effects will contribute to improving adherence to both (TB and HIV) treatment regimens.

**Barriers:**

1. Supply and demand-side barriers continue to impede access to diagnostic and treatment services.
2. Supply-side barriers include stock-outs of commodities, high cost of laboratory tests and medicines,
regulatory barriers, restrictive screening and diagnostic algorithms, centralized and separated TB and
HIV service delivery arrangements, lack of adequate social support to patients and stigma prevailing
among providers.
3. Demand-side barriers include financial and geographical barriers experienced by patients, existence of
stigma and discrimination in the community and lack of awareness on seriousness of TB/HIV co-
infection.

**Action points:**

1. Ensure combined funding and integrated people-centred service delivery for both TB and HIV.
2. Address supply- and demand-side barriers to ensure universal access for integrated TB and HIV services.
3. Address the high price of commodities through pooled procurement, ensure human resources and
training for multi-disease platform and ensure proper cartridge disposal.
4. Enhance utilization of civil society organizations and the private sector for service delivery.
6. Provide joint training, supervision and support for TB/HIV service providers.

2.4 Thematic area 2: Latent TB infection (LTBI)

2.4.1 What is new in TB prevention?

Dr Kalpeshsinh Rahevar presented on the WHO’s updated and consolidated guidelines for Programmatic Management of the Latent Tuberculosis Infection.

About 25% of the global population is estimated to be infected with TB bacilli, but on average, only 5–10% develop active TB during their lifetime. Certain groups of people including PLHIV are more at risk of developing TB than others. There is long-standing and substantial evidence about the efficacy of preventive treatment in reducing the risk of TB among selected high-risk groups including PLHIV. The evidence suggests that TB preventive treatment reduces the risk for TB by 64% among PLHIV who test positive using the tuberculin skin test (TST).

The updated and consolidated WHO guidelines on LTBI, published in 2018, expanded the indications for TB preventive treatment beyond children under 5 years of age who are household contacts of people with pulmonary TB and PLHIV. The guidelines also reiterate that either a TST or interferon-gamma release assay (IGRA) can be used to test for LTBI. Several shorter treatment options (e.g. isoniazid plus rifampicin daily for 3 months and isoniazid plus rifapentine weekly for 3 months) in addition to isoniazid monotherapy for 6 months have been recommended for the treatment of LTBI in high and low incident settings.

Despite previous guidelines having been available for more than 15 years, less than 40% of PLHIV and 20% of children under 5 years who were household contacts of pulmonary TB cases were initiated on TB preventive treatment in 2017 in the Western Pacific Region; coverage of TB preventive treatment in priority countries among PLHIV ranged from 4% in Mongolia to 57% in the Philippines.

2.4.2 Panel discussion

Dr Kitty van Weezenbeek, Executive Director, KNCV, moderated the panel discussion.

China

Different epidemiological surveys and studies conducted between 2000 and 2015 reported varied TB infection rates. In 2000, the TB infection rate was 44.5% according to an epidemiological survey of the whole population; in 2014, it was reported to be 19.2% (TNT positive) by a study of 21,022 people, and in 2015, it was reported to be 16.4% by a survey conducted among primary and secondary schoolchildren. As per the national guidelines for LTBI treatment, China identified all children under 5 years who were household contacts of pulmonary TB cases, students who had been in contact with active TB cases, PLHIV, people on immunosuppressive agents and workers employed in infectious environments such as medical employees. Between 2010 and 2016, in three selected provinces, treatment completion rates for PLHIV on isoniazid preventive therapy (IPT) ranged from 84% to 100%, while incidence of adverse drug reactions ranged from 1.4% to 20%.
Malaysia
PLHIV are categorized as one of the high-risk groups for TB screening and subsequent LTBI treatment. Symptom screening and/or chest X-ray are used for ruling out TB before initiating LTBI treatment. From 2017 to 2018, an estimated 4000 PLHIV were screened annually for TB disease. The programme finds it difficult to capture all PLHIV, especially those who are not on ART. The Ministry of Health accepts help from nongovernmental organizations (NGOs) to reach certain marginalized groups.

Republic of Korea
The Government of the Republic of Korea enacted the TB prevention law in 1968 to establish the legal basis for the national TB control programme. All household contacts and other at-risk groups are screened by chest X-ray and TST/IGRA before initiating LTBI treatment. TST is recommended for people under 18 years, while TST or IGRA or a combination of the two is recommended for those 18 years and older. From 2016 to 2017, nearly 150 000 contacts were screened every year, and of them, 7–8% were found to have LTBI. In 2017, the Ministry of Health and Welfare carried out mass screening for TB among different categories of risk groups. Students and military conscripts had the lowest LTBI rates (below 3%), while the highest rates (nearly 30%) were found in prisons, social welfare facilities and postnatal care centres. Fostering cooperation between ministries and multiple sectors for LTBI management was one of the most challenging hurdles encountered by the programme.

Japan
LTBI is a notifiable condition as stipulated by the infectious diseases law in Japan. The medical cost of LTBI treatment is covered by health insurance (70%) and public subsidy (25%). Patients pay the remaining 5% of the medical cost. The programme currently uses 6 or 9 months of isoniazid as a fist-line LTBI treatment. In the case of isoniazid resistance in the index case or adverse drug reactions, rifampicin for 4 or 6 months is used. The programme is considering shorter regimens, including isoniazid plus rifampicin for 3 months and rifampicin for 4 months. Notification coverage is an issue. There are evidence gaps regarding the diagnostic value of IGRA among immunosuppressive conditions, older people, migrants, etc.

LoveYourself
LoveYourself was established in 2011 as an HIV testing centre for key populations in the Philippines. It added an ART hub in 2015 and a directly observed treatment, short-course (DOTS) centre in 2017. The NGO is accredited for PhilHealth insurance for TB and HIV testing and treatment. Under the joint KNCV-HIVOS project in 2017, the NGO began working on TB/HIV collaborative activities. In 2018, 14 465 clients were tested for HIV. Of the 10–12% of clients with a reactive result, about 90% were linked to care. TB screening is provided to all clients who visit the centre for antiretroviral (ARV) refills, and those eligible are started on LTBI treatment. Through their access to social media, the NGO raises awareness about TB/HIV co-infection and LTBI.

2.4.3 Group work and plenary feedback

Diagnosis of LTBI among PLHIV
Most countries use symptom screening for ruling out TB infection among PLHIV. Brunei Darussalam uses symptom screening, chest X-ray and TST, while Singapore sometimes uses IGRA to diagnose LTBI. The group reported some common challenges in expanding testing for LTBI among PLHIV, including: lack of funding for diagnosing LTBI (not covered under insurance); unavailability of TST; high cost of IGRA; stigma attached to testing family members; and gaps in information sharing between TB and HIV programmes. Suggestions to improve testing included: establish uninterrupted supply of commodities; subsidize diagnosis, especially in higher middle- and high-income countries; train both HIV and TB staff for testing; involve the
private sector in LTBI; and explore the role of newer technologies such as C-TB skin tests. It was also suggested to strengthen the engagement of community organizations, patients groups and NGOs for demand generation, policy-making and implementation.

**TB preventive treatment for PLHIV**

All high-priority countries have guidelines recommending TB preventive treatment for all eligible PLHIV. However, the coverage is proportional to the extent of collaboration between TB and HIV programmes, peer support, availability of champions in both programmes, and monitoring the coverage as a quality indicator. The barriers were divided into three categories: (1) provider-side barriers – poor quality of counselling and doubts about efficacy, adverse drug reactions and development of resistance, among health professionals; (2) user-side barriers – low awareness, pill burden, cost and side effects; and (3) system-side barriers – separate procurement systems, no clear demarcation of roles and responsibilities between the two programmes, low priority accorded to prevention in high-burden countries, and lack of data on LTBI treatment outcomes. The group suggested several measures to improve treatment of LTBI among PLHIV, including: strengthening collaboration between the TB and HIV programmes; developing an integrated procurement system; provider sensitization; addressing patient-side barriers through patient-centred initiatives, health education and use of digital technologies; engaging and empowering communities; and engaging the private sector.

