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Engaging Community-based Organizations in TB/HIV Collaborative Activities

A CASE STUDY IN NIGERIA

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fhi Family Health International

Cover photo: In Kano State, TB patients are visited by volunteers from Participatory Learning Action and Community Ownership (PLACO), a community-based organization. Credit: Jide Adeniyi-Jones

Inclusion of persons in photos should not be construed as indicating their health status.

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Acronyms

AFB	Acid-fast bacilli
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral treatment
ARV	Antiretroviral drug
CBO	Community-based organization
CB-DOTS	Community-based directly observed treatment short-course
CCM	Country Coordinating Mechanism (GFATM)
CDR	Case detection rate
CIDA	Canadian International Development Agency
CPT	Cotrimoxazole preventive therapy
CTBC	Community TB Control
CiSGHAN	Civil Society Consultative Group on HIV/AIDS in Nigeria
COMPASS	Community Participation for Action in the Social Sector
DEMI	Divine Emission Initiative
DFID	Department for International Development (UK)
DFB	Damien Foundation Belgium
DOT	Directly observed treatment
DOTS	Directly observed treatment short-course
FBO	Faith-based organization
FHI	Family Health International
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHAIN	Global HIV/AIDS Initiative Nigeria
GIPA	Greater Involvement of People Living with HIV/AIDS (UNAIDS policy)
HAST	HIV/AIDS/STI/TB (integrated care model)
HBC	Home-based care
HCT	HIV counseling and testing
HIV	Human immunodeficiency virus
IC	Infection control
IEC	Information, education, and communication
IMPACT	Implementing AIDS Prevention and Care Project
ILEP	International Federation of Anti-Leprosy Associations
IPT	Isoniazid preventive therapy
IUATLD	International Union Against TB and Lung Diseases
KAP	Knowledge, attitudes, and practices
LACA	Local Action Committee on HIV/AIDS
LGA	Local government area
MDR-TB	Multidrug-resistant TB
M&E	Monitoring and evaluation
NACA	National Action Committee on HIV/AIDS International Federation of Anti-Leprosy Associations
NAP	National AIDS Program
NASCP	National AIDS/STD Control Program
NELA	Network on Ethics/Human Rights, Law, HIV/AIDS Prevention, Support and Care
NEPHWAN	Network of People Living with HIV/AIDS in Nigeria
NGO	Nongovernmental organization
NTBLCP	National Tuberculosis and Leprosy Control Program
NTP	National TB Program
PEPFAR	US President's Emergency Plan for AIDS Relief
PLACO	Participatory Learning Action and Community Ownership
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission
SACA	State Action Committee on HIV/AIDS
SWAAN	Society for Women and AIDS in Africa, Nigeria
SPETBN	Society for Prevention and Eradication of TB in Nigeria
STI	Sexually transmitted infection
TB	Tuberculosis
TB CAP	Tuberculosis Control Assistance Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
WHO	World Health Organization
YOSPIS	Youth Society for Prevention of Infectious Diseases and Social Vices

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Executive Summary

The engagement of community-based, nongovernmental, and faith-based organizations has been promoted as a cost-effective strategy that can rapidly expand TB and HIV services and community TB care. Though these organizations are vital partners in the response to HIV/AIDS and have played a well-recognized role in expanding access to quality services, opportunities to engage them in TB/HIV activities are largely untapped.

This TB CAP study addresses how communities can be engaged in meaningful and effective ways in TB/HIV collaborative activities. After describing the characteristics, areas of practice, and core competencies of 12 selected community-based organizations (CBOs) engaged in HIV/AIDS prevention, care, and treatment in Nigeria, the study team examined whether and how they are engaged in TB/HIV collaborative activities and how this engagement can be expanded.

Nigeria was selected for this study because of its important TB and HIV epidemics. The country ranks fifth among 22 with high TB burden, and it is home to about 2.6 million people living with HIV/AIDS. Though policies and guidelines on TB/HIV collaborative activities have been developed with the support of many technical partners, the task of ensuring country-wide availability of comprehensive, high-quality, client-oriented, TB/HIV services continues to face major challenges.

TB center at Ajeromi General Hospital, Lagos.
FHI/NIGERIA PHOTO BY JIDE ADENIYI-JONES.

Study methodology

Twelve CBOs working in HIV/AIDS in four states in Nigeria were selected whose characteristics, core competencies, knowledge of TB/HIV, and current TB/HIV collaborative activities were captured through semi-structured interviews and the use of a questionnaire with 56 variables.

The study team reviewed factors that may help or hinder CBO engagement in TB/HIV collaborative activities and investigated practices the CBOs are currently implementing that could be applied to scale up TB/HIV collaborative activities—in Nigeria and elsewhere. In particular, the team focused on practices that seemed to be innovative, sustainable, and replicable. The study team also visited sites implementing the integrated model for HIV/AIDS, STI and TB care (HAST), one that makes considerable use of CBOs and has been developed under the Global HIV/AIDS Initiative Nigeria (GHAIN) by Family Health International.

Based on the lengthy interviews with the CBOs, the literature view, and other findings, the team developed recommendations for managers of TB and HIV programs, CBOs engaged in HIV services, TB and HIV consultants, and teams undertaking similar studies.

Findings and conclusions

All 12 organizations that were selected are client-centered and work with people living with HIV/AIDS (PLWHA) and those at risk of HIV.

While some organizations are small and recently formed, serving populations in a few local government areas, others are large, umbrella organizations that provide health services as well as support—through training and supervision—for smaller organizations across many states.

In spite of differences in their sizes, length of experience, and geographic reach, more than 80 percent of the organizations shared three core competencies: support groups for PLWHA; home-based care; and referrals between tertiary reference centers, primary healthcare facilities, and community support services. The organizations all recruit and manage volunteers who may accompany clients and facilitate and follow-up referrals between different points of care, helping them to find their way through the complexities of treatment and care in different facilities. Addressing stigma is another important element of their work.

The CBOs selected all had good knowledge of TB, its impact on PLWHA, and the risks the disease poses. Their levels of organizational development are noteworthy, and most possess written descriptions of their missions, goals, and objectives. Most have concurrently improved their internal management systems and developed their human resource base. Donor support has helped them to improve the administrative and technical aspects of various interventions, enhancing their ability to plan and monitor activities, recruit and motivate staff and volunteers, and undertake fundraising.

All 12 organizations had some level of engagement in TB/HIV services and in many activities outlined in the WHO *Interim Policy on TB/HIV Collaborative Activities.*[1] The study team had not anticipated this, and had planned to compare the HIV-related organizations engaged in TB/HIV collaborative activities with those who were not so engaged. The team also expected to analyze external and internal factors that might hamper or facilitate their engagement. This analysis was precluded by the involvement of all 12 organizations in TB/HIV activities.

Among the practices or sets of actions currently being undertaken by the 12 CBOs that could accelerate

Community mobilization rally in Kano organized by SWAAN. FHI/NIGERIA PHOTO BY JIDE ADENIYI-JONES.

Potential areas for CBO collaboration in TB/HIV

- Program planning and implementation
- Recruitment and management of volunteers
- Case finding and contact tracing
- Addressing stigma at client, community, and health-services levels
- Social mobilization to encourage symptomatic people to test for TB
- Provision of treatment, care, and support to TB patients as part of home-based care programs
- TB infection control in congregate settings and in the community
- Education of TB patients and counseling them to test for HIV
- Treatment literacy programs for both TB and HIV
- Tracing of treatment interrupters and defaulters
- Record keeping and reporting
- Poverty eradication projects
- Training of community health workers and health professionals
- Supervision and monitoring and evaluation
- Client-centered care
- Referral linkages between clinical and community care

the scale-up TB/HIV collaborative activities, the team considered the following to be the most important:

- referral systems between TB/HIV clinical services and services offered in the community
- client-focused care and support
- use of umbrella organizations
- gender-specific and culturally specific interventions
- implementation of the policy on Greater Involvement of People Living with HIV and AIDS (GIPA)
- volunteer recruitment and retention strategies
- novel approaches to income generation.

Establishing partnerships with CBOs that implement these practices and engaging them in collaborative TB/HIV activities is key to ensuring comprehensive TB/HIV care that extends into the community and includes the families of clients.

Recommendations

For managers of TB and HIV programs

- Map and assess CBOs already involved in HIV/AIDS programming, the services they offer, and their interest and capacity to work in TB/HIV.
- Ensure participation of these organizations in planning at all levels and from the outset, when introducing or scaling up TB/HIV collaborative activities.
- Consider using larger, established umbrella organizations to provide capacity building and supervision of the TB/HIV activities of their networked organizations, and facilitate communication between these networks and national TB and national AIDS programs.
- Consider adopting a methodology to identify additional practices employed by CBOs engaged in HIV/AIDS that support TB/HIV activities and assess the practices identified by this study.
- Closely monitor and assess the HAST model and its feasibility for rapid scale-up.
- Develop close partnerships with organizations that work successfully with volunteers, assess their needs, and include in the planning process the mobilization of resources to support these needs.
- Pay careful attention to TB infection control, a paramount consideration when negotiating appropriate roles and responsibilities for engaging volunteers.
- Develop a comprehensive strategy to address stigma.

For community-based organizations engaged in HIV/AIDS

- Ensure that TB forms part of the HIV/AIDS services in clinics and community settings and that client–centered activities by CBOs contribute to intensified case-finding and TB infection control.
- Use networks of volunteers to assist the national TB program in providing default tracing and DOT to dually infected clients.
- Actively pursue participation on TB/HIV coordinating bodies at all levels to synchronize and improve community-level TB and HIV control programs.
- If an umbrella organization, pursue partnerships that help to coordinate, plan, implement, and oversee TB and TB/HIV activities. In addition, advocate on behalf of CBO constituencies on coordinating bodies.
- Partner with local and state TB control programs to ensure a coordinated approach and feedback in both directions.

- Work with local partners to integrate appropriate, culturally sensitive TB messages into current community awareness and social mobilization activities.
- Advocate for common services points to ensure optimal patient care and lessen the burden of referral services for clients, health providers, and CBOs.
- Take part in operational research on stigma and advocate for strategies that address it.

For TB and HIV consultants

- Be aware of the potential roles that CBOs can play in scaling up TB/HIV activities. Become familiar with international and national policies and guidelines relating to engaging communities and those related to engaging them in TB and HIV activities.
- Assist the national TB program to map and assess the capacities of CBOs and to evaluate the state of readiness of clinical services to engage these organizations in TB/HIV services.
- Provide technical assistance to build the capacity of CBOs in TB/HIV activities. If necessary, mobilize funds to support this activity.
- Support efforts of the national TB program and national AIDS programs to measure the quality and effectiveness of CBO engagement, balancing the need for data and overstretched health services. The CBOs should be engaged throughout this process.
- Explore with national programs the extent of stigma and how to address it.

For teams conducting similar studies

- Consider the inclusion on the study team of staff of national TB and HIV programs and individuals who can influence policy.
- Involve team members in adapting and pilot-testing questionnaires to ensure ownership of the process and that appropriate questions are asked.
- Invite all major technical partners that support TB and HIV programs to stakeholder workshop at the beginning of the study and to participate in the debriefing.
- Consider next steps that assess the extent and quality of collaborative services provided by CBOs and the impact of these activities. Allocate time and resources to gather and analyze data that often exist in many locations.
- Plan for and publish the results of the study in peer-reviewed journals.
- Consider adding to the list of the CBO practices highlighted by this study and help decision-makers determine the kinds of community-based activities that should be pursued in going to scale.

Notes: Executive Summary

1. World Health Organization, Interim Policy on TB/HIV Collaborative Activities (Geneva: WHO, 2004) http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330.pdf

Background: Country Information

TB and HIV in Nigeria

Nigeria was chosen for this study because of its important TB and HIV epidemics. The country ranks fifth among 22 with high TB burden, with an estimated incidence of 311 TB cases per 100,000 population (table 1).[1] Nigeria is also considered to be a "next wave" country at a critical point in its HIV/AIDS epidemic.[2] Among its population of 148 million, an estimated 2.6 million are living with HIV/AIDS, and HIV prevalence within the 15–49 age group is estimated at 3.1 percent.[3]

In Nigeria, as in other countries, HIV is responsible for increasing active TB cases and rapid disease progression.[4] Nearly 20 million people are living with HIV worldwide, and as many as one-third are co-infected with TB. A majority of TB cases in PLWHA occur in sub-Saharan Africa, where up to 80 percent of TB patients may be co-infected with HIV.[5] Several African countries have seen their TB caseloads increase by as much as 200–300 percent over the past decade, and new patients with TB have levels of HIV prevalence of 50 percent or higher.[6]

Within this context, Nigeria—the most populous country in Africa—faces the formidable task of ensuring country-wide availability of comprehensive, high-quality, client-oriented, TB/HIV services. Within its federal system, states are responsible for secondary healthcare, and all 37 have adopted TB directly observed treatment short-course (DOTS). Its 774 local government areas (LGAs) are responsible for primary care, and 90 percent of them are implementing the DOTS strategy.[7]

States where the study team interviewed CBOs

Table 1. TB Statistics, Nigeria[a]

Rank among 22 high TB-burden countries, 2008	5
Estimated incidence (all cases/100,000 pop/yr)	311
Estimated number of new TB cases, 2006	450,079
DOTS population coverage	75%
Incidence (ss+) 100,000 pop/yr	137
DOTS case detection rate, new ss+, 2007	31%
DOTS treatment success rate, 2007	79%
TB cases (new and retreatment) tested for HIV	10%
HIV-positive of those tested	21–27%
Of new TB cases, % with MDR-TB	1.9%
Of previously treated TB cases, % with MDR-TB	9.3%

In spite of increased political commitment, Nigeria's progress on TB control has been slow. Access

Table 2. DOTS Expansion in Nigeria, 2001–07[b]

	2001	2002	2003	2004	2005	2006	2007	OPTIMAL
States with DOTS	21	27	36	37	37	37	37	**37**
% of optimal number	56.8%	72.9%	97.3%	100%	100%	100%	100%	
LGAs with DOTS	350	380	440	505	548	650	701	**774**
% of optimal number	45%	49%	56.8%	65.2%	70.8%	83.9%	90.5%	
Microscopy centers	417	437	493	547	592	694	796	**1,440**
% of optimal number	29%	30%	34%	38%	41%	48%	55%	
Treatment centers	1,605	1,665	1,725	1,929	2,015	2,219	2,321	**5,760**
Coverage (millions)	50 m	55 m	70.4 m	80 m	85 m	90 m	100 m	**144 m**

to services is still sub-optimal by World Health Organization (WHO) standards (table 2). Of estimated total TB cases, only 32 percent are being detected and 79 percent of these cases have been successfully treated—still far below the WHO targets of 70 percent and 85 percent, respectively.[8] TB case notifications have continued to increase since 1995, and relatively high case rates among young adults may reflect a real increase in incidence associated with HIV and important continuing transmission.

