Feedback from Taskforce on HIV/TB monitoring and evaluation

Taskforce members

William Coggin
Haileyesus Getahun
Jeroen van Gorkom;
Christian Gunneberg,
Reuben Granich,
Ya Diul Mukadi;
Obatunde Oladapo
Alasdair Reid;
Catherine Judy Watt;
Monitoring and Evaluation Taskforce
Areas of enquiry

• Revision of TB/HIV indicators
• Data harmonization between partners
• TB/HIV estimates

In each area I will discuss:

1. issues
2. recent developments
3. recommendations
Revision of TB/HIV indicators

- Issues:

  Original M&E guide 2004

  Revision of WHO TB and HIV R&R include TB/HIV data

  PEPFAR and UNGASS have own indicators

  Indicator harmonisation needed for countries

  See Annex 3 Table 1 - poor overlap of indicators
Revision of TB/HIV indicators

• Recent developments:

  WHO HIV department M&E revision
  reporting 3 TB/HIV indicators to national level?

  Revision of M&E guide on THD workplan
  proposed consultation with HIV department

  PEPFAR Indicator revision process
  with WHO/UNAIDS TB/HIV technical input.
  agreement on 5 indicators (Annex 3 Table 2)

  Global Fund M&E guide review August 2008
Revision of TB/HIV indicators

- **Recommendations:**

  - The task force notes the revision of the TB/HIV indicators currently planned and suggests that these should be in harmony with the current WHO HIV department M&E revisions and should ensure that this revision is able to deliver quality TB/HIV indicator data at national level.

  - Piloting of locality crosschecking of TB and ART registers between programmes should be encouraged as part of the M&E process.

  *(Caveat: some disagreement within the taskforce as to whether this is too much to ask for too little return)*
Data harmonisation between partners

• Issues:

TB/HIV data now from:
- WHO STB
- WHO HIV DEP
- UNAIDS (UNGASS indicator)
- PEPFAR (for focus countries)

Discordant data from different sources
Reported separately for different time periods.

Need for accurate harmonised TB/HIV data to come from national MoH source to all partners.

Not happening
Data harmonisation between partners

Recent developments:

- WHO STB/ PEPFAR TB/HIV data review (Annex2) (15 focus C)

HIV+TB patients. Pepfar 2 to 5 x NTP to WHO equivalent 1/3 rd of all TB notifications needs further exploration . eg data sources (4 countries)
Data harmonisation between partners

- **Recent developments**

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Data harmonisation between partners

• Recommendation:

In view of the recent expansion of TB/HIV monitoring and evaluation data sources at global level, there is a need for:

– Regular international and national review meeting processes to ensure that TB/HIV data collected is comparable and consistent, accurate, comprehensive and based on the country Ministries of Health data source and reporting cycle. Technical/donor partners should support that process.
TB/HIV estimates

• Issues:

Estimates until now based on indirect measure of global averages as not sufficient country data.
Perception in the past that these were low.
More testing data coming from countries allowing for more analysis and use of direct measurements for estimates.
The IRR is derived using latest data from 187 surveys (updated 2007)

- IRR 30 (range 21–39) for high-income countries
  6.0 (range 3.5–8.0) for all other countries.

The Growing Burden of Tuberculosis

Global Trends and Interactions With the HIV Epidemic

Elizabeth L. Corbett, PhD; Catherine J. Watt, DPhil; Neff Walker, PhD; Dermot Maher, BM, BCh;
Brian G. Williams, PhD; Mario C. Raviglione, MD; Christopher Dye, DPhil

Arch Intern Med 2003;163:1009-1021
Scale-up of TB/HIV activities has led to scale up of HIV testing in TB patients.
Global Tuberculosis report
Criteria for using a
direct measurement of
TB/HIV estimates.

1 60% of notified TB cases tested for HIV in 2006 and at least 1000 cases tested. (13 countries)

2 HIV prevalence in TB surveys undertaken in a representative sample of TB patients

• Use this surveillance data based on routine testing (13 countries)

• Use this estimate (Vietnam and Cambodia)
Three fold increase in HIV/TB estimates in countries where direct estimates were used.

Estimated HIV+ve Tuberculosis 2006:
Comparison of estimates by indirect method and direct methods in 27 countries meeting the direct method criteria.

Using the indirect method: Estimated TB HIV: 54,944,
Using the direct methods: Estimated TB HIV: 163,392.

Numbers above the bars is the ratio; direct estimate / indirect estimate.
Countries testing Tuberculosis Patients for HIV 2006

Blue: using direct country data

- 6.3% Ethiopia: 40%
- 16% Uganda: 59%
- 18% Tanzania: 50%
- 41% Rwanda
- 52% Kenya
- 70% Malawi

Proportion of TB patients tested for HIV

Key
- No reported activity
- < 15%
- 15% to 25%
- 25% to 50%
- More than 50%

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TB/HIV estimates

• **Recommendations:**

  in light of recent individual country reassessment of TB/HIV estimates based on direct country data,
  
  there is an urgent need for a dissemination strategy which should include revision of the global IRR and estimates in time for the June 9th global TB HIV leaders forum (New York. This revision should also re-examine the data now available for burden of death estimates, and should include the provision of estimate confidence intervals.

  *(Not all in agreement: There is a WHO Global Taskforce on TB impact measurement, one of whose subgroups will be reviewing the TB and TB/HIV estimates - meeting first time in June in Den Haag. Interim global estimate revisions between annual reports are not currently planned by WHO STB and would not be sensible)*