**Procurement for LTBI treatment**

Most countries in the region use TB and HIV notification data to forecast demand for LTBI treatment. Australia, Papua New Guinea and Viet Nam have central procurement systems, while China has a three-layer tendering process: central, province and direct by pharmacy. In Viet Nam, supply management is outsourced, while in the Philippines, supply is managed by a central office. The group identified common barriers in procurement, including: lack of a standard tool for forecasting; fragmented system; limited information on consumption; insufficient resources; and difficulty in forecasting of LTBI drugs if there are multiple regimens. The group suggested a few measures to improve the procurement process, including: strengthening cross information between TB, HIV and other relevant programmes; developing a forecasting tool; and establishing an integrated monitoring system.

**Surveillance for LTBI**

Most countries have separate vertical surveillance systems for TB and HIV programmes with minimum interlinking. The Lao People’s Democratic Republic has recently initiated the process of using a common District Health Information System (DHIS) platform for both programmes. LTBI is a notifiable condition in Japan, and Papua New Guinea uses a case-based system for PLHIV to monitor LTBI coverage. The group identified common barriers in effective surveillance for LTBI, including: lack of standard tools for data collection and recording for LTBI screening and treatment; housing of TB and HIV data and confidentiality; and no to limited recording of treatment completion, adverse drug reactions, etc. The group suggested countries move towards implementation of a case-based surveillance system to monitor the full spectrum of the condition; integrate the TB and HIV surveillance system, and make LTBI a notifiable condition.

### 2.5 Thematic area 3: Integrating monitoring and evaluation for TB/HIV

#### 2.5.1 Synthesis of strategic information for TB and HIV

Mr Fukushi Morishita, End TB and Leprosy, and Dr Linh-Vi Le, HIV, Hepatitis and Sexually Transmitted Infections, WHO Regional Office for the Western Pacific, presented an overview of strategic information for TB and HIV. Surveillance and programmatic data are not always shared between TB and HIV programmes,
and data collected from each programme often have some inconsistencies because of insufficient linkage of strategic information systems for TB and HIV. However, there are many commonalities in the area of monitoring and evaluation, including the global framework, flow of surveillance data within a country, and increasing emphasis on people-centred care in programme monitoring, which presents opportunities for integration of information systems. Electronic health information systems provide opportunities for TB/HIV information linkages and systems solutions, either as one platform or separate linked platforms, based on the country context including community needs and service delivery models.

2.5.2 Discussion

A panel discussion was led by Dr Taoufik Bakkali from UNAIDS, with participation by the representatives from Australia, Hong Kong SAR (China), Lao People’s Democratic Republic, Papua New Guinea and Solomon Islands. Country experiences were exchanged, and pros and cons for system integration were discussed. Integration of TB and HIV strategic information systems should take into account the needs of affected communities with emphasis on data security and patient confidentiality. It is also important to identify the information needed to ensure a comprehensive and joint approach to TB/HIV person-centred care, and then identify a workable information technology solution.

2.6 Parallel session - TB

2.6.1 Public–private mix (PPM) roadmap

In 2018, WHO and global partners published Public–Private Mix for TB Prevention and Care: A Roadmap. The PPM Roadmap includes 10 key priorities for action, namely: (1) build understanding about patient preferences and the rationale for engaging all care providers; (2) set appropriately ambitious PPM targets; (3) advocate for political commitment, action and investment in PPE; (4) allocate adequate funding for private provider engagement, including by capitalizing on financing reforms for UHC; (5) partner with intermediaries and key stakeholders; (6) establish a supportive policy and regulatory framework; (7) adapt flexible models of engagement applicable to local contexts; (8) harness the power of digital technologies; (9) deliver a range of financial and non-financial incentives and enablers; and (10) monitor progress and build accountability. The PPM Roadmap is very important for driving action to reach the targets of the End TB strategy.

2.6.2 Find. Treat. All. #ENDTB

Find. Treat. All. #ENDTB is a joint initiative of WHO, the Stop TB Partnership, the Global Fund, countries and partners. The aim of the initiative is to create an immediate push to urgently translate UN high-level meeting commitments into action and close the gaps in reaching the missing people with TB. It builds on the Strategic Initiative of 13 high TB burden countries with the Global Fund, WHO and the Stop TB Partnership, under the Catalytic Investment of the Global Fund and the related Strategic Initiative. The initiative highlights the importance of (1) jointly defining and endorsing concrete and measurable country-specific targets, (2) increasing resources to achieve country-specific targets including human and financial resources, (3) elevating the profile of the TB programme and response by establishing time-bound high-level national TB commissions or panels to help oversee ambitious accelerated response that includes civil society and multisectoral partners, and (4) national or local declarations of emergencies due to high levels of DR-TB and treatment gaps, backed by action and investments.

2.6.3 WHO updated guidelines on DR-TB treatment

In 2018, WHO updated its guidelines on treatment of DR-TB. WHO recommended that any patient – child or adult – with DR-TB should be treated with a recommended MDR-TB regimen, either a longer MDR-TB
regimen to which isoniazid may be added or a standardized shorter MDR-TB regimen, if isoniazid resistance is absent or unknown. WHO recommended that the longer regimen should start with at least four effective TB agents likely to be effective, and after bedaquiline is stopped at month six, at least three agents should remain in the regimen. WHO also recommended that all MDR-TB patients need to be tested for resistance to fluoroquinolones as a minimum before starting MDR-TB treatment. If the shorter regimen is being considered, or Amikacin is being considered in the longer regimen, then rapid testing for the second-line injectable agents would also be useful. Other tests for resistance to agents like bedaquiline, delamanid, linezolid, pyrazinamide and for mutation patterns commonly associated with resistance to isoniazid and Ethionamide/Prothionamide may help inform regimen choice and composition. The updated guidelines include eligibility criteria for the shorter regimen and the following recommendations: (1) shared decision-making between the clinician and patient is important when choosing between shorter and longer regimens; (2) drug susceptibility testing for fluoroquinolones and second-line injectable agents should start before treatment, as well as other regimen components where possible (e.g. pyrazinamide, mutations associated with isoniazid and ethionamide resistance); (3) Kanamycin should be replaced by amikacin; and (4) other exclusion criteria should be observed.

2.6.4 Child and adolescent TB roadmap: key actions

In the Western Pacific Region, in 2017, it is estimated that 207,300 children fell ill with TB, and that 90% of eligible household contacts under 5 years of age did not access preventive therapy. In 2018, WHO published a Roadmap towards Ending TB in Children and Adolescents with several key actions, including: (1) strengthen advocacy at all levels; (2) foster national leadership and accountability; (3) foster functional partnership for change; (4) increase funding for child and adolescent TB programmes; (5) bridge the policy–practice gap; (6) implement and expand interventions for TB prevention; (7) scale up TB case finding and treatment; (8) implement integrated family and community-centred strategies; (9) improve data collection, reporting and use; and (10) encourage child and adolescent TB research. Major interventions required are (1) strengthening active case finding (contact investigation) and integration of TB screening, diagnosis and treatment into other child health services such as HIV, nutrition, maternal and child health, integrated management of childhood illness (IMCI) and adolescent health programmes; and (2) provision of preventive therapy to all eligible young children exposed to or infected with TB.