Community-based DOTS (CB-DOTS), known in Nigeria as Community TB Control (CTBC), is only recently developed as a strategy for expanding and improving DOTS, and its implementation in selected LGAs is just underway. Challenges faced by the National TB and Leprosy Program (NTLCP) include recent drug distribution problems resulting in important stock-outs. Limited coverage of smear microscopy services has also hampered expansion efforts.[9]

Recent efforts have been made to expand HIV/AIDS services (table 3). A National AIDS Action Committee was established in 2000, and the federal government developed a HIV/AIDS strategic plan for 2005–09.[10] Between 2005 and 2007, the number of clinics providing antiretroviral treatment (ART) grew from 35 to 240.

A National TB/HIV Task Force has been put in place with broad representation from the NTLCP, the National AIDS Program (NAP), and other key stakeholders. Policies and guidelines have been prepared and are being scaled up through many implementing partners. Donors who support these efforts include the UK Department for International Development (DFID), the Canadian International Development Agency (CIDA), the US Agency for International Development (USAID), the WHO, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). The NTLCP coordinates partnership activities and the technical assistance funded by donors.[11]

Progress toward integrating services and increasing collaboration between HIV and TB programs has been slow, hampered by human and financial resource shortages and lack of political will.[12] Separate traditions and practices are also a consideration. On one hand, TB programs are characterized by firmly established algorithms and standardized measures and outcomes, and they are designed to treat large numbers of patients with few resources. On the other hand, HIV prevention, treatment, and care are characterized by a patient-centered approach and rapidly evolving treatment paradigms: ART regimens need frequent revisions of treatment guidelines and need to be intensively monitored for efficacy and toxicity over a patient's lifetime.[13]

Challenges to TB/HIV scale-up in Nigeria include lack of funding and difficulties in harmonizing partners' efforts. Coordinating bodies have not been rolled out to the LGA level, and

Table 3. HIV/AIDS Service Expansion in Nigeria, 2007[c]

INTERVENTION	# SITES	# CLIENTS, JAN.	# CLIENTS, AUG.	# CLIENTS, SEPT.
HCT	647 (incl. mobile services)	605,364	768,563	1,437,655
PMTCT	263	300,100	309,641 for HCT 12,993 for ART	486,330 for HCT 17,786 for ART
ART	240	108,572	168,447 (6,114 children)	182,512 (10,282 children)

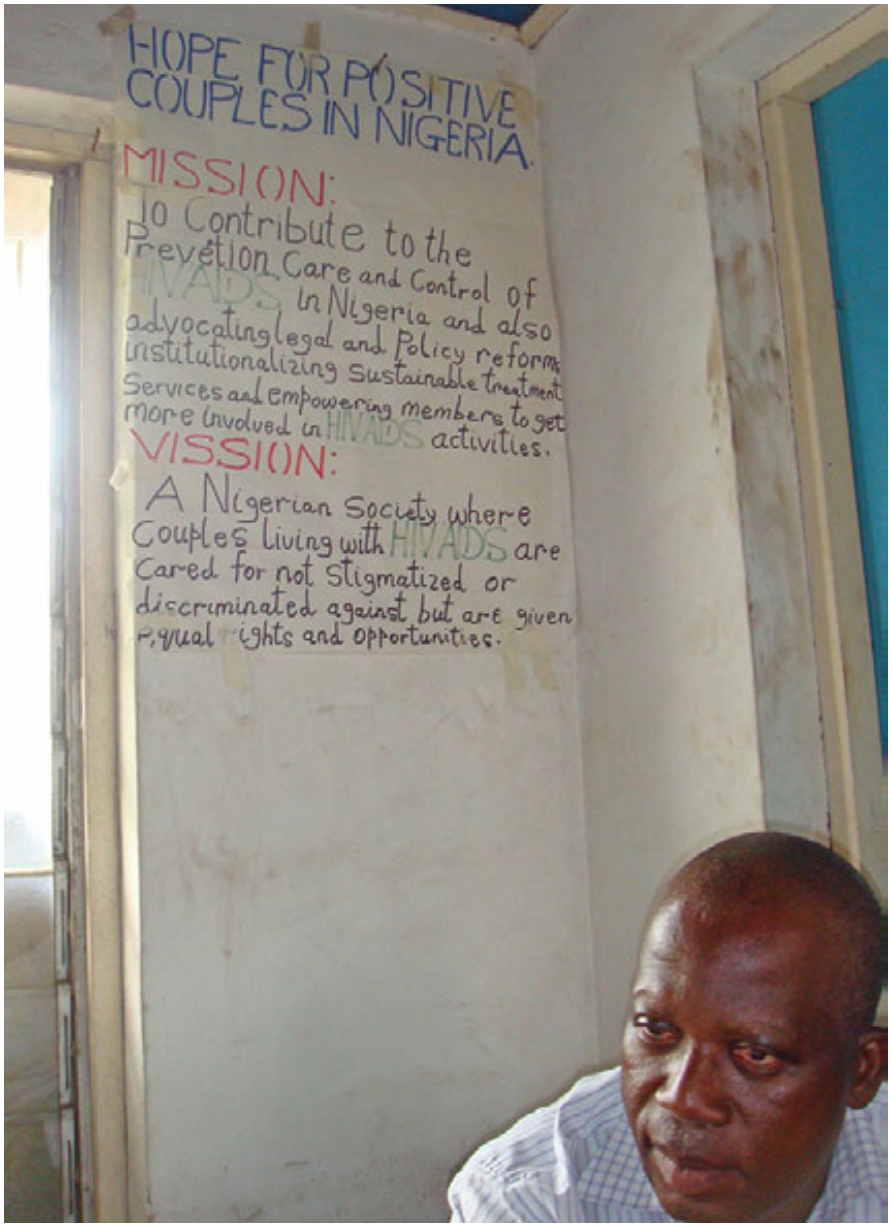
referral systems between programs are weak. In addition, there is very low implementation of TB infection control (IC), and supervisory systems are lacking at all levels.

The role of CBOs in TB/HIV services

The WHO has formulated recommendations on TB/HIV collaboration and integration, which, together with the Stop TB Strategy, highlight the importance of community involvement in TB and TB/HIV services.[14] Much has been said about involving communities as a cost-effective strategy to scale up quality TB programs and HIV services.[15] In spite of a consensus that community involvement is a cost–effective strategy to scale up quality TB programs and enhance the coordination and integration of TB/HIV activities,[16] a literature review found few articles that describe specific examples of this community engagement and their outcomes. Though several successful TB/HIV projects involving CBOs are reported in the grey literature,[17] few publications discuss the issue more broadly.

As the HIV/AIDS epidemic enters its 26th year, CBOs have become important partners in the response in every affected country and are engaged in diverse activities from prevention to palliative care. Moreover, support for an increased role for them in implementing national strategies—one that extends to equal partnership—will be reflected in new GFATM funding opportunities for civil society.[18]

In many countries, a significant proportion of healthcare is provided through CBOs, NGOs, and faith-based organizations (FBOs), whose collaboration with public health systems can vary greatly. Many of



Hope for Positive Couples, an NGO in Ibadan, Oyo State.
PHOTO BY DR. BABA GANA ADAM.

the important barriers that interrupt or prevent good treatment, care, and prevention of TB and HIV arise in communities and at home and need to be addressed in these contexts. Well-documented examples include stigma; fears based on myths and misunderstanding about TB and HIV/AIDS; gender and power imbalances; services that are not co-located; long distances to clinic sites for clients and long waiting times; and lack of funds for transportation, laboratory tests, and preventive measures such as condoms.[19]

CBOs, NGOs, and FBOs (hereafter, for the most part, referred to collectively as CBOs) can often address barriers that may be beyond the reach or resources of health providers. Their coordinated involvement can contribute importantly to accelerating the achievement of national targets for HIV and TB diagnosis, treatment, and care.[20] The increased

Table 4. TB/HIV Activities Undertaken in Nigeria[d]

INDICATOR	2006	2007
Cumulative no. of state TB/HIV working groups	6	12
Cumulative no. of TB-DOTS centers implementing TB/HIV collaborative activities	36	90
No. of ART sites implementing TB/HIV collaborative activities*	6	22
No. of TB-DOTS staff trained as counsellors	72	112
No. of TB-DOTS, ART, and support group staff trained to implement TB/HIV collaborative activities	96	122
No. of lab staff trained to implement TB/HIV collaborative activities	36	18
No. of state TB and HIV/AIDS program managers trained	12	12

involvement of CBOs in collaborative TB/HIV activities is crucial; these organizations constitute an untapped yet potentially very important avenue to scale up TB/HIV services.[21] Greater involvement by governments is required to increase CBO involvement, not only in formulating policies and comprehensive plans but also in coordinating the efforts of donors and service providers.[22]

Table 4 summarizes activities supported by the Federal Ministry of Health and partners to expand TB/HIV services. Community-based support groups were selected to assist the introduction and implementation of TB/HIV collaborative activities, with the aim of enhancing linkages between DOTS centres, ART sites, and the support groups. However, no further detail was provided on how this was done or how information on CBO involvement will be collected and reported. ■

Scene at a community mobilization rally in Kano. FHI/NIGERIA PHOTO BY JIDE ADENIYI-JONES.

Notes: Background

1 World Health Organization, WHO report 2005. Global tuberculosis control: surveillance, planning, financing (Geneva: WHO, 2005) <www.who.int/tb/publications/global_report/2005/en/index.html>

2 National Intelligence Council, The next wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China. Intelligence community assessment, Sept. 2002 <www.dni.gov/nic/PDF_GIF_otherprod/HIVAIDS/ICA_HIVAIDS20092302.pdf>

3 UNAIDS, Nigeria UNGASS report 2007 (Geneva: UNAIDS, 2008) <http://data.unaids.org/pub/Report/2008/nigeria_2008_country_progress_report_en.pdf>

4 Corbett EL, Marston B, Churchyard GJ, De Cock KM, Tuberculosis in sub-Saharan Africa: opportunities, challenges, and change in the era of antiretroviral treatment, Lancet 367, 9514 (Mar 18 2006):926-937 <www.ncbi.nlm.nih.gov/pubmed/16546541>; Bates I, Fenton C, Gruber J et al, Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part 1: determinants operating at individual and household level, Lancet Infect Dis, 4, 5 (May 2004):267–77.

5 Forum for Collaborative HIV Research, HIVMA, and Infectious Diseases Society of America, HIV/TB coinfection: Basic facts, October 2007 <www.idsociety.org/uploadedFiles/IDSA/Resources/Fact_Sheets/HIV_TB_Coinfection_Oct_2007.pdf>

6 De Cock KM, Chaisson RE, Will DOTS do it? A reappraisal of tuberculosis control in countries with high rates of HIV infection, Int J Tuberc Lung Dis 3(1999):457–65 <www.ncbi.nlm.nih.gov/pubmed/10383056?dopt=Abstract>

7 World Health Organization, The World Health Report 2007—A safer future: global public health security in the 21st century (Geneva: WHO, 2007) <www.who.int/whr/2007/whr07_en.pdf>

8 van der Grinten E, Oyama E, A desk study TB-CAP. Nigeria. September 2008 (unpublished); Global Fund to Fight AIDS, Tuberculosis and Malaria, Grant performance report: scale up of comprehensive HIV and AIDS treatment, care and support, Nigeria, August, 2008 (Geneva: GFATM, 2008) <www.theglobalfund.org/search/docs/5NGAH_1180_515_gpr.pdf>

9 Nigeria, Federal Ministry of Health and National TB/HIV Working Group, Draft report on 2007 TB/HIV collaborative activities in Nigeria, 2007 (unpublished).

10 Nigeria, National Action Committee on AIDS, HIV/AIDS national strategic framework for action (2005–2009) (Abuja: Government of Nigeria, 2005). <www.naca.gov.ng/index.php?option=com_content&task=view&id=80&Itemid=118>

11 US Agency for International Development, USAID assistance to Nigeria, fact sheet (Washington, DC: USAID, 2008) <www.usaid.gov/press/factsheets/2003/03fs_nigeria.html>; Nigeria, Federal Ministry of Health and National TB/HIV Working Group, Draft report on 2007 TB/HIV collaborative activities, op cit; van der Grinten E, Oyama E, A desk study TB-CAP, op cit.

12 Nunn P, Reid A, De Cock K, Tuberculosis and HIV infection: the global setting, J Infec Dis 196, Suppl 1 (2007): S5–S14 <www.journals.uchicago.edu/doi/abs/10.1086/518660>; Tsiouris SJ, Gandhi NR, El-Sadr WM, Friedland F, Tuberculosis and HIV—needed: a new paradigm for the control and management of linked epidemics, Med Gen Med 9(3) 2007: 62 <www.iasociety.org/Web/WebContent/File/Tuberculosis%20and%20HIV.pdf>;

13 Tsiouris SJ, Gandhi NR, El-Sadr WM, Friedland F, Tuberculosis and HIV, op cit.

14 World Health Organization, Interim policy on TB/HIV collaborative a¡ctivities, op cit; UNAIDS and Stop TB Partnership. Fight AIDS, fight TB, fight now, op cit.

15 World Health Organization, Community TB care in Africa. Report on "lessons learned" meeting in Harare, Zimbabwe, 27-29 September 2000 (Geneva: WHO, 2001) <http://www.afro.who.int/tb/res-pub/community_tb_care_in_africa.pdf>; World Health Organization, Community contribution to TB care: practice and policy: review of experience of community contribution to TB care and recommendations to national TB programmes (Geneva: WHO, 2003) <http://whqlibdoc.who.int/hq/2003/WHO_CDS_TB_2003.312.pdf> ; World Health Organization, Report of a "lessons learnt" workshop on the six ProTEST pilot projects in Malawi, South Africa and Zambia, 3-6 February 2003 (Geneva: WHO, 2004) <http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.336.pdf>; World Health Organization, Interim Policy on TB/HIV Collaborative Activities, op cit; Creese A et al, Cost-effectiveness of HIV/AIDS interventions in Africa: a systematic review of the evidence, Lancet 359, 9318 (May 11, 2002):1635-43.