2.7 Parallel session – HIV, STI and key populations

2.7.1 Sustainable service delivery for HIV

Dr Anne Brink presented updates on HIV pre-exposure prophylaxis (PrEP), HIV self-testing and roll-out of dolutegravir (DTG). PrEP has been rolled out nationally in Australia, New Zealand and Viet Nam; however, there are some barriers on accessibility (high drug cost), availability, acceptability and quality. Innovation for improving PrEP access should be considered, including: de-medicalization of PrEP, task shifting, community involvement and m-health (mobile apps). HIV self-testing and assisted partner notification should be offered as complementary approaches to HIV testing services. Fifty-nine countries have policy in place and 29 have implemented HIV self-testing. In 2016, WHO included DTG-based HIV treatment as an alternative first-line regimen, and in 2018, WHO recommended DTG-based HIV treatment as the preferred first-line regimen. Almost all countries in the Region (excluding China, Mongolia and Philippines) have included DTG in their national HIV treatment guidelines. A smaller number of countries, including Cambodia, Fiji, the Lao People’s Democratic Republic, Malaysia, Papua New Guinea and Viet Nam, are procuring drugs. Guidance on the use of DTG in women shows concern regarding neural tube defects. The results of a study in Botswana will be available by the end of March 2019. For adolescent girls, DTG should be provided with pre-pregnancy care to avoid use of DTG during preconception.
2.7.1.1 Roll-out of dolutegravir (Cambodia)

Cambodia has been using DTG as part of third-line therapy. It is now introducing tenofovir disoproxil fumarate/lamivudine/dolutegravir (DTDF/3TC/DTG or TLD) in first-line therapy and DTG in second-line therapy. DTG was procured in December 2018, and all 67 ART sites were trained on its use. Targets are treatment-naïve patients (over 10 years and over 30 kg) including women and adolescent girls of childbearing age who are using consistent and reliable contraception. Health-care providers should educate women to make informed choices about using lifelong ART regimens. Patients experiencing Efavirenz side effects and patients with treatment failure with non-DTG-based first-line regimen are also targets. TB patient on Rifampicin containing regimen require additional single dose of DTG 50 mg.

2.7.1.2 Transitioning to sustainable mechanisms for HIV – financing and supply chain management

Dr Ishikawa presented on transitioning to sustainable mechanisms for HIV. External funding is declining, and domestic funding is covering more. For HIV, TB, malaria and other infectious disease, there is one Regional Framework for Action on Transitioning to Integrated Financing of Priority Public Health Services in the Western Pacific (2018).

**HIV financing - Transition from donors supports to national social health insurance (Viet Nam)**

In 2013, Viet Nam’s Prime Minister issued Decision No. 1899/QD-TTg approving a sustainable financing scheme for the HIV programme for the period 2013–2020. The aim is to transition ART services from donor aid to social health insurance (SHI) and to support PLHIV to enrol in SHI with the target of 100% by 2020.

HIV treatment facilities are being integrated into the hospital system and contracted with SHI agencies. The transition process has been steady: (1) SHI reimbursement for laboratory services except for viral load testing, CD4 count and ARVs (2015–); (2) SHI reimbursement for viral load testing in selected sites and for central procurement of ARVs (2017–2018); and (3) SHI reimbursement for viral load testing, CD4 count and ARVs in selected sites (2019–). On 8 March 2019, Viet Nam celebrated its first case receiving SHI-covered ARV.

Challenges are: (1) ensuring patients can use their SHI for HIV services without exposing their status and identity; (2) strengthening coordination between ARV suppliers from different sources to ensure the continuity of ARV supplies and avoid interrupted treatment for patients (Viet Nam experiences stock-outs of drugs); and (3) ensuring competitive market for ARVs: Work with manufacturers and supplier companies to boost number of Marketing authorization (MA)-approved ARVs in Vietnam, including 3rd line ARV, new ARVs (TLD, etc.) and paediatric ARVs.

Solutions are: (1) support PLHIV to enrol in SHI and utilize their SHI card for ARVs, viral load testing, CD4 count, and other HIV services; (2) advocate the importance of ensuring confidentiality in providing health services, including HIV, to patients and health staff; (3) establish ARV management software to monitor and coordinate ARVs from different sources nationwide; (4) strengthen collaboration between health facilities, Vietnam Administration of HIV/AIDS Control and SHI to ensure ARV supply, reimbursement and support for co-payment; and (5) apply fast-track medicine approval procedure for ARVs, especially new ARVs, third-line ARVs and paediatric ARVs.

**Implementation of mSupply by the Centre for HIV/AIDS and STI (CHAS)**

The Global Fund has supported implementation of mSupply in the Lao People’s Democratic Republic since 2014 (piloted in Savannakhet and Khammouane provinces). mSupply is an electronic logistics information management system used to track the flow of stock in and out of health facilities. Specifically, health facility staff use mSupply to track stock receiving, management, distribution and dispensing. When staff at district
and provincial levels enter information into mSupply, this information becomes available in real time at the central level. mSupply is being used in four out of 11 ART sites in the Lao People’s Democratic Republic; currently these sites are tracking stock all the way through the patient dispensary point. The operational plan for programme scale-up targets national coverage at 18 warehouses, 22 provincial and 148 district hospitals by end of 2019 CHAS can get real-time data and monitor stock movement (coverage of 36.36%) through mSupply.

2.7.2 Sexually transmitted infections and key populations

2.7.2.1 Regional update on STIs – syphilis, gonococcal AMR and condom promotion

Dr Takeshi Nishijima, HIV, Hepatitis and Sexually Transmitted Infections, presented updates on STIs in the Western Pacific Region. Reported syphilis cases are on the rise in multiple countries (Australia, Japan, Republic of Korea and New Zealand). In 2016, estimated maternal syphilis prevalence was 0.26% and the number of pregnant women with active syphilis was 64 000. *Neisseria gonorrhoeae* is a priority pathogen for antimicrobial resistance (AMR). Among 87 million new *N. gonorrhoea* infections in adults aged 15-49 years in 2016, 35.2 million (40%) were in the Western Pacific Region. For treatment of *N. gonorrhoeae*, WHO guidelines recommend dual therapy of ceftriaxone 250 mg IM or cefixime 400 mg PO plus azithromycin 1 gram PO. Three cases of extensively drug-resistant *N. gonorrhoeae* were reported from the United Kingdom of Great Britain and Northern Ireland (2) and Australia (1); two cases were infected in South-East Asia. Since 1992, the WHO Gonococcal Antimicrobial Surveillance Programme (GASP) has been identifying AMR, monitoring trends and informing refinements of policy and treatment. In the Western Pacific, enhanced GASP was implemented in the Philippines. An STI Spectrum workshop for disease burden estimation was held and attended by participants from Cambodia, China (Yunnan), Fiji, Lao People’s Democratic Republic, Federated States of Micronesia, Mongolia, Papua New Guinea, Philippines, Samoa and Viet Nam. For STI diagnosis, WHO-prequalified rapid test kit is used for syphilis, nucleic-acid amplification test (NAAT) is used for chlamydia, and smear/culture/NAAT is used for gonorrhoea. For STI prevention, the WHO Regional Office promotes condom use by creating infographics.

**Burden of STIs among women and high-risk groups in Papua New Guinea (Anup Gurung)**

Prevalence of STIs in women in Papua New Guinea is high: gonorrhoea (16.9% [2000], 11.1% [2017]), chlamydia (24.8% [2000], 15% [2017]) and syphilis (14.8% [2000], 4.29% [2017]). Papua New Guinea has been treating *N. gonorrhoea* with amoxicillin and Augmentin (clavulanic acid and amoxicillin). Historically, Papua New Guinea has shown high levels of penicillinase-producing *N. gonorrhoea* (PPNG) and has not participated in GASP since 2010. To alleviate the burden: a WHO collaborating centre at the University of New South Wales in Australia is now linked to the Institute of Medical Research (IMR) for external quality assurance; national guidelines in line with the WHO guidelines and recommending cefixime (oral) and azithromycin are under review (have to be passed by the senior management); looking at high levels of gonorrhoea among female sex workers in the Integrated Biological and Behavioural Survey (IBBS), a presumptive treatment operational research in close settings is planned; surveillance of gonorrhoea is being planned at the national level using the special surveys (Nano IBBS) among key populations; and the problem of over-the-counter drug use needs to be checked with norms and regulations.

**STIs in the Philippines (Gerard Belimac)**

Prevalence of gonorrhoea in the Philippines is 29.4% among males and 1.8% among females. The Philippines has participated in enhanced gonococcal AMR (eGASP) and two facilities report to WHO and the United States Centers for Disease Control and Prevention (US CDC). eGASP is implemented to monitor trends in antimicrobial susceptibilities in *N. gonorrhoeae* using standardized sampling and laboratory protocols at
selected sentinel clinics and referral laboratories in the Philippines, and to characterize male clients with gonorrhea at selected sentinel clinics, particularly those infected with *N. gonorrhoeae* not susceptible to recommended antimicrobials. Four sentinel clinics – Outpatient Department Clinic at the STD AIDS Cooperative Center Laboratory (SACCL), Manila Social Hygiene Clinic, LoveYourself Uni and Paranaque Social Hygiene Clinic – refer samples to two national reference laboratories – SACCL and Research Institute for Tropical Medicine (RITM). Treatment is done in combination of cefixime and azithromycin.

### 2.7.2.2 Reproductive and sexual health – updates for triple elimination of mother-to-child transmission (EMTCT) and developments in cervical cancer elimination (Anne Brink)

Three interlinked global health sector strategies (2016–2021) call for an end to the epidemics of HIV, STI and viral hepatitis as a public health threat by 2030. The *Regional Framework for Triple Elimination of Mother-to-Child Transmission of HIV, Hepatitis B and Syphilis in Asia and the Pacific 2018–2030* was endorsed by Member States in 2017. Regional targets and progress on triple elimination were presented for four process indicators and two impact indicators. The process indicators were (1) antenatal and delivery care, (2) antenatal testing for HIV, syphilis and hepatitis B, (3) treatment of pregnant women (HIV and syphilis); and (4) hepatitis B immunization of infants. The impact indicators were (1) mother-to-child transmission rate of HIV and (2) case rate of congenital syphilis per 100 000 live births. In Malaysia, the HIV MTCT rate is 2% and the case rate of congenital syphilis is 1 per 100 000 live births. In 2018, Malaysia became the first country in the Western Pacific Region to eliminate mother-to-child transmission of syphilis and HIV.

Globally, cervical cancer is the fourth most common cancer among women, with 570 000 new cases and 311 000 deaths in 2018. Of those, 142 300 new cases (25%) and 63 700 (20%) deaths were recorded in the Western Pacific Region, and 90% of deaths were in low- and middle-income countries. The WHO Director-General made a global call for coordinated action towards elimination of cervical cancer at the World Health Assembly in May 2018, endorsed by many partners. A regional consultation on the draft global strategy towards elimination of cervical cancer will be held in June 2019, and discussion will be ongoing during the Regional Committee meeting in October 2019. Submission of the final agenda to the Executive Board will be in January 2020 and expecting endorsement at the World Health Assembly in May 2020.

### 2.8 Thematic area 4: Governance and financing

#### 2.8.1 The multisectoral accountability framework for TB

Dr Avinash Kanchar, WHO Global TB Programme, gave a presentation on the multisectoral accountability framework for TB. He highlighted that strengthened accountability for the TB response at national and global levels should contribute to faster progress towards the SDG and End TB strategy targets and milestones and that the health sector alone cannot end TB. The draft multisectoral accountability framework to accelerate progress to end TB was presented at the first UN high-level meeting on TB in September 2018, with the requirement that its timely implementation should be ensured no later than 2019.

The framework is a guidance document for adaptation at country level that describes who is accountable, the commitments and actions for which they are accountable and how they will be held accountable through monitoring, reporting and review. It is built upon the foundation of the SDGs, the End TB strategy and associated political declarations, and it emphasizes the fundamental role of civil society and people with TB. It identifies actions to be taken by countries in implementing the End TB strategy and by global and regional agencies to support countries, including developing or strengthening periodic high-level national and regional reviews of progress on SDG and global TB commitments, taking a multisectoral perspective through national interministerial commissions and engaging key stakeholders.
Next steps for the multisectoral accountability framework include developing the final draft of the framework, based on comments from Member States and civil society; sharing the draft in six official languages with Member States in advance of the World Health Assembly in May 2019; supporting adaptation for use at country level, and defining indicators for monitoring use of the framework; and working with global and regional partners to promote and support use of the framework by all stakeholders.

2.8.2 Provider payment methods to support national efforts to end TB

Dr Nobu Nishikiori, WHO Global TB Programme, gave a presentation by live video on provider payment methods to support national efforts to end TB. He highlighted the importance of provider payment methods for health programmes given the global move towards UHC, the transition away from external financing, a flourishing private health-care sector and the integration of TB into health insurance schemes in many countries. There are many different forms of payment methods (e.g. global budget, line-item budget, fee-for-service, case-based, capitation, performance-based), each of which has implications for the volume and quality of service provision, either positively or negatively influencing TB programme performance, public health functions and community-based approaches to service delivery. Currently, most TB diagnostic and treatment services are included in primary health-care packages free of charge, leading to limited provision of services with no incentives to increase coverage of services. Recent moves to fee-for-service or case-based payment (in hospitals) can lead to overprovision of services and contribute to catastrophic costs incurred by patients and their families, while capitation-based payment methods tend towards under provision of critical TB services. In order to promote better access to affordable, quality and patient-centred TB services, performance-based payment (payment for performance, P4P) methods should be considered and carefully designed, especially at primary health-care level. When provider payment methods are aligned with TB programme objectives, they can be a powerful tool to improve programme performance, incentivizing community-based care, increasing early testing and treatment at the primary health-care level and reducing hospitalization but increasing quality of care.

2.8.3 Civil society involvement

Dr Taoufik Bakkali, UNAIDS Regional Support Team Asia and the Pacific, talked about the role of civil society involvement in TB programmes, stating that the principle of civil society engagement is already agreed upon and taken for granted. However, for civil society to be engaged in a meaningful and sustainable way, involvement needs to be at multiple levels, including the planning and design stages of the response and for advocacy. Civil society perspectives on the needs of people may bring solutions to bottlenecks during service delivery. Evidence from HIV programmes in Asia and the Pacific indicates that strong collaboration with community-based organizations correlates with better HIV testing coverage among key populations. There is overwhelming evidence to show that community-based service delivery is effective and efficient and that social contracting enables interventions to be sustainable over time. However, in the current changing financial landscape, plans need to be in place for transitioning to other funding mechanisms and civil society responses need to become self-sustaining. Civil society has played an important role in the monitoring of service delivery, providing important input on issues such as quality of services, stigma and discrimination, access to and stock-outs of drugs and commodities. Civil society needs to be formally engaged in global reporting and national reviews for increased accountability. UNAIDS and UN co-sponsors are required to report on civil society engagement. A civil society budget marker has been developed and is being systematically used to report on accountability towards civil society. The scale is: 1= no involvement of civil society; 2= partial involvement of civil society; 3= civil society leads the activity. It should not be forgotten, however, that partnerships between programmes and civil society should be strong and meaningful, ensuring that civil society is not overburdened with multiple tasks and functions.
2.8.4 Panel discussion

The panel discussion on governance and financing of TB/HIV collaborative activities was moderated by Dr Pieter van Maaren and included presenters from Fiji, the Asia Pacific Council of AIDS Service Organizations (APCASO), Philippines, Brunei Darussalam and Viet Nam.

Waisale Turava (Fiji) spoke about the challenges faced in implementing joint activities when the TB and HIV programmes are separate vertical programmes with different priorities at national and community levels. Bidirectional cooperation between the programmes is required, including strengthened coordination, joint reviews and a joint coordinating body at all levels. Standardized treatment and care for TB and HIV must be provided through a comprehensive package of services. There is a need for additional funding, better access to X-ray and laboratory facilities, specialty hospitals and more human resources, as well as a monitoring tool to monitor and evaluate TB/HIV collaborative activities.

APCASO represents a regional coalition of 31 member organizations working in 12 countries to support people affected by TB, key population groups including PLHIV, people who inject drugs (PWID) and migrants. Jeff Acaba explained how APCASO’s objective is to assess gender-responsiveness, patient-centredness and the level of human-rights based approach of national HIV and TB responses. Advocacy toolkits on human rights have been used in several countries with the support of the WHO South-East Asia and Western Pacific regional offices. Assessments conducted in Cambodia brought together TB and HIV groups to discuss and advocate with TB and/or HIV programmes to close gaps, and in Philippines, work has focused on alignment of TB and HIV guidelines as well as addressing stigma and discrimination in healthcare settings. APCASO was present at the UN high-level meeting on TB, ensuring that TB/HIV issues are being brought to the table.