16 The WHO reported in 2004 on eight pilot studies in six countries in sub-Saharan Africa that demonstrated that community-based TB care is a "feasible, acceptable, effective, and cost-effective way to deliver TB DOTS services." World Health Organization, Report of a "lessons learnt" workshop on the six ProTEST pilot projects, op cit.

17 Wandwalo E, Kapalata N, Tarimo E, Corrigan CB, Morkve O, Collaboration between the national tuberculosis programme and a non governmental organisation in TB/HIV care at a district level: experience from Tanzania, African Health Sciences 4, 2 (August 2004): 109–14 <www.cababstractsplus.org/google/abstract.asp?AcNo=20053191790>; Kereta W, Gebreselassie G, Gebremedhin H, Stuer F, Waites BA, Involving HIV/AIDS volunteer home-based care providers through community-based organizations to strengthen TB control in Addis Ababa, Ethiopia, The XV International AIDS Conference, abstract no. TuPeD5213, July 2004. <www.skillsbuilding.org/Abstracts/A2169319.aspx>

18 Mathai R, Galbraith J, Faith-based leadership in effective HIV/AIDS program delivery: Improving access to treatment through church health institutions and parish networks in Africa, India and the Caribbean, 15 Int Conf AIDS (2004), abst. no. MoPeE4292 <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102280571.html>; Swannepha, TN, Promoting implementation of WHO's Policies on collaborative TB/HIV activities. Lessons learned from PLWH Groups in Côte d'Ivoire, Nigeria, Swaziland and Uganda. Presented on behalf of partners in RCI, Nigeria and Uganda, HIV/AIDS implementers meeting, Uganda, June 6, 2008 <www.hivimplementers.com/pdf/H6/H6_515_PEREZ%20SUE.pdf>

19 International HIV/AIDS Alliance, Shift in HIV/AIDS project funding required. Press release, 6 Dec. 2007 <www.aidsalliance.org/sw51811.asp>

20 International HIV/AIDS Alliance, Community engagement for universal access, 2007 <www.aidsalliance.org/graphics/secretariat/publications/What_is_community_engagement_for_ARV_treatment.pdf>

21 World Health Organization, Community contribution to TB Care, op cit; World Health Organization, Report of a "lessons learnt" workshop on the six ProTEST pilot projects, op cit; World Health Organization, Interim policy on TB/HIV collaborative activities, op cit; World Health Organization, The Stop TB Strategy. Building on and enhancing DOTS to meet the TB-related millennium development goals (Geneva: WHO, 2006) <http://whqlibdoc.who.int/hq/2006/WHO_HTM_STB_2006.368_eng.pdf>; World Health Organization, Community involvement in tuberculosis care and prevention: towards partnerships for health. Guiding principles and recommendations based on a WHO review (Geneva: WHO, 2008) <http://whqlibdoc.who.int/publications/2008/9789241596404_eng.pdf>; RESULTS, The US President's Emergency Plan for AIDS Relief: Achieving impact through scale up of TB-HIV activities (Washington, DC: RESULTS Educational Fund, 2007) <www.results.org/website/download.asp?id=2808>; Wandwalo E et al, Collaboration between the national tuberculosis programme and a non governmental organisation in TB/HIV care, op cit.

22 World Health Organization, Interim policy on TB/HIV collaborative activities, op cit.

Notes: Tables

a World Health Organization, WHO report 2008: Global tuberculosis control: surveillance, planning, financing (Geneva: WHO, 2008) <www.who.int/tb/publications/global_report/2008/en/index.html>. DOTS case detection rate and treatment success rate are from van der Grinten E, Oyama E, A desk study TB-CAP Nigeria (unpublished, 2008). Data on the percentage HIV-positive among those tested are from Nigeria Federal Ministry of Health and National TB/HIV Working Group, Draft report on 2007 TB/HIV collaborative activities in Nigeria (unpublished. 2007); and from Family Health International, HIV/AIDS, sexually transmitted infections, and tuberculosis (HAST) model of community TB care: Project assessment of Yakurr Local Government Area, Cross River State (unpublished, 2008). There is no information on co-trimoxazole preventive therapy (CPT) or antiretroviral treatment for TB patients.

b Nigeria Federal Ministry of Health and National TB/HIV Working Group, Draft report on TB/HIV collaborative activities, op cit, and WHO 2008b for CDR. The calculation of the expected number of treatment centers is based on one center per 25,000 persons. Global Fund to Fight AIDS, Tuberculosis and Malaria, Grant performance report: scale up of comprehensive HIV and AIDS treatment, care and support, Nigeria, August, 2008 (Geneva: GFATM, 2008) <www.theglobalfund.org/search/docs/5NGAH_1180_515_gpr.pdf>

c Nigeria Federal Ministry of Health and National TB/HIV Working Group, Draft report on TB/HIV collaborative activities, op cit, and World Health Organization, WHO report 2008: Global tuberculosis control, op. cit.

d Data are from Nigeria Federal Ministry of Health and National TB/HIV Working Group, Draft report on TB/HIV collaborative activities, op cit. The following TB/HIV collaborative activities are supported by the Federal Ministry of Health in selected health facilities in these 12 states: quarterly meetings of the national and state TB/HIV working groups; situational analyses to identify health facilities and health workers for implementation, including identification of training needs; capacity building for health workers from DOTS centers in HIV testing and counseling for all TB suspects and patients; capacity building for health workers from ART sites and selected members of community support groups to implement TB/HIV collaborative activities and enhance linkages between DOTS centers, ARV sites, and community support groups; procurement and distribution of HIV test kits for TB suspects and patients; CPT for TB-HIV co-infected patients at DOTS centers; supervision, monitoring, and evaluation of TB/HIV collaborative activities in the states; and renovation of selected DOTS facilities.

The Case Study: 12 CBOs in Nigeria

Given the urgent need to increase the involvement of CBOs in scaling up services that address the dual epidemic, this case study set out to examine how 12 CBOs in Nigeria working in HIV/AIDS prevention, care, and treatment are and can be engaged in TB/HIV collaborative activities. It attempted to identify the characteristics of the selected CBOs and their core competencies and to draw conclusions on factors intrinsic and extrinsic to the organizations that may help or hinder their implementation of collaborative TB/HIV activities at the community level. The overarching goal was to determine how community and CBO engagement in TB/HIV control—particularly the engagement of CBOs working in HIV/AIDS programs—might be increased and shed light on how communities could be further involved in the scale-up TB/HIV collaborative activities.

The target audience for this study includes policymakers, TB and HIV program managers, consultants to such programs,[1] and CBOs. The study recommendations may also be of value for other projects and governments that are working to take TB/HIV collaborative activities to scale and improve the quality of life of individuals affected by TB and HIV.

The study team and its methodology

The study team comprised one senior international TB consultant and three Nigerian professionals: a state-level TB and leprosy coordinator; the deputy director of the National TB Training Institute; and the executive director of the Society for the Prevention and Eradication of Tuberculosis in Nigeria (SPETBN), who serves on executive committee of the GFATM Country Coordinating

A PLACO volunteer caregiver assists a client in his home in a village in Kano State.
FHI/NIGERIA PHOTO BY JIDE ADENIYI-JONES.

Mechanism (CCM) and chairs its Grant Performance Task Team.

During the initial phase, the study team benefited from the expert opinions provided by the TB CAP technical advisory group from FHI, the Union, and KNCV. Input was also derived from key stakeholders in Nigeria, including experts from GHAIN, the WHO, and TB CAP.

A literature review used the database Medline and the browser Google Scholar to search for the following keywords: TB/HIV, treatment, scale up, home-based care, community care, CBO, civil society, and collaborative activities. References cited in key articles and documents produced by the US President's Emergency Plan for AIDS Relief (PEPFAR) were examined. Websites that addressed best practices were scrutinized, and websites of well-known organizations were investigated for program information on TB/HIV collaborative activities.

The study team also examined the HAST model, which engages CBOs and their volunteers in integrated TB/HIV activities. Recently developed and supported by the FHI-led GHAIN program, the model is owned and implemented at LGA levels. CBO volunteers are attached to primary healthcare facilities, and CBOs are represented on multistakeholder HAST committees that draft work plans detailing where new integrated services should be located and how many people should be trained. The HAST committees and their work plans make extensive use of collaborative rapid assessments, initiated and funded by GHAIN, that identify public and private service-provision points within the LGA and supply extensive KAP and health management information system data.

Senior staff from GHAIN and from WHO/Nigeria participated in selecting the 12 CBOs working in HIV/AIDS that were studied (annex 1). Half of them were expected to have experience with TB/HIV activities. The organizations varied in size and geographic coverage and operated in four states—Oyo and Osun in the south west, Cross River in the south east, and Kano in the north. GHAIN provided the necessary logistic support for the study team, since the initiative is scaling up integrated TB/HIV activities in these states. Even more importantly, GHAIN facilitated entry into communities and helped to organize meetings with LGA staff and key stakeholders.

The literature review, the 2004 WHO *Interim Policy on TB/HIV Collaborative Activities*, and other technical frameworks contributed to 56 variables that were integrated into a questionnaire that the study team devised to capture characteristics and core competencies of the 12 organizations (annex 2). These sources also contributed to the team's identification of internal and external

Table 5. Characteristics of CBOs Interviewed, Areas of Practice and Core Competencies, and Internal and External Factors that May Affect Their Engagement in TB/HIV Activities

COMMUNITY-BASED ORGANIZATION ENGAGED IN THE RESPONSE TO HIV/AIDS	NO. OF VARIABLES
Characteristics Type; function; geographic size; coverage; umbrella organization; length of time in the community; level of interventions; work with volunteers and/or peer educators	10
Areas of practice and core competencies Capacity building for individuals, groups, or other organizations; advocacy; community awareness; social mobilization; stigma reduction; support groups to PLWHA; HCT; home-based or palliative care; clinical care; skills transfer for PLWHA; referral mechanisms; research, IEC; focus on special populations; legal support; small grants management; clinical care; income-generation for clients; orphans and other vulnerable children; gender and women's rights	22
Internal factors Organizational and management practices, including access to financial and human resources and M&E; types of services delivered; volunteer recruitment and management; internal policies on TB/HIV; knowledge of national TB/HIV policies; knowledge of TB and interaction between TB and HIV; linkages with NTP and NAP; knowledge of health-seeking behavior, stigma, KAP studies of health care workers	12
External factors National policies on CBO/NGO engagement in general and in TB/HIV specifically; CBO involvement in planning at all levels; delivery of health services in the community; access to technical assistance; mechanisms of collaboration; access to funding; training opportunities; availability of and access to IEC materials in TB/HIV; involvement of partners in joint planning; information on health-seeking behaviors of catchment populations; knowledge of TB/HIV among health workers	12
TOTAL	56

A community meeting in Kano. PHOTO BY DR. BABA GANA ADAM.

factors that could hamper or support CBO implementation of collaborative TB/HIV activities (table 5).

The questionnaire was piloted with three CBOs in Oyo State and one in Osun State. Since only minor changes were made, the results were retained. All team members participated in pilot interviews and agreed on most appropriate approach for future interviews: certain questions would be open-ended, and respondents would be prompted only if they provided no response. Respondents would also be encouraged to ask questions if they needed clarification at any time. At the end of each interview, respondents were invited to respond to questions that attempted to elucidate their perceptions of barriers to scaling up TB/HIV services more broadly. The involvement of all team members in the further elaboration of the questionnaire, pilot-testing, and the interview methodology helped to ensure ownership of the process and appropriate questions.

After the pilot-testing, two two-person teams interviewed representatives from four CBOs in Kano and Cross River between March 12 and 28, 2008. A written statement had been developed by and for team members to guide introductions. Care was taken to assure the CBOs that their activities were not being assessed or evaluated. Instead, they had an opportunity to learn more about their own work and some of the challenges they face.

The lengthy questionnaire developed by the team was filled in during each interview, results entered into an electronic version, and subsequently compiled into a master template Excel file by one team member. Data cleaning was done at each transfer, and the final data were reviewed and cross checked for any missing information. Written profiles provided by the CBOs supplemented the information gathered during interviews.

Sets of CBO activities were reviewed in light of the well-recognized need to engage the community in expanding access to quality services and through the lens of a definition of a practice developed by Advance Africa: “a specific action or set of actions within a program or activity that is consistently used in response to a problem or identified need.”[2] The team attempted to determine the CBO practices that might be employed to introduce or scale up TB/HIV collaborative activities, taking into consideration whether these practices were innovative, sustainable, and replicable, and if their success might be context-specific.

Billboard in Ibadan, Oyo State. PHOTO BY DR. BABA GANA ADAM.

Study limitations

That some key stakeholders were not available at the beginning of the study period may have limited their influence and contributions. Important international technical partners from International Federation of Anti-Leprosy Associations (ILEP) who provide support to the NTLCP were not interviewed, perhaps an oversight in the study design.

The study obtained a snapshot of different kinds of CBOs in different locations in Nigeria. Time and funds limited interviews to 12 in four states, and it may not be possible to generalize results to the rest of the country.

Though the criteria for selection should have resulted in an equal number of organizations undertaking any or no TB/HIV collaborative activities, this was not the case. All 12 organizations were so engaged, and this precluded a comparative analysis. However, the CBOs selected offered opportunities to examine the depth and breadth of activities that the organizations are undertaking.

Although several mechanisms are in place to coordinate national and donor programs, the team did not research the degree to which coordination is occurring. In addition, the study team did not investigate systematically the barriers being encountered by CBOs implementing collaborative activities. Instead, the CBOs were asked to comment on barriers to scaling up TB/HIV collaborative activities that similar organizations might encounter. ■

Notes: Case Study

1 For the purposes of this study, TB and HIV consultants are experts who provide technical support to national TB and/or HIV programs and to CBOs.

2 Torres, Mercedes, Advance Africa Project: best practices final report (Arlington, Va.: Management Sciences for Health, 2005) <http://pdf.usaid.gov/pdf_docs/PDACF704.pdf>

CBOs Interviewed: Characteristics, Core Competencies, and Engagement in TB/HIV Activities

Characteristics

The 12 organizations selected for the study are private and not-for-profit. All are registered: four at the national level, nine at state level, and three at LGA level (see annex 1). Seven described themselves as CBOs, one as an FBO, and four as NGOs; one of these is a local branch of a national NGO.

The organizations have been working in HIV/AIDS for between 1 and 17 years (five for more than 10 years and four for between 5 and 10 years). All stated that they have plans for expansion, but only one suggested that this was contingent on funding levels.