Celine Garfin (Philippines) described how public-private partnerships in the Philippines lead to better provision of TB services, recognizing that patients seek services in the private sector and that working with the private sector provides more options for patients and delivers better results. One-stop shops provide HIV and TB services under the same roof, and private sector players such as medical societies and business partners are involved in the Philippine Coalition Against Tuberculosis (PHILCAT). Such collaborations lead to people-centred care, better access, less financial burden, less stigma and discrimination and ultimately increased programme achievement against targets. Partnerships have been developed through champions for advocacy, provision of some resources by the public sector (including the national health insurance benefit packages for TB and HIV) and other services by the private sector; involvement of the private sector as co-chair in the HIV technical working group, planning, monitoring and implementation of services and by creating a regular forum to share contributions and accomplishments and to address issues and concerns.

Noraskhin Fadillah (Brunei Darussalam) explained how strong political commitment for control of infectious disease underpins provision of free services for all at the point of care (including for migrants) as protection against catastrophic costs. The Government provides a TB allowance for eligible TB patients and TB/HIV co-infected patients while they are on treatment, covering residents, students, retirees and those with no income. Government employees are granted six months leave on full pay while on TB treatment.

Do Thi Nhan (Viet Nam) described the National Committee for AIDS, Drugs and Prostitution Prevention and Control, which includes the Ministry of Health, other ministries (Ministry of Finance, Ministry of Labour, Invalids and Social Affairs, Ministry of Public Security) and other central NGOs and social organizations. This multisectoral platform for HIV/AIDS control exists at the national, central, provincial and district levels. Joint TB/HIV committees are chaired by the same people at the three lower levels. In March 2019, the Ministry of Health requested the Prime Minister to add TB prevention and control to the Committee.
2.8.5 Global Fund experience in single TB/HIV Concept Notes and joint programming

Mohammed Yassin, Global Fund to Fight AIDS, Tuberculosis and Malaria, presented on the organization’s experience in single TB/HIV Concept Notes and joint programming. The Global Fund mobilized over US$ 12 billion globally for the 2017–2019 funding cycle, of which US$ 1.85 billion was allocated to TB. The Philippines and Viet Nam were among the top 11 countries accounting for 60% of the TB allocation. The number of TB patients tested for HIV has been increasing globally, while the number of TB/HIV patients initiated on ART is increasing more slowly. In many countries, the number of TB facilities is much higher than that of ART facilities. ART services need to be decentralized more to increase access and coverage. Expenditures for TB/HIV collaborative activities prior to 2012 were very low for both programmes: 3% for TB and 1% for HIV grants. As a result of the slow uptake of evidence-based global TB and HIV policies, insufficient planning and resources to quickly roll out national policies and evidence-based practices, logistical and administrative challenges and mismatch between TB and HIV prevention, treatment and care services, the Global Fund decided to request joint TB/HIV Concept Notes for more integrated planning. There has been some improvement, with 13% of the grants now allocated to TB/HIV joint activities (7% and 1.9% of the TB and HIV budgets, respectively), but the development of joint proposals has not been followed by joint programming, implementation and monitoring. There has been significant improvement in HIV testing of TB patients and ART coverage among co-infected patients, but gaps remain in screening PLHIV for TB and providing preventive therapy to PLHIV without active TB. Mismatch between TB and ART sites remains and there has been limited collaboration between TB and HIV programmes beyond TB/HIV joint activities. There are opportunities to strengthen TB/HIV responses further using multi-disease diagnostic platforms, new recommendations for management of LTBI and the momentum provided by the UN high-level commitment on TB. In the Global Fund, there are opportunities for finding additional resources for TB/HIV through reprogramming and reinvestment of efficiencies and savings, as well as through portfolio optimization for TB diagnosis, transition to new WHO-recommended treatment for drug-resistant TB and LTBI, as well as to leverage support from domestic and other donors.

2.8.6 Partner panel

Partner organizations were given an opportunity to present their work.

Patrick Duigan, International Organization for Migration (IOM), reminded participants of the critical importance of migrants in the global discourse on health, from the humanitarian, political, human rights and human security perspectives. Migration is occurring at an unprecedented scale, principally for labour and economic reasons. Migrants contribute significantly to global gross domestic product (GDP) economic development, boosting working age population sizes and filling labour market shortages. Remittances dwarf all foreign aid, leading to continued development of their home countries. Migrants are not a homogenous group and not all are vulnerable, but the nature of movement can lead to increased vulnerability to health risks. Migrants have a fundamental human right to health. Migrant-inclusive health systems improve public health and global health outcomes, and there will be no end to TB or HIV without a focus on migrant health. Most migrants are fit, young and healthy, but over time, poor working conditions in host countries and limited access to health services and social protection can lead to decreased health status. In 2008, the World Health Assembly passed a resolution on the health of migrants and an operational framework was developed to help guide Member States in implementing the resolution. The framework has four pillars: (1) monitoring migrant health; (2) policy and legal frameworks; (3) migrant-friendly health systems; and (4) networks, partnerships and multisectoral engagement. IOM supports the implementation of the operational framework in many areas including through health assessments in nearly 100 countries worldwide, the development of migrant-friendly health services, and multisectoral engagement beyond the health sector, working with departments of immigration and labour and foreign affairs.
Kitty van Wezenbeek, KNCV Tuberculosis Foundation, described the work of KNCV towards the global goal of eliminating TB. With 13 country offices in Africa and Asia, KNCV is providing technical assistance around the world as the lead partner in four USAID-funded flagship projects between 2000 and 2019. She highlighted that this is a very dynamic era for TB control, with new drugs, diagnostic tests and molecular sequencing techniques becoming available, while, at the same time, “old” innovations have not yet been fully implemented in many parts of the world because of issues including political commitment, financing, health systems capacity and sustainability. KNCV special initiatives take a patient-centred approach to finding and treating all missing patients through correct diagnosis and treatment, TB prevention and treatment of LTBI, TB/HIV co-infection and using digital health innovations to empower decision-making and reducing TB-related stigma. In the Philippines, KNCV partners with LoveYourself to improve the quality of care for TB and HIV by engaging civil society and key populations in decision-making and monitoring of TB and HIV services and developing “one-stop shops” for patient-centred TB and HIV care.

Hemant Bogati, Médecins Sans Frontières (MSF), described the work of MSF in the Western Pacific Region. MSF collaborates with the National TB Programme and the National Department of Health in Papua New Guinea to fill gaps in collaboration between the TB and HIV programmes and to establish and strengthen integrated TB and HIV services in “one-stop shop” models of care. In a setting where 12% of TB patients are co-infected with HIV and only 52% of TB/HIV co-infected patients access ART, it is important to lower both the burden of HIV among TB patients and the burden of TB in PLHIV. The integrated package of services includes counselling and HIV testing for all TB patients together with psychosocial support, prompt ART initiation with viral load monitoring (using the common laboratory platform), coordinated follow-up of patients including transfer of patients to ART sites after completion of TB treatment and timely reporting and sharing of data.

Jeff Acaba spoke on behalf of the Stop TB partnership, describing the role of the organization in fully harnessing community-based responses to TB both inside and outside health systems. Areas of work include stigma assessment, gender responsiveness, and overcoming barriers to access to services; monitoring the availability of TB support groups and services; and generating demand for services, ensuring the full engagement of the community.

2.9 Country planning and next steps

As a final exercise, country participants from nine high-burden countries were given an opportunity to work together to develop plans for addressing their three key priorities for improving TB/HIV joint activities. Technical advisers, donors and partners, as well as participants from low-burden countries, were invited to act as resource persons, answering questions and providing information and assistance. Each high-burden country was allocated 10 minutes to interact with each of four groups of resource persons in a “speed-dating” format before finalizing and presenting their plan in the plenary feedback session. Details of the country plans can be found in Annex 3.

3. KEY MESSAGES, CONCLUSIONS AND RECOMMENDATIONS

3.1 Key messages and ways forward

Key messages and action points to address them were compiled for each of the four thematic areas and presented to all participants by the rapporteur, together with the word cloud developed from the key words identified by participants (Annex 4).
3.1.1 Thematic area 1: Find and treat

Findings:
1. Testing of people affected by TB for HIV and PLHIV for TB is improving steadily, in part because of newer diagnostic tools, but the testing gap remains significant.
2. Treatment of people affected by TB/HIV has also improved significantly, although further progress is still required.
3. Supply- and demand-side barriers continue to impede access to diagnostic and treatment services.

Ways forward:
1. Review testing policies and guidelines for both programmes to ensure that people are tested for both TB and HIV.
2. Ensure joint training, supervision and support for health-care workers at all levels of TB/HIV service provision.
3. Maximize collaboration with civil society organizations and private partners.
4. Address the high price of commodities through pooled procurement.
5. Enhance utilization of digital technologies for treatment adherence.

3.1.2 Thematic area 2: Latent TB infection

Findings:
1. Sixty-two per cent of PLHIV without active TB were not receiving TB preventive therapy in 2017.
2. Global TB/HIV targets will not be achieved by 2030 if prevention is not implemented effectively.
3. Surveillance (recording and reporting) for LTBI remains weak in many countries.
4. Procurement and supply is challenging because of missed opportunities in collaboration between TB and HIV programmes.

Ways forward:
1. Set country-specific targets in line with UN high-level meeting commitments; develop plans and allocate resources to reach all who are eligible for LTBI treatment.
2. Strengthen collaboration between TB and HIV programmes and wider stakeholder engagement for effective implementation.
3. Maximize opportunities to improve prevention coverage (noting that symptom screening is sufficient to rule out active TB among PLHIV before starting LTBI treatment).

3.1.3 Thematic area 3: Integrating monitoring and evaluation for TB/HIV

Findings:
1. Linkage of strategic information systems for TB and HIV is insufficient to inform and support person-centred care and close the current gaps in diagnosis and treatment for TB/HIV co-infected persons.
2. Electronic health information systems provide opportunities for TB/HIV information linkages and systems solutions, either as one platform or separate linked platforms, based on the country context including community needs and service delivery models.
3. Integration of TB and HIV strategic information systems should take into account the needs of affected communities with emphasis on data security and patient confidentiality.

Ways forward:
1. Identify the information needed to ensure a comprehensive and joint approach to TB/HIV person-centred care, and then identify workable information technology (IT) solutions.
2. Establish or strengthen integrated surveillance for LTBI.
3.1.4 Thematic area 4: Governance and financing

Findings:
1. High-level political commitment is a major opportunity for both programmes to progress towards UHC and to develop multisectoral accountability (such as UN high-level meeting for TB, ASTANA conference for primary health care).
2. Community support and public–private partnerships exist for both TB and HIV programmes.
3. The financial landscape is changing throughout the Region, and countries are moving towards sustainable domestic financing.

Ways forward:
1. Leverage high-level and multisectoral commitment and collaborate to ensure accountability at all levels.
2. Ensure that communities are at the centre of all levels of the response.
3. Continue to develop sustainable domestic funding models including consideration of provider payment methods to support improved programme performance.

3.2 Conclusions

Most countries in the Region have some form of collaboration between TB and HIV programmes in line with WHO guidelines. Major components of the collaboration lie in governance, cross-screening and treatment among co-infected persons and monitoring and evaluation of joint TB/HIV activities. Although there has been significant progress in the last decade, startling gaps still remain. In this joint TB and HIV meeting, Member States shared their experiences and best practices, identified major challenges faced while implementing interventions on the patient pathways from TB and HIV entry points, and agreed on a concrete way forward for addressing these challenges.

3.3 Recommendations

3.3.1 Recommendations for Member States

Member States are encouraged to consider the following:

1. Set country-specific targets and accelerate implementation plans for TB detection and prevention in line with the political declaration signed by countries at the first UN high-level meeting on TB in September 2018.
2. Improve access to screening, diagnosis and treatment for both diseases through review and revision of existing policies that may include:
   a. Co-location of services and/or efficient referral mechanisms to ensure that all TB patients receive HIV screening and all PLHIV are screened for TB disease.
3. Address stigma, financial barriers and awareness among patients and the community for TB and HIV and co-infection.
4. Maximize opportunities to improve coverage of TB preventive therapy among PLHIV through:
   a. simplifying the screening algorithm (symptom screening is sufficient to rule out active TB before initiating LTBI treatment);
   b. adopting shorter rifamycin-based regimens;
   c. using digital technologies for adherence;
   d. improving surveillance; and
   e. engaging communities and the private sector to improve uptake.
5. Ensure an uninterrupted supply of commodities for diagnosis and treatment of TB (infection and disease) and HIV that may include:
   a. centralized procurement;
b. pooled procurement to address high prices, specifically in countries that are not in the preferential pricing list; and
c. integrated supply mechanisms.

6. Develop and/or strengthen an integrated electronic surveillance system that provides complete, consistent and credible information on TB/HIV care and prevention.
7. Leverage high-level and multisectoral commitments for both TB and HIV through wider stakeholder engagement and ensuring accountability at all levels.
8. Strengthen domestic health financing models and provider payment mechanisms for TB and HIV care and prevention especially in the wake of increasing need and diminishing external funding.

3.3.2 Recommendations for WHO and partners

WHO and partners are requested to consider the following:

1. Provide high-level advocacy and technical support to Member States for translating political commitments into concrete planning and implementation.
2. Support Member States in reviewing existing policies and planning for improving access for both TB and HIV care and prevention.
3. Provide support for adoption and adaptation as well as implementation of the updated guidelines on LTBI and newer ART regimens.
4. Continue to coordinate/negotiate with global commodity service suppliers for uninterrupted supplies of commodities and preferential pricing.
5. Support Member States in strengthening integrated surveillance systems and using data for improving programme performance.
6. Continue to collaborate with stakeholders at regional and country levels for coordinated support to Member States for implementation of TB and HIV care and prevention within the wider health system and Sustainable Development Agenda.
7. Support Member States in establishing and/or strengthening multisectoral bodies and frameworks and their accountability.
8. Continue to support Member States in mobilizing resources and planning for transition to domestic financing for TB and HIV programmes.
# Annex 1

## Meeting Programme

### Day 1: Tuesday, 12 March 2019

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
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<tbody>
<tr>
<td>08:00 – 08:30</td>
<td>Registration</td>
</tr>
<tr>
<td>08:30 – 09:20</td>
<td><strong>Opening Session</strong>&lt;br&gt;  - Welcome remarks by the Regional Director&lt;br&gt;  - Opening remarks by WHO/GTB Director&lt;br&gt;  - Opening remarks by WHO/CDS/HIV Director&lt;br&gt;  - Opening remarks by Director, Regional Support Team (RST) for Asia and Pacific&lt;br&gt;  - Patient testimony&lt;br&gt;  - Self-introduction and objectives of the meeting&lt;br&gt;  - Administrative announcements</td>
</tr>
<tr>
<td></td>
<td>Takeshi Kasai (WPRO)&lt;br&gt;  Tereza Kasaeva (WHO HQ)&lt;br&gt;  Gottfried Hirnschall (WHO HQ)&lt;br&gt;  Eamonn Murphy (UNAIDS)&lt;br&gt;  Naoko Ishikawa/Tauhid Islam (WPRO)</td>
</tr>
<tr>
<td>09:20 – 09:50</td>
<td>Group photograph followed by coffee/tea break</td>
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### Setting the scene

**Chair:** Nguyen Viet Nhung (Viet Nam); **Co-Chair:** Jackson Rakei (Solomon Islands)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>09:50 – 10:30</td>
<td><strong>Plenary Presentations</strong>&lt;br&gt;  Ending TB and AIDS – leaving no one behind:&lt;br&gt;  - TB&lt;br&gt;  - HIV&lt;br&gt;  - Patient-centred simulation&lt;br&gt;  - Regional TB and HIV summary&lt;br&gt;  - Discussion</td>
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<tr>
<td></td>
<td>Tereza Kasaeva (WHO HQ)&lt;br&gt;  Gottfried Hirnschall (WHO HQ)&lt;br&gt;  Naoko Ishikawa/Tauhid Islam (WPRO)</td>
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<tr>
<td>12:00 – 13:00</td>
<td>Lunch break</td>
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<tr>
<td>13:00 – 14:00</td>
<td><strong>Poster Marketplace</strong>&lt;br&gt;  [Country representatives to present their poster]</td>
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### Thematic area 1: Find and treat