Two of the organizations are national in scope, two intervene at the regional level (several states in the south west), and all provide services that usually cover the populations of several LGAs. Four described themselves as "umbrella organizations" that support smaller organizations in the same state or within a region, in addition to the services they provide for local populations. Another large NGO provides consultation services to other institutions and organizations, but did not consider itself to be an umbrella organization. One of the larger umbrella NGOs supports as many as 50 smaller organizations across several states.[1] Four smaller CBOs are part of the umbrella organizations interviewed.

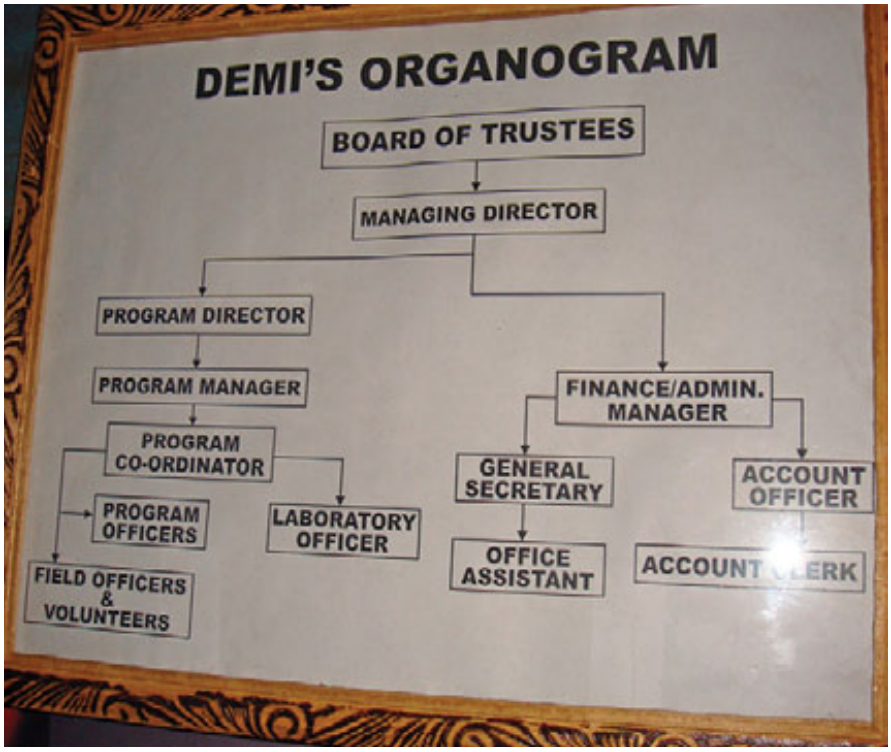
Only one large umbrella organization reported that it participates in meetings of TB/HIV coordinating bodies at state and LGA levels. With one exception, all organizations are members of state action committees on AIDS.

A SWAAN hotline volunteer. FHI/NIGERIA PHOTO BY JIDE ADENIYI-JONES.

Through their referral activities, all organizations have linkages with health facilities that provide TB services. All belong to various HIV/AIDS networks—for example, four to the Network of People Living with HIV/AIDS in Nigeria (NEPHWAN) and five to CiSHAN. Two organizations belong to the network of Damien Foundation Belgium (DFB) that works in TB.

Organization and management of CBOs

With donor assistance, most of the CBOs have improved their governance structures and operations and concurrently developed their human resource base. The CBOs—especially those long established in their communities and the umbrella organizations—had quite well defined governance structures, and most possessed lists of current and past activities or projects. Nine of the organizations seemed



Example of an organogram developed and implemented by a local CBO, Oyo State. PHOTO BY DR. BABA GANA ADAM.

to possess components of good management: paid staff, planning, internal supervision, and capacity for resource mobilization and monitoring and evaluation (M&E). The three that did not fulfill these criteria had no paid staff, though they managed a cadre of volunteers. The quality and effectiveness of the management components were beyond the scope of the study.

The team found that CBO mandates were enshrined in vision and mission statements, goals and objectives, and in descriptions of strategic approaches to achieve goals. Three organizations said they were familiar with national policies and current guidelines on collaborative TB/HIV activities, although none could produce copies of these documents. Organizations that have been working for many years with DFB are familiar with its policies on TB/HIV and possess protocols and algorithms for TB/HIV collaborative services.[2]

Ten organizations have policies to engage PLWHA on staff or as volunteers, although these policies may be unwritten. Two stated specifically that they adopted GIPA as guidance for their hiring policies. Only two stated they have an HIV/AIDS workplace policy, and one described educational materials on HIV/AIDS that had been provided to staff for that purpose.

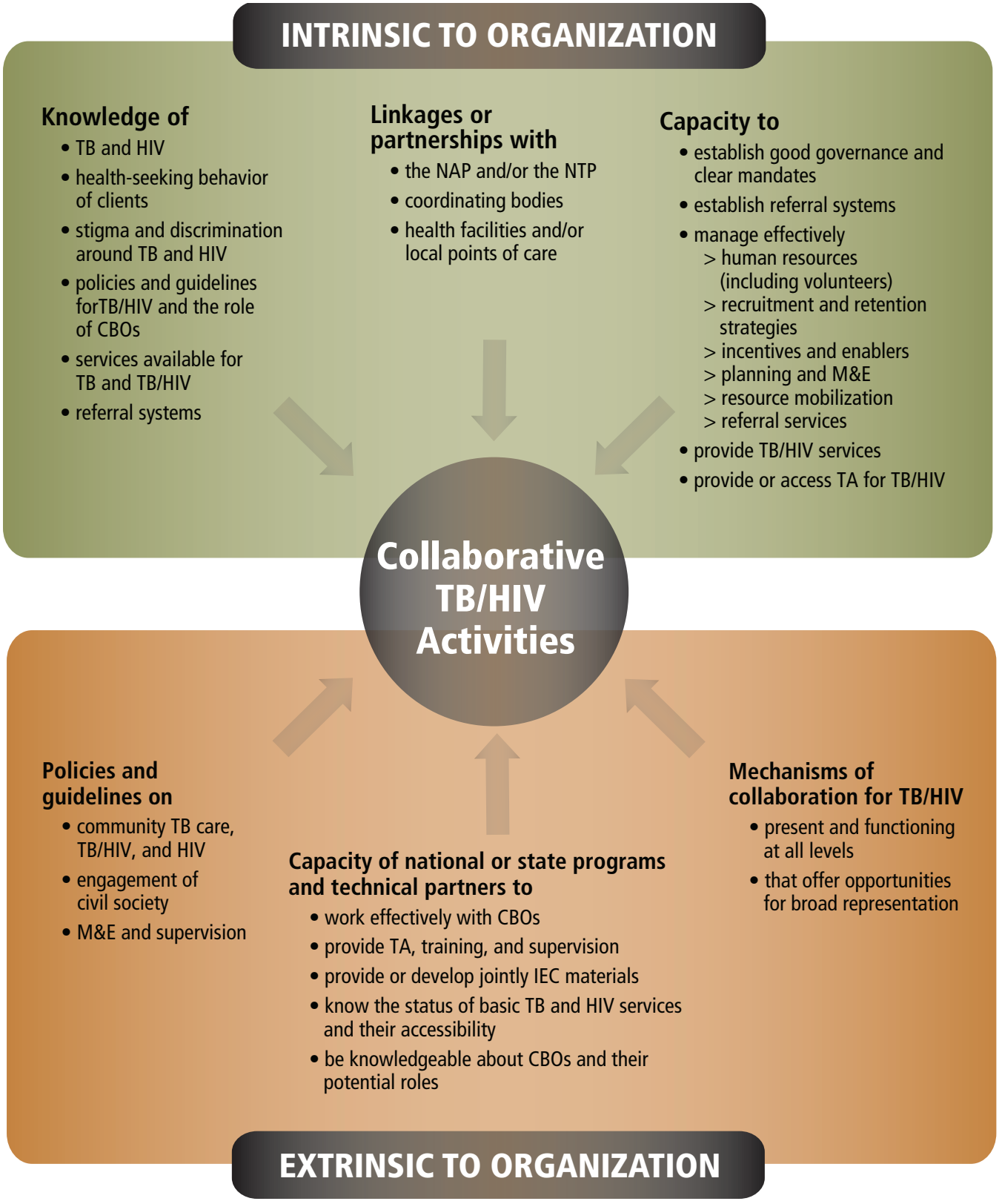
Three organizations provided copies of annual plans that outlined objectives, activities, time lines, and persons responsible for meeting objectives. All responded that internal supervision occurs on a regular basis, but with little detail about it beyond regular meetings with staff. One CBO suggested that supervision was accomplished through the board of trustees, and four reported "internal audits" as part of internal supervision.

Nine of the CBOs have paid staff with specific managerial responsibilities and technical expertise. Six of the organizations have dedicated M&E officers or at least part-time staff whose time is dedicated to M&E. These staff use a variety of tools, depending on the activity and the donor, and indicators are often based on project-specific requirements. Some tools are improvised, including handmade wall charts that keep track of activities and the number of clients receiving care. However, in two sites where DFB operates in partnership with the CBOs, standard records, registers, and reporting formats are used to capture TB/HIV information. In sites implementing the HAST model, new referral formats are used, along with state recording and reporting formats.

All staff work with full-time or part-time volunteers who carry out most of the organization's activities. The number of volunteers depended on the CBO's size and reach, and ranged from 5 to more than 200.[3] Some volunteers are considered to be community leaders and have paid employment elsewhere, and some have opted for a volunteer position in the hope that a paid one becomes available.

The recruitment process for volunteers varies greatly. Some organizations actively recruit during presentations at church functions or community mobilization efforts, while others place advertisements in local papers. Passive recruitment also occurs when attendees at CBO events ask to join the organization. Few organizations referenced a formal screening process for volunteers.

Most organizations said their senior staff train and mentor volunteers. None of the CBOs provide volunteers with financial remuneration, though all but two report volunteer incentives that may include a small stipend or vouchers to cover transportation


INTRINSIC TO ORGANIZATION
Knowledge of
• TB and HIV
• health-seeking behavior of clients
• stigma and discrimination around TB and HIV
• policies and guidelines forTB/HIV and the role of CBOs
• services available for TB and TB/HIV
• referral systems
Linkages or partnerships with
• the NAP and/or the NTP
• coordinating bodies
• health facilities and/or local points of care
Capacity to
• establish good governance and clear mandates
• establish referral systems
• manage effectively
> human resources (including volunteers)
> recruitment and retention strategies
> incentives and enablers
> planning and M&E
> resource mobilization
> referral services
• provide TB/HIV services
• provide or access TA for TB/HIV
Collaborative TB/HIV Activities
Policies and guidelines on
• community TB care, TB/HIV, and HIV
• engagement of civil society
• M&E and supervision
Capacity of national or state programs and technical partners to
• work effectively with CBOs
• provide TA, training, and supervision
• provide or develop jointly IEC materials
• know the status of basic TB and HIV services and their accessibility
• be knowledgeable about CBOs and their potential roles
Mechanisms of collaboration for TB/HIV
• present and functioning at all levels
• that offer opportunities for broad representation
EXTRINSIC TO ORGANIZATION

or other logistical costs. Four referred to training opportunities as incentives for volunteers.

Volunteers support CBO fundraising activities in local communities; they are also active in peer education, community mobilization and awareness, and advocacy. As well, volunteers provide psychosocial support for HIV-positive clients, accompanying them to clinic visits, to referrals and counter referrals, and often to some kind of follow-up. Ten organizations said their volunteers provide home-based or palliative care, and four said a few of their volunteers either assisted with or provide HIV counseling and testing (HCT). Eight organizations referred specifically to the involvement of their volunteers in TB/HIV activities, such as referrals for symptomatic individuals (8); default tracing from TB treatment (6), community mobilization (6), and DOT (6).

Technical assistance

All 12 organizations received technical assistance to improve their management functions. FHI provided technical assistance to six, under the Implementing AIDS Prevention and Care Project (IMPACT) and under GHAIN. The COMPASS Project was referenced by one organization. Support provided by other donor initiatives has been delivered through the Network on Ethics/Human Rights, Law, HIV/AIDS Prevention, Support and Care (NELA); the National Action Committee on HIV/AIDS (NACA); and the Civil Society Consultative Group on HIV/AIDS in Nigeria (CiSGHAN).

Most CBOs interviewed have also received training in TB from either a technical partner or the state TB program.[4] Though many of these partners have the capacity to provide technical assistance to scale up TB/HIV collaborative activities, assistance is largely donor-driven and has been targeted to 12 states.

Resource mobilization

The CBOs had different methods of accessing funds for their operations. Most undertake local fundraising events, and five receive donations from patrons or individuals on an ad-hoc basis. To finance new initiatives, three organizations state they track and respond to calls for proposals. Others seek out donors who may be interested in their projects and then write concept papers requesting support and send them on through local or state action committees on AIDS. One NGO hosts a computer course on its premises whose revenues cover 50 percent of the organization's rent and operating costs.

One umbrella organization provides grants to smaller organizations, and some of the smaller CBOs interviewed obtain funds and fundraising support from umbrella organizations. CBOs linked to DFB and GHAIN are provided with targeted funding to undertake TB/HIV activities.

CBO knowledge of TB, TB/HIV, and stigma

All organizations reported a heightened level of awareness within their organizations of TB, its mode of transmission, TB signs and symptoms, treatment, and the impact of TB on PLWHA. Some organizations responded that both TB and HIV lower the immune system, and all underscored the importance of completing therapy. They all identified TB as an important cause of morbidity and mortality among their HIV-positive clients.

TB was seen as a problem and health concern for CBO staff, especially for HIV-positive volunteers.

At least two staff from different CBOs testified on the impact of their personal experiences with TB, access to care, and eventual cure. One respondent said he actively encourages all clients attending his support groups to be screened for TB and urges those who are symptomatic to seek immediate care.

Nine organizations referred to legal issues and discriminatory actions that had adversely affected their clients. The legal issues pertained to matrimonial inheritance or access to university training, while

Table 6. Core Competencies and Areas of Practice Reported by CBOs

BY MORE THAN 80%	BY 50 TO 80%	BY LESS THAN 50%
Referral: 12	Income generation: 9	Gender and women's rights: 6
Home-based care: 10	Capacity building (groups): 9	IEC printing and distribution: 6
Support groups: 11	Community awareness: 8	Advocacy: 5
	Special or hard-to-reach populations: 9	Social mobilization: 5
	Stigma reduction: 8	Research: 5
	Capacity building (organizations): 7	Clinical care:5
	Training, management of peer educators: 7	Skill-building for PLWHA: 4
	Impact alleviation: 7	Counseling/referral for testing: 3
		Legal support or legal advocacy: 3
		Small grants management: 1

SWAAN community mobilization rally in Kano. FHI/NIGERIA PHOTO BY JIDE ADENIYI-JONES.

the actions included domestic discrimination and barred access to housing. Two organizations said they had been targets of discriminatory acts. One relocated as a result and no longer advertises its services beyond its name on the office premises. Respondents also related personal experiences with stigma and discrimination; many of these involved healthcare services.