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>14:00 – 14:10</td>
<td>1. What is new in screening and treatment?&lt;br&gt;  Shalala Ahmadova/Donghyok Kwon (WPRO)</td>
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<tr>
<td>14:10 – 14:20</td>
<td>2. Digital health&lt;br&gt;  Kitty van Weezenbeek (KNCV)</td>
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<tr>
<td>14:20 – 15:00</td>
<td>3. Panel discussion&lt;br&gt;  Mean Chhivun (Moderator)&lt;br&gt;  Cambodia, Mongolia, Philippines, Viet Nam, Asia Pacific Network of PLHIV&lt;br&gt;  Chris Coulter (QMRL)</td>
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<tr>
<td>15:00 – 16:15</td>
<td>4. Group work (includes coffee break)&lt;br&gt;  1) Screening and detection&lt;br&gt;  2) Common laboratory platform&lt;br&gt;  3) Access to treatment&lt;br&gt;  4) Patient-centred approach&lt;br&gt;  Conference Hall A&lt;br&gt;  Sampaguita Hall A&lt;br&gt;  Sampaguita Hall B&lt;br&gt;  Sampaguita Hall C</td>
</tr>
<tr>
<td>16:15 – 17:00</td>
<td>Plenary feedback</td>
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<tr>
<td>17:30 – 19:30</td>
<td><strong>Regional Director’s reception</strong></td>
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### Day 2: Wednesday, 13 March 2019

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>08:30 – 08:45</td>
<td>Recap of Day 1</td>
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<tr>
<td>08:45 – 09:15</td>
<td>1. What is new in TB prevention?&lt;br&gt;  Kalpesh Rahevar (WPRO)</td>
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<tr>
<td>09:15 – 10:00</td>
<td>2. Panel discussion:&lt;br&gt;  Kitty van Weezenbeek (Moderator)&lt;br&gt;  China, Japan, Malaysia, Korea, Love Yourself</td>
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<tr>
<td>10:00 – 10:30</td>
<td><strong>Coffee/tea break</strong>&lt;br&gt;  Marketplace: WHO CC</td>
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<tr>
<td>Time</td>
<td>Session</td>
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<tr>
<td>10:30 – 11:45</td>
<td>Group work</td>
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<tr>
<td></td>
<td>1) Diagnosis of LTBI among PLHIV</td>
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<td></td>
<td>2) Treatment of LTBI among PLHIV</td>
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<td></td>
<td>3) Procurement</td>
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<td></td>
<td>4) Surveillance</td>
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<tr>
<td>11:45 – 12:30</td>
<td>Plenary feedback</td>
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<tr>
<td>12:30 – 13:30</td>
<td>Lunch break</td>
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<tr>
<td>13:30 – 13:50</td>
<td>Synthesis of strategic information for TB and HIV</td>
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<td>13:50 – 15:00</td>
<td>Discussion</td>
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<tr>
<td>15:00 – 15:30</td>
<td>Coffee/tea break</td>
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<tr>
<td>15:30 – 17:30</td>
<td>Parallel session A</td>
</tr>
<tr>
<td></td>
<td>1) Find and treat-all initiative</td>
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<td></td>
<td>2) Road map for public-private mix</td>
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<td></td>
<td>3) New guidelines for MDR/RR-TB</td>
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<td></td>
<td>4) Roadmap towards ending TB in children and adolescents</td>
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<tr>
<td>15:30 – 17:30</td>
<td>Parallel session B</td>
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<tr>
<td></td>
<td>HIV, STI and Key Populations:</td>
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<tr>
<td></td>
<td>Sustainable service delivery for HIV</td>
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<td>Roll-out of Dolutegravir</td>
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<td></td>
<td>Transitioning to sustainable mechanisms for HIV</td>
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<tr>
<td></td>
<td>– financing and supply chain management</td>
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<td></td>
<td>Sexually transmitted infection and key populations</td>
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<td></td>
<td>Regional update on STIs</td>
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<td></td>
<td>– syphilis, gonococcal AMR and condom promotion</td>
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<td></td>
<td>Reproductive and sexual health</td>
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<tr>
<td></td>
<td>– updates for triple elimination of mother-to-child transmission (EMTCT)</td>
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<tr>
<td></td>
<td>and developments in cervical cancer elimination</td>
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<td>Day 3: Thursday, 14 March 2019</td>
<td><strong>Thematic area 4: Governance and financing</strong></td>
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<tr>
<td>08:30 – 08:45</td>
<td>Recap of Day 2</td>
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<tr>
<td>08:45 – 09:30</td>
<td>1) Multi-sectoral accountability</td>
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<td></td>
<td>2) Civil society involvement</td>
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<td>3) Innovative financing</td>
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<tr>
<td>09:30 – 10:15</td>
<td>Panel discussion</td>
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<td>10:15 – 10:45</td>
<td>Coffee/tea break</td>
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<tr>
<td>10:45 – 11:00</td>
<td>Global Fund experience in joint TB/HIV proposals and joint implementation</td>
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<tr>
<td>11:00 – 11:15</td>
<td>Discussion</td>
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<tr>
<td>11:15 – 12:00</td>
<td>Partner panel</td>
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<tr>
<td>12:00 – 13:00</td>
<td>Lunch break</td>
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<tr>
<td>13:00 – 14:30</td>
<td>Planning and next steps</td>
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<tr>
<td>14:30 – 15:00</td>
<td>Coffee/tea break</td>
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<tr>
<td>15:00 – 16:00</td>
<td>2) Plenary feedback and discussion</td>
</tr>
<tr>
<td>16:00 – 16:30</td>
<td>Key messages and recommendations</td>
</tr>
<tr>
<td>16:30 – 16:35</td>
<td>Closing remarks</td>
</tr>
</tbody>
</table>
ANNEX 2

LIST OF PARTICIPANTS

1. Participants

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ANNEX 3

COUNTRY PLANS

Cambodia:

Key priority 1: Case detection of HIV and TB
Action 1:
- Scale up intervention of active case finding (including PLHIV contacts)
Action 2:
- Scale up Health Provider Initiated Testing and Counselling (PITC) for TB patients (including TB suspects)
Action 3:
- Implement, follow up, and improve plans
- Conduct regular meetings for both programmes at sub national levels for strengthening referral and follow up mechanisms of both programmes

Key priority 2: Logistic Supply Management of isoniazid / B6/HIV tests (to address stock-outs)
Action 1:
- Joint TB /HIV planning, forecasting, procurement
Action 2:
- Develop real-time electronic data base system stock management
Action 3:
- Joint regular implementation and monitoring on stock inventory

Key priority 3: Strategic information (no connections between data systems of the two programmes)
Action 1:
- Review current HIV and TB data systems for opportunities to link to each other at National / subnational levels at least for common indicators for both programmes
Action 2:
- Develop guidance, tools, agreement by both programmes
Action 3:
- Implement, follow up and action taken accordingly on integration of data information systems
China:

Key priority 1: To strengthen the coordination between two programs

Action 1:
- High level coordination meetings between the two programs
  - Decisions taken to strengthen cooperation: financing, integration/linkage of information systems, referral/linkage in services delivery (screening, isoniazid preventive therapy (IPT), etc.)

Action 2:
- Develop budgeted action plan on TB/HIV co-infection management

Action 3:
- Establish the link between the two electronic information systems by ID, then relevant data could be interchanged

Key priority 2: Bi-direction screening for TB/HIV

Action 1:
- Establish the new two-way screening algorithm based on the linked system
  - HIV clinics
    - TB symptom screening for all HIV patients is being implemented
    - The referral to TB clinic for diagnosis to be improved through the linked information systems
  - TB clinics
    - Tracing and diagnosis of TB among the PLHIVs referred in the system
    - Risk assessment of HIV infection for the confirmed TB patients, and provide HIV testing for those in higher risks

Action 2:
- Strengthen the counselling and follow-up for the co-infections

Key priority 3: IPT

Action 1:
- Orientation and promotion of IPT among clinicians to reduce the reluctance of IPT providers

Action 2:
- Strengthen the patients education and counselling

Action 3:
- Utilize digital tool for management of preventive therapy
Fiji:

**Key priority 1: Bi-directional cooperation between programmes**

Action 1:
- Establish joint TB/HIV planning to integrate the delivery of TB and HIV services

Action 2:
- Set up a coordinating body for TB/HIV activities functional at all levels – National/Division/Sub-Division

Action 3:
- Comprehensive Package for screening, admission, continuum of care and follow-up, linkages to other services

**Key priority 2: Resources**

Action 1:
- Funds for joint TB/HIV activities (propose for increased allocation by providing facts)

Action 2:
- Specialty Hospital not supporting any of the TB, HIV or TB/HIV activities (3 Tertiary Hospitals – only 1 Specialized Setting)

Action 3:
- Human Resources

**Key priority 3: Monitor and evaluate TB/HIV activities**

Action 1:
- Monitoring tool to assess impact of program implementation being implemented

Action 2:
- Encourage management support to oversee progress of TB/HIV programme collaboration

Action 3:
- Collecting and sharing TB/HIV data for policy and decision making
Lao People’s Democratic Republic:

Key priority 1: Strengthening capacity building of both TB/HIV programmes

Action 1:
- Review policy, strategies and guidelines

Action 2:
- Provide training on service delivery (on TB/HIV for prevention, detection and treatment)

Action 3:
- Provide training on services delivery (on TB/HIV for prevention, detection and treatment)

Key priority 2: TB/HIV technical integration

Action 1:
- Technical working group (Joint implementation planning)

Action 2:
- Joint quarterly meeting progress update on implementation

Action 3:
- Joint monitoring and evaluation

Key priority 3: Information System District Health Information System (DHIS)2

Action 1:
- Review of set common TB/HIV indicators

Action 2:
- Set up SOP on electronic platform (data collection, analyse reporting)

Action 3:
- Training on common TB/HIV electronic platform to address TB/HIV integration
Mongolia:

Key priority 1: HIGH-LEVEL: Lack of advocacy for decision making and awareness on integration of TB/HIV joint activities

Action 1:
- Accelerate advocacy and Information, education and communication activities at all levels

Action 2:
- Develop the transition plan on TB/HIV activities with budgeting and ensuring the sustainability of GF projects implementation by support from the Government of Mongolia

Action 3:
- Strengthen the multisectoral collaboration through conducting the integrated national TB and HIV forum

Key priority 2: PROGRAMME LEVEL: Lack of integrated screening and trainings on TB and HIV prevention, treatment, data management among medical doctors at the national and sub-national level of health care delivery

Action 1:
- Conduct training on TB and HIV prevention, treatment among medical doctors at the national and sub-national level of health care delivery ensuring the integrated provision of TB and HIV service delivery

Action 2:
- Integration of information system (reporting and recording system) of TB and HIV, and conducting the integrated training on data management

Action 3:
- Conduct joint screening, diagnosis, and prevention of TB and HIV

Key priority 3: COMMUNITY/PATIENT LEVEL: Low coverage of TB preventive therapy among HIV patients

Action 1:
- Increase knowledge about TB among PLHIV and about HIV among TB patients

Action 2:
- Scale-up screening for HIV key and target populations (SWs, pregnant women/Antenatal care attendees, MSM)

Action 3:
- Accelerate early screening of “High risk groups” (pregnant women, children, prisoners, people living with HIV, drug users, mining workers, poor people, malnourished people)
Papua New Guinea:

**Key priority 1: Adapting physical existing infrastructure to be one stop shop**

Action 1:
- Integrate HIV VL load testing using a gene-Xpert platform, using TB gene Xpert

Action 2:
- Fast track national guidance/policy for integration

Action 3:
- Prevention, diagnosis and treatment for both TB and HIV including infection control as a priority in major urban areas

**Key priority 2: Active case finding**

Action 1:
- Training for staff to integrate services for screening in outreach, contact tracing, mass population screening and to reach high risk populations

Action 2:
- Supply chain management including use of open data kit (ODK) to monitor stock position

Action 3:
- Demand generation by providing quality of services, community involvement in care and advocacy/C4D. (Communities to be involved from the stage of design to implementation)

**Key priority 3: Integrating information systems**

Action 1:
- Development of case based management for TB in NCD and link to HIV by developing one national form/output

Action 2:
- SEM to fast track information and communications technology (ICT) policy and law making sure that integration of HIV /TB SI and ownership is with the GoPNG

Action 3:
- Train the health care providers to implement electronic systems and ensure no duplication as in terms of paper to reduce carbon footprint
Philippines:

**Key priority 1: Low TB Preventive Therapy Coverage**

Action 1:
- Training/e-training of health implementers and CSOs on IPT provision

Action 2:
- Provision of adequate isoniazid through PhilHealth

Action 3:
- Treatment compliance monitoring and IPT implementation of health care providers and CSOs

**Key priority 2: Low HIV Testing among TB patients**

Action 1:
- Expand the implementation of PICT among TB patients nationwide

Action 2:
- Provision of adequate HIV testing kits

Action 3:
- Monitoring of implementation

**Key priority 3: Incomplete information system for IPT, TB/HIV treatment co-infection**

Action 1:
- Review existing recording and reporting systems

Action 2:
- Ensure all critical TB/HIV indicators are captured in the existing strategic information systems, and data sharing

Action 3:
- Consider standardized notification of diseases

**Key priority 4: Separate benefit package for TB and HIV**

Action 1:
- Generate demand for PhilHealth package

Action 2:
- Provide information to patients on PhilHealth entitlements

Action 3:
- Collaborate with PhilHealth to ensure effectiveness of the benefit package
Solomon Islands:

**Key priority 1: Governance**

Issues:
- Management structures are separate

Action 1:
- Coordination of the two management structures needs to be strengthened.

Action 2:
- Currently collaborative meetings are underway, but issues identified need to be resolved on a regular and timely basis

**Key priority 2: Financing**

Issues:
- No funding for HIV program activities.
- Currently activities funded through the TB program
- Timely release of funds
- Period for retiring of funds is only 2 weeks

Action 1:
- Negotiating the activities for HIV activities from domestic budgets

Action 2:
- More dialogue on efficient and speedy means of fund acquisitions with the Finance team

**Key priority 3: Service delivery**

Issues:
- Human resource capacity at the health facility level
- Lack of resources for training the human resources

Action 1:
- Referrals and linkages at the provincial level need to be strengthened

Action 2:
- Joint capacity building effort

Action 3:
- Need to build greater capacity through a systems approach
Viet Nam:

Key priority 1: Screen and detect early and more TB cases among PLWHA

Action 1:
- Update and standardize a national joint guideline and SOPs and joint training

Action 2:
- Strengthen laboratory capacity at local district level by utilizing GeneXpert for detection and diagnosing TB among PLWHA

Action 3:
- Roll out SOPs on follow-up mechanisms for referral of TB- HIV cases in TB and HIV facilities

Key priority 2: Scale up LTBI Treatment for PLWHA

Action 1:
- Advocate on the importance of LTBI treatment to policy makers and increase demand among HCWs, patients, high risk groups, and general population

Action 2:
- Decide appropriate LTBI treatment regimens (9H - 3HP - 1HP - 3RH)

Action 3:
- Standard SOPs on supply chain for LTBI drugs including forecasting, procurement, distribution, and conduct joint training

Key priority 3: Joint M&E on TB/HIV

Action 1:
- Develop a consensus on common indicators for TB-HIV

Action 2:
- Link VITIMES and HIV platforms to register, monitor, and follow up TB and HIV patients and LTBI treatment

Action 3:
- Regular review and use of data among policy makers and service providers for planning and improving quality of programme/services
ANNEX 4

WORD CLOUD FOR TB AND HIV COLLABORATION