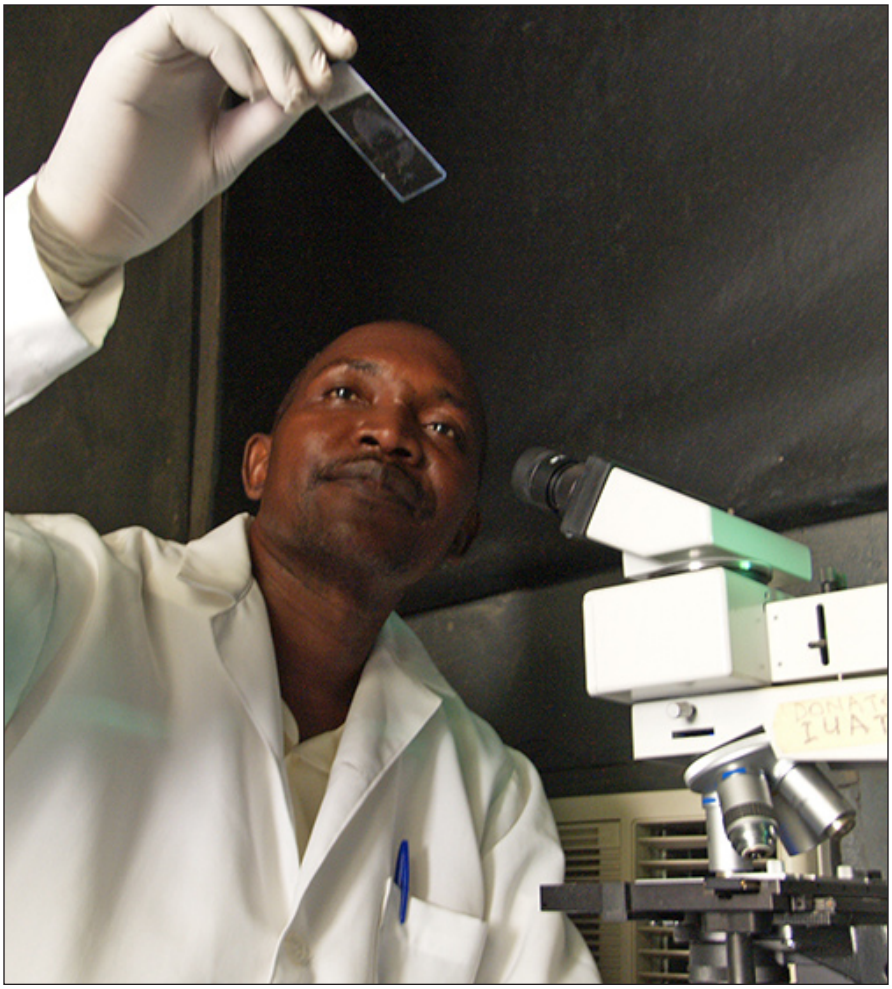
Stigma around TB is seen as very important, negative influence on timely health-seeking behavior. One respondent CBO suggested that more stigma exists around TB than around HIV infection. Another respondent attested that TB was a "big issue," even among his own family members. Certain common beliefs were said to perpetuate ignorance and fear, including that TB can be contracted by sharing cups and utensils.

Eight organizations take part in stigma-reduction activities, including awareness campaigns and the development and dissemination of information, education, and communication (IEC) materials. Two reported that they take an aggressive approach to reducing stigma within the healthcare system by developing and implementing training courses that target both health workers and CBOs.

Volunteers from one CBO attested that people who are on ART and do well often become advocates, and they have helped to dispel issues around stigma. Many support-group leaders who have been on ART for several years now focus their attention on wellness, and this has helped to decrease the stigma that affects their clients. A few individuals said they had TB in the past, but followed the treatment regimen and are now doing well. They provide examples of how TB can be cured and are advocates in their support groups and among the clients and communities they serve.

CBO core competencies and areas of practice

Table 6 and annex 3 summarize the core competencies articulated by the CBOs during interviews. All provide support to PLWHA, and most said they also support individuals outside their catchment areas. All provide psychosocial support and home-based care (HBC), and more than 80 percent are involved in patient referrals. The umbrella organizations also undertake direct service provision for PLWHA. More than half of the CBOs interviewed already have experience



TB lab at Lagos Mainland Hospital. FHI/NIGERIA PHOTO BY JIDE ADENIYI-JONES.

that would be useful for introducing and scaling up TB/HIV activities. These include IEC and community awareness campaigns; social mobilization; and work to reduce stigma.

Clinical services and referrals

The CBOs' levels of intervention within the health system varied. Though only one stated that clinical care is a core competency, five provide clinical services in an onsite facility.

Although no organization considers its work in TB/HIV as a core competency, all are involved in referrals and counter referrals that include TB services. Eleven undertake screening and referral for TB-symptomatic individuals or refer TB-symptomatic clients for screening and further investigation. Only two provide isoniazid prevention therapy (IPT), two provide DOT through their HBC programs, and six assist in tracing individuals defaulting from TB treatment. None has a plan for TB IC, though many implement cough hygiene in congregate settings.

All organizations referenced their support for referral and counter-referral services between HIV/AIDS clinics (ART sites) and TB services and to other services, such as prevention of mother-to-child transmission of HIV. CBOs that provide facilitated referrals for both TB and HIV services assign volunteers who accompany clients to clinic visits and assist them with any follow-up required.

Referral systems reported and observed involved tracking patient movement between clinical services and community care. Many organizations maintain patient files and registers for recording these activities and any follow-up that is expected. Other CBOs were more informal in recording and reporting; at least three inscribed part of the information on wall charts and tables.

Respondents also mentioned stigma and denial resulting in loss to follow-up and to feelings of being stigmatized by healthcare workers at clinical visits. They also mentioned staff in clinics who feel overwhelmed, as well as a lack of funds for transportation. Three organizations that provide HCT often do so in the privacy of clients' homes, but they reported an irregular supply of kits and materials such as gloves.

Work with special or hard-to-reach populations

In addition to working with PLWHA, many CBOs work with high-risk populations or in high-risk settings. One works with drug users; nine work with in-school and out-of-school youth; five with prison populations; and five with motorcyclists in community transportation and/or truck drivers. One organization focuses exclusively on HIV-positive couples, two said they work with uniformed men, and two have developed interventions that target sex workers. Six assist with the registration of orphans and other vulnerable children and train volunteers to care for them.

Two organizations work specifically with women. One took a special interest because women in their catchment area were "un-reached with HIV information because of

cultural issues. Their husbands were not willing to provide them access to information, and many of these women were giving birth to HIV positive babies."

Research

While five organizations said they had undertaken or been involved in any research activity, only one considers research a core competency. This CBO was currently engaged in a validation of syndromic treatment with an on-site laboratory and a KAP study on STIs.

Two organizations mentioned their contributions to GHAIN baseline surveys and needs assessments. Organizations implementing the HAST model were aware of a baseline assessment for TB, including knowledge, attitudes, and practices (KAP) studies.

Factors external to CBOs that may affect their engagement in collaborative TB/HIV activities

CBO collaboration in TB/HIV activities may be facilitated by national policies that encourage their engagement in general and in TB/HIV specifically; the existence of mechanisms of collaboration and linkages between CBOs and national TB and national AIDS programs; and the availability of technical assistance, training, funding, and IEC materials in TB/HIV.

During the study, CB-DOTS or CTBC had only just begun in Nigeria, and it is now being implemented in selected LGAs. Draft CTBC guidelines did not mention inclusion of CBOs, although volunteers and community health workers figure prominently. This has changed as a result of study findings: CBOs and NGOs are now to be considered in implementing and scaling up TB-DOTS.

At the time of the study team's mission, national guidelines for TB/HIV collaborative activities that stipulate the involvement of CBOs in the planning and implementation of TB/HIV activities were still in draft form and had not been circulated broadly. Though GHAIN and DFB include CBO involvement in their targets for TB/HIV collaborative activities, no further information was available on how other technical partners work with CBOs to implement TB/HIV collaborative activities in other areas of Nigeria.

As of the end of 2007, Nigeria's national TB/HIV work plan had been introduced in at least 12 states. The draft report of Nigeria's National TB/HIV Working Group for 2007 makes scant mention of the non-TB CBO community, though it describes the status of TB/HIV collaboration nationwide, lists technical partners and their geographic and technical focus, and includes recommendations to improve services.

With few exceptions, opportunities to enhance collaboration through local and or state mechanisms are poorly defined.[5] The promise of better coordination between partners, implementers, and other stakeholders can be seen in the HAST committees whose establishment at the LGA level is facilitated by GHAIN. These committees have broad representation; their members may include HIV and TB coordinators, community and religious leaders, youth organizations, volunteers, and public and private providers (including pharmacists and general practitioners).[6]

CBO contributions that address TB/HIV implementation challenges

Table 7 (page 22) uses the framework set out by the WHO *Interim Policy on TB/HIV Collaborative Activities* alongside reports that refer to challenges in implementing TB/HIV activities. The framework is also used to categorize TB/HIV activities being undertaken by the CBOs interviewed as well as gaps observed.

Major contributions of the CBOs included—but are not limited to—M&E, screening for TB and referrals; HIV prevention services, including HCT or counseling and referral for testing; and care and support to PLWHA. Major gaps included participation in coordinating mechanisms for TB/HIV and provision of IPT and cotrimoxazole preventive therapy (CPT). ■

Notes: CBOs Interviewed

1 It proved difficult to estimate the sizes of populations reached by umbrella organizations and the array of networked organizations that they support, since target populations varied and depended on specific activities.

2 The DFB is one of the four member-organizations of the International Federation of Anti-Leprosy Organizations (ILEP) that is working to support TB and TB/HIV in Nigeria. The DFB works in coordination with other ILEP associations, and with the International Union Against TB and Lung Diseases (IUATLD) and the WHO.

3 The FBO interviewed works with about 120 volunteers. Four NGOs work with between 6 and 238, the range for three CBOs is between 5 and 33, and for three others it is between 119 and 238.

4 The Tuberculosis Training Institute, based in Zaria, offers courses in TB and in TB/HIV and will tailor curricula to healthcare workers in the public or private sectors. To date, however, no plan has been developed to increase CBO access to these training opportunities.

5 van der Grinten E, Oyama E, A desk study TB-CAP, op cit.

6 Family Health International, Draft concept paper for the engagement of community- based organizations (CBOs) for the implementation of the LGA HAST model, unpublished, 2007; Family Health International, HIV/AIDS, sexually transmitted infections, and tuberculosis (HAST) model of community TB care, op cit.

Table 7. WHO Policy, Implementation Challenges, and CBO Contribution to Address Gaps

WHO INTERIM POLICY ON COLLABORATIVE TB/HIV ACTIVITIES	REPORTED GAPS AND PROBLEM AREAS		CBO CONTRIBUTIONS TO ADDRESS GAPS
	2007 Report on TB/HIV Collaborative Activities in Nigeria	**2008 TB CAP Desk Study**	**Collaborative Activities Reported**
ESTABLISH THE MECHANISMS OF COLLABORATION			
Set up a coordinating body for TB/HIV activities effective at all levels	• 12 of 37 states have TB/HIV coordinating bodies. However, possible cessation of funding cited as potential problem • Coordination of all partners • Activities mostly donor-driven • Great distances between TB and HIV services • GFATM recipients in same areas • Different training needs for TB and HIV staff • Poor logistics	• Only some states with TB/HIV collaborative activities • Gaps at LGA levels for coordination	• One CBO said it had participated in a coordinating body meeting for TB/HIV at any level—in this case, at both the LGA and state levels with TB counterpart (DFB)
Conduct surveillance of HIV prevalence among TB patients	• Sentinel surveillance planned but lacks funds		• Twelve CBOs ensure referral • Many maintain registers, though variability in registers observed registers
Carry out joint TB/HIV planning	• Joint planning only at national level, in 12 states, and in pilot areas	• Coordination between partners and activities still not harmonized	• Only two CBOs mentioned participating in joint planning activities outside DFB pilots
Conduct monitoring and evaluation (M&E)	• Lack of adequate supervision at all levels • Poor record-keeping	• M&E tools used by some implementers not standardized or comprehensive enough • Need for updated NTP records, TX cards, and registers • Little funding available for reproduction	• Five of seven CBOs participated in M&E activities for TB/HIV; however tools are not standardized • DFB and GHAIN sites receive regular monitoring for TB/HIV collaborative activities • Two CBOs cross-check HCT and TB registers with TB clinic staff
DECREASE THE BURDEN OF TB IN PEOPLE LIVING WITH HIV			
Establish intensified TB case-finding	• Cost and access to x-rays for SS+ clients • Increased workload precludes testing patients • Stock-out of drugs		• Eight of eleven CBOs screen and refer TB suspects • Two refer for screening and diagnosis • All follow-up referrals
Introduce isoniazid prevention therapy (IPT)	• Only few sites • Availability of x-rays for diagnosis • Isoniazid problematic	• Availability of x-rays • Reading of x-rays	• Three CBOs provide IPT to DFB collaborating partners
Ensure TB infection control (IC) in high-risk settings	• No TB IC plans at facility level • No mention of congregate settings	• Few facilities with TB IC plans • TB IC guidelines not available	• None of the CBOs has a plan for TB IC, although many implement cough hygiene and cough etiquette in many support groups • One has formal policy to separate TB suspects
DECREASE THE BURDEN OF HIV IN TB PATIENTS			
Provide HIV testing and counseling (HCT)	• Lack of support for free HCT in TB-DOTS centers	• Many partners provide HCT	• Three CBOs provide HCT or counseling and eight refer for testing • One small CBO located within hospital provides HCT to TB patients
Introduce HIV prevention methods	• n/a	• n/a	• Eleven CBOs distribute condoms • All target high-risk groups
Introduce co-trimoxazole preventive therapy (CPT)	• Poor uptake of CPT	• Only some HIV partners provide CPT	• Two CBOs provide CPT • CPT is provided through ART clinics
Ensure HIV/AIDS care and support	• Some partners are working through the NGO community in different states	• Provided by US Government partners	• All CBOs provide social support to PLWHA—HBC (12), nutritional support (7), counseling (12), health and wellness education (3), income-generation for clients (9), skills-building for future employment (4)
Introduce antiretroviral therapy (ART)	• n/a	• n/a	• No CBO is providing ART, but all are involved in treatment adherence through HBC

Practices that Facilitate the Scale-up of TB/HIV Collaborative Activities

After conducting interviews, the study team considered practices implemented by the CBOs that might contribute the most to efforts to scale up TB/HIV collaborative activities. Though subjectivity could not be avoided, the backgrounds of team members in TB control minimized it and contributed to reaching consensus. The team identified seven current CBO practices whose introduction and replication were likely to make contributions to this scale-up and noted the CBO involvement in the HAST model developed by GHAIN.

CBO Practices

Referral systems between clinical and community care

Two of the CBOs partnering with DFB (an ILEP member) use its standardized referral systems to link TB services, HIV/AIDS care, and community support for quality care for co-infected patients. This has contributed to the scale-up of comprehensive TB/HIV services. The points of entry of clients into TB/HIV care and referral include the TB clinic, HCT services offered by the CBO, and HIV clinical care. Good management practices through joint M&E and supervision have had a significant impact on the success of this integrated referral system, and the joint effort has contributed to increased client uptake and resulted in greater credibility and recognition from the community, government, and other NGOs.

Government policy on care and support of dually infected patients has been influenced by the success of these partnerships. The government now has greater confidence in the ability of partnerships between local TB clinics and the CBOs to deliver high-quality care, and it has also contributed to the evidence-base for rapid scale-up of comprehensive TB/HIV services that encompass health facilities and the community.[1]

Many CBOs maintain and update records on their clients and refer them for TB screening and follow-up. PHOTO BY DR. BABA GANA ADAM.

CBOs serve as an important entry point to a continuum of client–focused care: They offer intensified case-finding through symptom screening and appropriate referral, and the follow-up they provide for clients is incorporated into their PLWHA support groups.

Many of the individuals who provide HBC as part of CBO activities are trained in DOT for TB and provide patient follow-up. The CBO organizes and keeps track of client referrals, maintains HCT registers, and refers individuals testing positive to TB clinics for screening and follow-up. CBOs, together with the TB clinic staff, review and cross-check HCT and TB program registers and provide support in IPT and in tracing defaulters through networks of volunteers. These CBOs

also provide HCT services to those patients diagnosed with TB and referred from the local TB clinic.

At the same time, the NTP and ILEP partners ensure policies, procedures, and protocols are in place; flow charts are available; and standard recording and reporting formats capture referrals to different services. These partners, together with the CBOs, are responsible for regular systems of supervision. The technical partners also provide training in TB and TB/HIV, HIV test kits for TB patients, and isoniazid for IPT for HIV-positive clients who are screened and found negative for TB disease.

Client-focused care

Most of the CBOs interviewed provide client-oriented support services. The promotion of client-focused care has helped to increase community awareness and decrease stigma around HIV, and it is making attempts to deal with stigma around TB. Client-focused care has also resulted in increased testing for HIV in TB patients, better adherence to treatment for TB and HIV, and improved quality of life for many clients. Some of the CBOs address gaps in TB/HIV services by providing facilitated referrals, directly observing treatment, and tracing defaulters from clinical appointments.

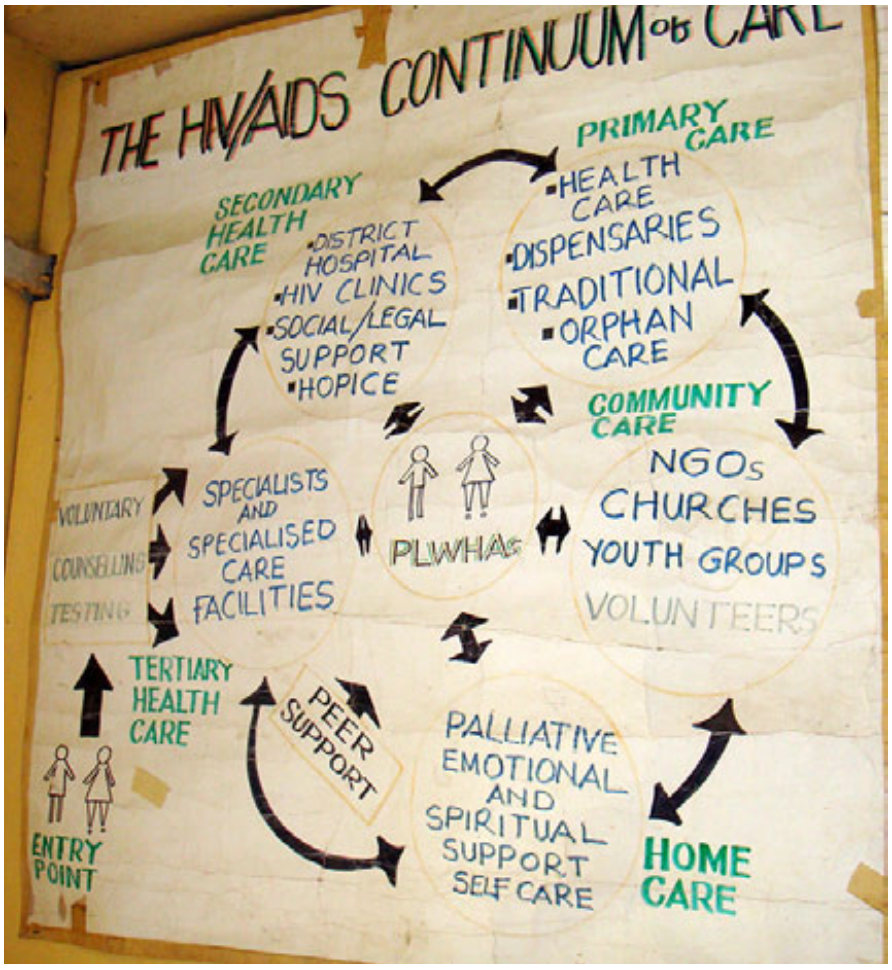
Client-focused care is provided by CBOs whose mandates focus on PLWHA care. Respect, dignity, and confidentiality are important elements, and PLWHA involvement is usually encouraged. Many PLWHA who are active volunteers now concentrate on wellness and caring for others. Compassionate care is the hallmark, provided through direct services or indirectly through support groups affiliated with and supported by the CBOs. In addition, many CBOs will also refer PLWHA to programs that offer spiritual and emotional support and provide support for treatment literacy and adherence. HBC is provided as needed.

Though the entry point for PLWHA is often through HCT, it can occur anywhere on the continuum of care. The intake assesses clients' cultural and socioeconomic status, and needs are recorded in patient files. Referral appointments to clinical care are provided with follow-up.

Most CBOs undertake fundraising efforts that allow supportive activities to be tailored to clients' specific needs, such as paying for the cost of their x-rays or other diagnostic tests and nutritional support. Some CBOs may also offer skills-building and income-generation opportunities for their clients. All clients are referred to local support groups for PLWHA.

Many CBOs also address cough etiquette and cough hygiene—one of ten essential actions in effective TB IC in congregate settings such as support groups. Most provide condoms and information about HIV prevention to clients.

CBO staff and networks of full-time and part-time volunteers establish and maintain relationships with staff in health facilities. Some of the volunteers are active or retired healthcare workers, and they provide training on interpersonal communication and stigma reduction for health workers. In addition to being involved in client care, many volunteers are engaged



Hand-drawn poster of client-centered continuum of care and entry points into clinical and community services. PHOTO BY DR. BABA GANA ADAM.

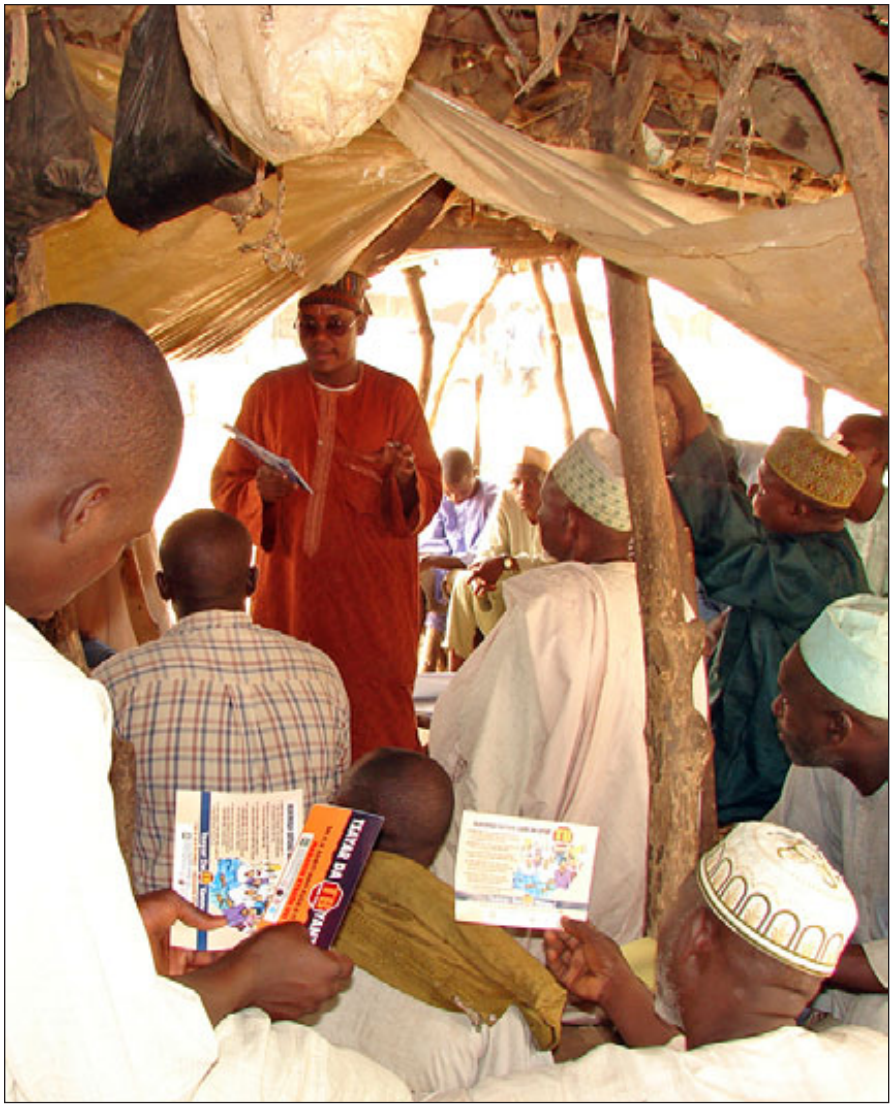
in community–level activities, such as community mobilization and awareness efforts. Stigma is addressed through such efforts, as well as on an individual level and within support groups.

Use of umbrella organizations

Umbrella organizations engaged in HIV can contribute efficiencies to the scale-up and implementation of national and regional policies and assist communication between national programs and communities. This is particularly important in countries such as Nigeria, where umbrella organizations with networks of many local CBOs can provide training and supportive supervision and deliver culturally appropriate messages through their networks to enhance awareness of TB/HIV.

In addition, umbrella organizations can represent and act on behalf of similar institutions on state and national platforms. They make available lessons learned by one small NGO to others in the network, and they make available to national programs knowledge about the experiences of local HIV organizations and the infrastructures they are using for advocacy and to mobilize communities.

Umbrella organizations with long presence in communities usually have clear mandates, as well as delineated roles and responsibilities vis-à-vis networks and partner organizations. When they have strong relationships with national, state, and local networks, they ensure coherent strategies and implementation of policies. Umbrella organizations provide technical assistance to smaller organizations; help to coordinate their networks; and provide managerial and organizational support, mentoring, and supportive supervision. These organizations often attract highly skilled professionals as employees and as volunteers. They may also possess the ability to manage small grants programs, monitor and supervise recipients, and mobilize and access funding from different sources.



Community TB mobilization, Deidei Cattle Market, Abuja.
PHOTO BY DR. BABA GANA ADAM.

When involved in planning and implementing HIV and TB/HIV services, umbrella organizations use their extensive networks to expand and outsource activities, including HBC, HCT, advocacy, social mobilization efforts, community awareness campaigns, and distribution of IEC materials. Through their networks, they can reach marginalized populations that may be at high risk for HIV and TB.

Gender-sensitive and culturally sensitive strategies

Culturally sensitive approaches developed and implemented by CBOs have resulted in changes in health-seeking behavior and increased diagnosis and treatment of TB and HIV. Their culturally specific and gender-specific activities have been recognized as such by organizations who request from the CBOs technical assistance and support to replicate their approaches.

PLACO volunteer caregivers. FHI/NIGERIA PHOTO BY JIDE ADENIYI-JONES.

The work of CBOs is often adapted to local cultural environments and to significant gender issues. Often female volunteers work with women, reaching many who have limited access to information, support, and services.

CBOs with gender-specific and culturally sensitive approaches have taken great care to cultivate good working relationships with community and religious leaders (such as pastors and imams) and garner their support. The organizations thus raise awareness among religious and community leaders who can effectively promote interventions.

Implementation of GIPA

UNAIDS policies on GIPA (greater involvement of people living with HIV and AIDS) foster a focus on wellness and help to decrease stigma. GIPA has enabled many PLHWA who work or volunteer for CBOs to speak freely about their experiences, hopes, aspirations, and reasons for becoming active in the response. The policy also encourages ownership of issues around care and support. It encourages PLWHA to take back control of their lives, keep themselves well, and reach out to others who are affected.

Ten organizations stated that they adhere to the GIPA policy, and PLWHA were well represented among the staff and volunteers interviewed. For many, both wellness and access to comprehensive care are important topics. Some were open about their status and eager to share personal experiences relating to their access to health services and to stigma. Stigma continues to be a real issue, but many suggested that some improvements have been seen, and that stigma will continue to decrease as ART becomes more available. Most were well aware of the linkages between TB and HIV, and they have incorporated prevention of TB into their activities. Two respondents related personal experiences as TB patients, their treatment, and ultimate cure, and they said are enthusiastic advocates for early detection and treatment completion.

Many PLWHA lead PLWHA support groups and provide assistance to other groups that are starting up. Many have become involved in promoting skills-building opportunities for income generation. They also take part of fundraising activities and engage in community

mobilization, awareness campaigns, and peer education.

Volunteer recruitment, retention, and management

All CBOs interviewed have mandates to work with volunteers. Although the focus is on supporting community–based activities to prevent and mitigate the impact of HIV, the organizations have expanded their volunteer activities to encompass TB, and they seem to address it consistently.

To date, the NTLCP program has limited experience with recruiting, retaining, and managing volunteers and even more limited experience in working with a volunteer base through CBOs. Volunteers, under the direction of the CBO, and, to some degree, in partnership with the NTLCP, have contributed to increased awareness of TB, active case finding, support to IPT, treatment literacy, and DOT and IC in congregate settings.

The number of volunteers working for the CBOs ranged between 6 to more than 200. Recruitment strategies varied among and within organizations. CBO volunteers who participate in regular meetings where activities, problems, and client issues are discussed and reviewed are kept engaged and up to date. Senior staff often provide ongoing training and mentoring.

Many volunteers have served a given organization for long periods, and they are highly valued by its staff as well as by their communities. They are rewarded with a sense of belonging, the gratification derived from helping others, and recognition from their communities, including from religious institutions whose missions and mandates support the concepts of compassionate care and volunteerism. None of the CBOs provide financial remuneration to volunteers.

Incentives and enablers are important factors in attracting and retaining volunteers. They are also provided with training opportunities, and they learn skills that they can apply elsewhere and that may help them to obtain paid employment. Some CBOs can access funds to support volunteer activities, such as facilitated referrals, transportation, and HBC kits.

Income-generation to sustain operating costs and client-focused activities

All organizations have well-defined donor bases within their communities. Fundraising is also supported through linkages with local and/or religious institutions and sometimes by the business sector. Some CBOs have patrons or board members who make regular donations and to whom they can turn if they have an immediate need. The CBOs host local social events and fundraising campaigns.

The CBOs interviewed do not rely on one donor to sustain their work; other sources can sustain activities if a donor ends its support. Flexibility in resource mobilization allows the organizations to be responsive to their mandate and permits more flexibility in addressing individual client's needs. Entrepreneurial approaches decrease reliance on donors and community philanthropy and promote sustainability.

SWAAN counselor with a client. FHI/NIGERIA PHOTO BY JIDE ADENIYI-JONES.

The HAST integrated service model

The HAST model provides integrated care for HIV/AIDS, STIs, and TB at primary health centers and in communities. Tools and

approaches developed support comprehensive service-planning and coordination. HAST ensures that basic services such as HCT and TB diagnosis and treatment are within reach of the communities. The establishment of HAST committees has increased community representation and participation.

GHAIN provides technical and financial assistance to implement the model, but state and LGA authorities own and support it. After agreements are signed, GHAIN, the LGA, and disease control programs conduct a collaborative rapid assessment of a given LGA to identify service provision points and collect KAP and health management information system data. GHAIN then transparently selects umbrella CBOs that have the capacity to render community-based activities through their volunteers.

The CBOs that are selected work in a specific catchment area, and they identify the volunteers who are to be attached to the primary healthcare facilities within it. The volunteers receive training and supportive supervision. The CBOs are represented on HAST committees, which draft initial work plans for integrated activities that are based on the findings of the rapid assessments.

The HAST model also entails the implementation of standardized reporting and recording formats, monitoring systems, and regular M&E. Service-related problems are fed back to the HAST committee, and corrective actions are taken through the LGA's supervisory mechanism.

Though recently designed and implemented, the HAST model seems to be well known in the communities it serves. This is a reflection of important efforts to be inclusive and the in-depth knowledge that is collected about the populations and health services in these locales, including with KAP surveys. The model has many entry points into the community—through the TB program, the HIV program, or CBOs. Staff engaged in implementing the HAST model provide continual technical support to the CBOs and respond to immediate operational issues, such as the lack of laboratory supplies for TB diagnosis. Recording and reporting formats have been designed to ensure follow-up of patients between services, but the data they generate are not yet available. ■

Notes: CBO Practices

1 International HIV/AIDS Alliance, Community engagement for universal access, op cit.

Discussion, Conclusions, and CBO Recommendations

Community involvement has been advocated as a cost-effective strategy to accelerate the expansion of TB and joint TB/HIV services. Studies demonstrate that treatment outcomes among TB patients cared for in their communities were equivalent to or frequently better than those of patients treated through health facilities. TB treatment success rates for programs implementing community-based TB care often reached the global target of 85 percent, even when taking into account the frequently high TB case fatality in high HIV prevalence populations. In addition, costs associated with community-based TB care were often 40 to 50 percent lower than for health facility-based care, and the cost-effectiveness of community-based TB care was approximately 50 percent higher.[1]

Since the late 1990s,[2] the WHO has been making recommendations in this area that have been reinforced by international bodies. The WHO has recognized the contributions of CBOs and community structures developed to respond to the HIV/AIDS epidemic, and it has advocated that these be harnessed to expand TB and TB/HIV activities. Exactly how they could contribute should be determined in partnership from the outset. This approach, building on extant CBO infrastructure, is preferable to setting up new systems, groups, and organizations.[3]

Notwithstanding, few articles in peer-reviewed journals describe how CBOs working in HIV/AIDS have been employed to scale up TB/HIV collaborative activities.[4]

Community TB mobilization, Abuja. PHOTO BY DR. BABA GANA ADAM.

Though the grey literature contains numerous references to relevant reports or pilot projects, including in Cambodia, Tanzania, Ethiopia, and Rwanda,[5] peer-reviewed literature does not reflect the enormous amount of work undertaken by CBOs to expand HIV/AIDS services—only two articles referred to their work in TB as well as HIV/AIDS.[6] Perhaps one explanation is that the AIDS community until recently referred to TB as one of many opportunistic infections in HIV-infected individuals and no special reporting was deemed necessary when organizations paid attention to TB.[7]

Since 2002, Nigeria has been moving forward with TB/HIV collaborative activities. Many partners have contributed, both technically and financially, to the country's joint TB/HIV national work plan. Recent reports by the National TB/HIV Working Group suggest that demonstrable progress has been made on many fronts.[8] The CBO community in Nigeria has and continues to marshal efforts to address the growing HIV/AIDS epidemic with unprecedented donor funding and technical support, including from the GFATM, PEPFAR, and World Bank's Multi-Country HIV/AIDS Program.

Community mobilization rally in Kano. FHI/NIGERIA PHOTO BY JIDE ADENIYI-JONES.

The HAST model has been only recently implemented in Nigeria. Among many components of interest are its systematic baseline assessments that review the availability and quality of service delivery, KAP of both clients and healthcare workers, mechanisms of coordination with broad representation, new tools for recording and referral, and its extensive training and regular supervision. Plans for monitoring the HAST model may in the future provide useful information on lessons learned with a view to scaling up.

The HAST assessments include a review of CBOs in the communities,[9] and support is provided for the engagement of these new partners. Laboratory networks and supply chains are also assessed and mapped, and strategies are developed to ensure sustainability in the short, medium, and long term. In the HAST model, basic TB services are strengthened as collaborative TB/HIV activities are introduced and scaled up.[10]

Potential areas for CBO collaborative activities

While CB-TB DOTS and TB/HIV collaborative activities have yet to be scaled up in Nigeria, a vast CBO infrastructure that has responded to the HIV/AIDS epidemic[11] is largely untapped as a contributor to TB and TB/HIV collaborative activities. Most of the CBOs interviewed have improved their management structures and systems and developed their human resource base through various donor–supported initiatives, though the robustness of their management systems vary, along with their capacities to absorb more activities or expand services.

The larger umbrella NGOs have demonstrated their capacity to take on leadership roles. They channel funds to smaller organizations and provide them with technical assistance, training, and mentorship. All four umbrella organizations interviewed contribute to TB/HIV activities, though none considers this area to be a core competency.

Advocacy and communication to reduce stigma is a vital area for CBO collaboration. Stigma continues to be a salient factor, within communities as well as in healthcare practices. Many individuals interviewed reported internal stigma and discriminatory acts they experienced when they sought healthcare. Also worrisome is the finding of a study in Zambia that stigma surrounding TB has increased in the context of high rates of HIV. This has serious

implications for the management of HIV and TB outcomes.[12]

A survey reported in 2005 in four states in Nigeria reported discriminatory behaviors and attitudes toward PLWHA among a significant proportion of healthcare professionals. These behaviors can negatively affect their relationships with clients, thus contributing to missed opportunities for prevention, positive-living education, and treatment, all of which undermine concerted national efforts to address the HIV/AIDS epidemic.[13] The survey identified four factors that contribute to these behaviors and attitudes on the part of healthcare professionals: lack of correct information and education about HIV/AIDS and prevention of infection; lack of protective materials needed for the practice of universal precautions; lack of materials needed to care for and treat patients with HIV/AIDS; and prevailing attitudes about PLHWA. To counter them, the survey's author advocates attention to rigorous implementation of anti-discriminatory policies, the training of health professionals, efforts to ensure that healthcare facilities have adequate resources.

Individuals who know their HIV status play an important role in breaking the vicious cycle of fear, stigma, and denial associated with the virus.[14] As a consequence, increased HCT and the adoption of GIPA policies contribute to decreasing stigma and earlier access to diagnostic, treatment, and care services and to improving the quality of life for patients who are infected by TB and HIV.

CBOs involved in TB control have stated that stigma decreased significantly with the introduction of community-based care. Approaches to stigma reduction in these communities have involved various awareness–raising activities that use radio, street theatre, and flipchart presentations.[15]

Of great concern is the stigma associated with the dual TB/HIV infection. In one Ugandan study, TB patients reported stigma that is associated with TB/HIV and also with the care provided by an organization strongly associated with HIV/AIDS care.[16] A more recent paper suggests that TB/HIV stigma may be more important than the stigma associated with HIV alone.

However, in the WHO-ProTEST pilot models, raising the profile of HIV-related TB at all levels and improved program collaboration contribute to reducing the stigma that is attached to TB and HIV.[17] Unless stigma is addressed in a comprehensive fashion, it may undermine efforts to scale up TB/HIV services. Thus, a multi-pronged approach that addresses stigma among affected individuals, healthcare professionals, and the community is needed, and CBOs can play a significant role.

The author of a study in Zambia advocated that interventions to reduce the stigma of TB/HIV must address the link between the two diseases and correct popular misconceptions: that all people with TB have HIV; TB is no longer curable; and PLWHA with TB cannot be cured.[18] Interventions must also address the cycle of judgment, shame, and blame that drives the stigma, as well as balance legitimate fears of TB transmission with avoidance of unnecessary precautions.

In Nigeria, as in many countries, CBOs play important roles in these areas and in addressing stigma.[19] Most of the CBOs interviewed do so through support groups for PLWHA and their community awareness and social mobilization activities. Many CBOs also advocate on behalf of clients exposed to discriminatory acts. At least two of the organizations provided training that addressed stigma among healthcare workers.

As an extension to current social mobilization efforts for HIV, CBOs can extend their messages to encompass TB, encouraging symptomatic people to test for TB as well as educating and counseling TB patients on the need to be tested for HIV. CBOs can also be engaged in treatment literacy programs for TB as well as HIV and in efforts to reduce stigma at client, community, and health-service levels.

CBO advocacy, awareness campaigns, and community mobilization to increase demand for TB/HIV services must be implemented in conjunction with key stakeholders of TB and HIV programs and health services. To respond effectively to the demand created, it is vitally important to first take stock of the state of readiness of these national control programs and services. For example, sputum smear microscopy services fall short of current needs in Nigeria. Untimely demand for screening and diagnosis for TB may tip the balance between current services and the rational scaling up of diagnostic capability, which may result in a lack of community confidence in the services. This means that engaging and coordinating CBOs in the expansion of services as early as possible is essential.

Potential areas for CBO collaborative activities in clinical and community-care settings include program planning and implementation; recruitment and management of volunteers; M&E; and recordkeeping and reporting. CBOs are and can be further engaged in providing DOT, care, and support to TB patients as part of an HBC program; in TB IC in

Support group meeting at Muritala Mohammed Hospital, Kano State. FHI/NIGERIA PHOTO BY JIDE ADENIYI-JONES.

community and congregate settings; and in training community health workers and health professionals in addressing issues such as stigma.

Other areas for engagement are client-centered care, referral linkages between clinical and community care services, case finding and contact tracing, and tracing of treatment interrupters and defaulters. Many such activities are being undertaken by the CBOs interviewed, and they can be linked to many areas listed in the WHO *Interim Policy on TB/HIV Collaborative Activities*.

Studies from a client perspective in Malawi, Uganda, and Kenya indicate that key areas to ensure good TB treatment outcomes include provision of nutritional support, availability of drugs, and a positive attitude among healthcare providers, including treatment partners.[20] Many of these areas were covered by many of the CBOs studied, although they were not necessarily bundled as a standard package of care. All CBOs interviewed provide psychosocial support and incentives in the forms of nutrition. Some facilitate skills-building opportunities for their clients to address issues of poverty.

The framework of the WHO *Interim Policy* can be used to assess gaps and as a tool to plan, implement, and monitor TB/HIV collaborative activities. It can also be used to assess the type and extent of current CBO involvement in TB/HIV collaborative activities. An important gap noted by the study team is the lack of CBO involvement in coordinating mechanisms at any level. Though this may not be true throughout Nigeria, it might be a factor contributing to slow uptake of CB-DOTS and TB/HIV collaborative efforts in the country.

CBO practices that support scale-up

The CBO practices that this document describes could be used to scale up TB/HIV collaborative activities. These are the CBOs' referral systems, client-focused care, use of umbrella organizations, culturally sensitive and gender-sensitive strategies, implementation of GIPA, and practices used to recruit and retain volunteers and to raise funds. Though the scaling up of TB/HIV services by relying on organizations that, in turn, rely heavily on volunteers may be feasible in the short term, the strategy needs to be addressed

comprehensively and systematically, taking into account national, state, and local financing mechanisms and human resource strategic plans relating to health services.

Most of the CBOs interviewed have the skills, experience, and volunteer base to address many TB/HIV collaborative efforts outlined, and they expressed willingness to do more. Some of the activities may be seen as the responsibility of national program staff tasked with the delivery of quality care, including HCT, treatment literacy for DOT, intensified case finding, TB infection control in congregate settings, and recording and reporting. Shifting these responsibilities to cadres of volunteers to scale up services raises many issues—a major one being whether incentives for volunteers are a good idea.

The remuneration of volunteers' services has been raised in a recent international conference on TB, and advocates and activists alike are now demanding that the activities undertaken by volunteers should be recognized through more formal approaches to training and payment for services. But a recent discussion paper states that the work of the volunteers is "built on intangible resources, such as collective sense of solidarity and social capital. Any attempt to substitute these with material incentives undermines the basis of volunteerism."[21]

Another concern is that some kinds of incentives may create expectations that are neither sustainable nor replicable. On the other hand, lack of incentives or insignificant incentives may also pose problems, particularly when activities expand to meet needs relating to the dual epidemic.

An informal survey in 24 sites in 18 countries reported that money, food, and transport (in that order) were the top three incentives for staff and volunteers alike. Providing such incentives led to positive results for TB control, including improved case finding, adherence, cure rates, and referrals and improved coordination with the private sector. The survey reflected concerns about added staff responsibilities for managing the incentives, their lack of sustainability, the need for management controls, and the need to conduct M&E related to these incentives with little or no dedicated funding.[22]

Incentives can also have perverse effects, such as decreased motivation when they are discontinued. In addition, already scarce healthcare staff and volunteers may leave a program with no incentives to go to another that offers them. Careful planning and monitoring are needed to mitigate these and other undesirable effects, especially since few initiatives coordinate program incentives at national or local levels.

In the medium term, developing and supporting a new, paid cadre of healthcare workers may need to be considered to ensure access to care for all. There are many recent examples of task shifting, since HIV/AIDS simultaneously brought about staff shortages and increased need for healthcare.[23] To support key elements, a health systems response is needed that includes the development and maintenance of partnerships, sustainable financing, and supportive systems.[24]

In summary, the strengths of the HIV-related CBOs and their networks have largely been untapped in scaling up TB/HIV activities in Nigeria and elsewhere, though these organizations could play an important role. Engaging them during the period when strategic plans and action plans are being developed will make an important contribution to scaling up and ultimately achieving TB, HIV, and TB/HIV targets.

CBO recommendations

At the end of each interview, respondents were invited to describe what other CBOs working in HIV could do to strengthen TB programs and TB/HIV services. All seemed to draw from their own experiences in responding.

Organizations providing clinical care said that such services could be expanded to include TB treatment. Although only two provide TB DOT, all CBOs engaged in HBC suggested that the care could include DOT, with proper training and supervision. Two organizations suggested defaulter tracing, one mentioned fundraising, and half suggested advocacy and IEC or community mobilization. One umbrella organization recommended capacity building, direct supervision, support, and M&E for smaller NGOs.

Those interviewed indicated that CBOs similar to their own that are not engaged in collaborative activities may lack awareness of the need to be or may not see a role for themselves. Lack of technical capacity, training, and IEC materials as well as fear of infection may be contributing to such non-engagement. One organization suggested that the federal government had little interest in engaging CBOs. Two organizations referred to lack of funding as an important impediment to implementing TB/HIV collaborative activities.

When asked how TB programs could engage more CBOs in TB/HIV activities, most stated that this involvement should be based on a given organization's capacity, history, and linkages in communities they serve. This requires a

better sense of who is out there and what they are doing; it also requires matching the organizations to the needs of the program.

Many suggested that the NTP should be providing CBOs with more information and training, and one said that policies for proper integration were needed. Funds for training materials and IEC for communities and for outreach were also required. One organization involved with TB/HIV treatment and care suggested that the NTP should make available standard reporting formats and registers to all organizations engaged in these activities. ■

Notes: Discussion

1 World Health Organization, Community contribution to TB care, op cit.

2 De Cock KM, Chaisson RE, Will DOTS do it? op. cit.

3 World Health Organization, Community involvement in tuberculosis care and prevention, op cit.

4 Examples include Malawi, Zambia, and Tanzania. Chimzizi R, Gausi F, Bwanali A, Mbalume D, Teck R, Gomani P, Zachariah R, Zuza W, Malombe R, Salaniponi FM, Harries AD, Voluntary counselling, HIV testing and adjunctive cotrimoxazole are associated with improved TB treatment outcomes under routine conditions in Thyolo District, Malawi, Int J Tuberc Lung Dis 8, 5 (2004):579–85 <www.ncbi.nlm.nih.gov/pubmed/15137534?dopt=Abstract>; Zachariah R, Teck R, Buhendwa L, Labana S, Chinji C, Humblet P, Harries AD. How can the community contribute in the fight against HIV/AIDS and tuberculosis? An example from a rural district in Malawi. Trans R Soc Trop Med Hyg 100 (2006): 167–75 <http://fieldresearch.msf.org/msf/bitstream/10144/17717/1/trans%20buhendwa%20labana%20HIV.pdf>; Nsutebu EF et al, Scaling-up HIV/AIDS and TB home-based care, op cit; Wandwalo E et al, Collaboration between the national tuberculosis programme and a non governmental organisation in TB/HIV care, op cit.

5 Global Fund and International HIV/AIDS Alliance, Khana's Integrated Care and Prevention Program, in Civil society success on the ground: community systems strengthening and dual fast-track financing: nine illustrative case studies (Geneva and Brighton, UK: Global Fund and the Alliance, 2008) 10-14 <www.aidsalliance.org/graphics/secretariat/publications/Civil_society_success_eng.pdf>; Makame MH, Ramaiya K, Munuo G, Private health-care sector involvement in the provision of TB/HIV collaborative services in Tanzania, Poster for PEPFAR implementers meeting, Rwanda <www.path.org/files/HIV-AIDS_iualtd_poster_10-07.pdf>; Kereta W et al, Involving HIV/AIDS volunteer home-based care providers through community-based organizations to strengthen TB control, op cit.

6 See Makame et al, Private health-care sector involvement in the provision of TB/HIV collaborative services op cit; Kereta W et al, Involving HIV/AIDS volunteer home-based care providers through community-based organizations to strengthen TB control, op cit; Mathai R, Galbraith J, Faith-based leadership in effective HIV/AIDS program delivery, op cit.

7 Nunn P, Reid A, De Cock K, Tuberculosis and HIV infection: the global setting, J Infec Dis 196, Suppl 1 (2007): S5–S14 <www.journals.uchicago.edu/doi/abs/10.1086/518660>

8 Nigeria Federal Ministry of Health and National TB/HIV Working Group, Draft report on 2007 TB/HIV collaborative activities, op cit.

9 A draft of the community-based DOT for Nigeria that was available during the study neglected to mention the importance of working with CBOs, but this was added in the subsequent draft (personal communication, Dr. M. Gidado).

10 Family Health International, Draft concept paper, op cit; Family Health International, HIV/AIDS, sexually transmitted infections, and tuberculosis, op. cit.

11 International Centre for HIV/AIDS Care and Treatment Programs (ICAP), Partnerships with community-based organizations key to delivering patient support services in Nigeria, ICAP News, Jan. 2008 <www.columbia-icap.org/news/icapnews/January08ENews.html>

12 Bond V, Nyblade L, The importance of addressing the unfolding TB-HIV stigma in high HIV prevalence settings. J Comm & Appl Soc Psych 16, 6 (2006): 452–61 <www3.interscience.wiley.com/journal/113440475/abstract?CRETRY=1&SRETRY=0>

13 Reis C, Heisler M, Amowitz L, Moreland RS, Mafeni JO. Chukwuemeka A, Iacopino V. Discriminatory attitudes and practices by health workers toward patients with HIV/AIDS in Nigeria, PLoS Medicine 2,8 (2005) <http://medicine.plosjournals.org/archive/1549-1676/2/8/pdf/10.1371_journal.pmed.0020246-L.pdf>

14 Zachariah R, Spielmann MP, Harries AD, Buhendwa L, Chingi C, Motives, sexual behaviour and risk factors associated with HIV in individuals seeking voluntary counselling and testing in a rural district of Malawi, Trop Doct 33 (2003): 88– 91 <www.ncbi.nlm.nih.gov/pubmed/12680541>

15 World Health Organization, Community involvement in tuberculosis care and prevention, op cit.

16 World Health Organization, Community contribution to TB care, op cit.

17 World Health Organization, The Stop TB Strategy, op cit.

18 Bond, V, Nyblade L, The importance of addressing the unfolding TB-HIV stigma in high HIV prevalence settings, op cit.

19 International Centre for HIV/AIDS Care and Treatment Programs (ICAP), Partnerships with community-based organizations key to delivering patient support services in Nigeria, ICAP News, Jan. 2008 <www.columbia-icap.org/news/icapnews/January08ENews.html>

20 Kapulula, P, Banda R, Kagoli M, Kaswaswa K, Kwanjana J, Quality of care from the perspective of the TB patient in Malawi:; Mugisha, F, Puta C, Ndyahikayo J, Adatu F, Matovu JB, Nkolo A. Quality of care from the perspective of the TB patient in Uganda; Onyango-Ouma, W, Muthama D, Sitienei J, Adala S and Gacheri S, Quality of Care from the perspective of the TB patient in Kenyain QUOTE-TB: Development of Quote TB tool. Measuring the quality of TB services: the patient's perspective (The Hague: Tuberculosis Coalition for Technical Assistance, 2005).

21 Munga MA, Mbilinyi, DR, Non-financial incentives and retention of health workers in Tanzania. Combined evidence from literature review and a focused cross-sectional study, EQUINET Discussion Paper Series 61 <www.equinetafrica.org/bibl/docs/DIS61HRmunga.pdf>

22 Sanderson J, Beith A, Do incentives and enablers improve TB program outcomes? Evidence from an informal survey and a literature review," Workshop on the Use of Incentives and Enablers to Improve TB Program Performance, UNION Conference, Paris, Fall 2001 www.msh.org/projects/rpmplus/Documents/upload/IE_Survey_Lit_Review_Presentation.pdf

23 Examples can also be seen in literature that predates the HIV/AIDS epidemic.

24 World Health Organization, Task shifting to tackle health worker shortages (Geneva: WHO, 2007) <www.who.int/healthsystems/task_shifting_booklet.pdf>

Study Team Recommendations

Developing and maintaining partnerships requires time and effort, especially when these are forged between programs that often act independently. Nevertheless, such partnerships are required to rapidly scale up comprehensive and cost-effective TB/HIV care. Though there will be associated costs, these may not be a major barrier in the current funding era.

For TB and HIV program managers

Map and assess CBOs already involved in HIV/AIDS programming, the services they offer, their linkages with communities they serve, and their interest in and capacity for working in TB/HIV. In Nigeria, as in many other countries, this process can be facilitated by CCMs, HIV/AIDS networks such as NEPHWAN, and AIDS control bodies at the national, state, and local levels.

- Approach these organizations to determine how they might be able to make a contribution to scaling up TB/HIV services. Areas of work outlined in a recent WHO publication on community involvement in TB care and prevention should be taken into consideration,[1] since these can be easily adapted to TB/HIV.
- Ensure CBOs participate in planning from the outset and at all levels to introduce and scale up comprehensive TB/HIV collaborative activities.
- Consider the engagement of larger, established umbrella organizations that have an established track record with the HIV/AIDS community and use them to facilitate communication between the NTP, NAP, and their networks. The umbrella organizations can also represent smaller organizations when developing policy platforms and planning activities. They can also keep smaller organizations abreast of current approaches that improve the quality of comprehensive care. They may also be engaged in training and supervising TB and TB/HIV activities, and may be able to leverage and/or secure funding to implement training activities because of their engagement at national and regional levels.
- Consider adopting a methodology to identify those practices implemented by HIV/AIDS-related CBOs that do the most to support TB/HIV collaborative activities. In Nigeria, the study team considered that the following were among those that could be used to scale up integrated services: referral systems, client-centered approaches, culturally sensitive and gender-sensitive care, consistent application of GIPA.
- Recognize that CBOs can help to ensure client–centered approaches and build on current activities to ensure that PLWHA have access to intensified screening for TB and IPT when indicated, according to national protocols. CBOs can also ensure that TB IC is a consideration in all healthcare and congregate settings. They can also assist in the uptake of HCT for TB patients and support appropriate referrals to HIV services, including CPT and ART.
- Closely monitor and assess the HAST model and its feasibility for rapid scale-up. The model's standardized recording and reporting formats are unique, seem very comprehensive, and lend themselves to better patient management. These tools should also be carefully evaluated by a given national task force so their use can be considered when scaling up through other partner sites. A variety of such tools are currently being used in different sites in Nigeria, and they need to be standardized for use in referral systems and to scale up TB/HIV services.
- Develop close partnerships with CBOs that have a successful history in working with volunteers. Consider how to sustain volunteer efforts and include this area in planning.
- TB IC must be taken into consideration when determining how and when to engage all volunteers in TB/HIV collaborative activities. Work to ensure that volunteers have appropriate information on TB transmission and skills, and that they receive appropriate training and supportive supervision. Ensure that clear roles and responsibilities that are negotiated between local health staff and CBO are agreed to by all.
- Consider incentives and enablers, balancing need with sustainability, and ensuring that some funds are made available to support them.

CBOs can help to determine the appropriate level of support.

- Assess stigma—whether it is a problem and its magnitude, if so—as part of TB/HIV programming and involve persons with TB and HIV in the assessments. Develop a comprehensive strategy to address findings.

For CBOs

- Ensure that TB forms part of HIV/AIDS services provided in clinic and community settings and that CBO client–centered activities contribute to intensified case finding, DOT, IPT, and TB infection control.
- Use networks of volunteers to assist the NTP in providing default tracing and DOT to dually infected clients.
- Actively pursue participation on TB/HIV coordinating bodies at all levels to synchronize and improve TB and HIV control programs in communities.
- Umbrella organizations should be assertive in pursuing partnerships with the NTBLCP that help to coordinate, plan, implement and oversee TB and TB/HIV activities. They should also advocate on behalf of their CBO constituency on coordinating bodies. At a minimum, this advocacy should be consistent with current mandates, such as capacity development and M&E. Umbrella organizations can help to bridge gaps between the mandates of their networks and activities undertaken by TB and HIV/AIDS programs.
- Partner with local and state TB control programs to ensure a coordinated approach, either directly or through an umbrella or another organization that provides effective representation and feedback in both directions. Membership on TB/HIV coordinating bodies will ensure effective and efficient planning to scale up services. Staff from coordinating bodies should be encouraged to participate in TB and TB/HIV training for CBOs.
- Work with the local partners to integrate appropriate, culturally sensitive, TB messages into current community awareness and social mobilization activities.
- Advocate for common services points to ensure optimal patient care and lessen the burden of referral services for clients, health providers, and CBOs.
- Take part in operational research on stigma and advocate for strategies that address it.

For TB and HIV consultants

- Be aware of the potential roles that CBOs can play in scaling up TB/HIV. Knowledge of national and international policies and guidelines on engaging civil society is key to understanding how best to proceed. CBOs can support the NTP in many ways, and TB staff in local clinics may not have the time or the skills to provide some of these services. CBOs can also facilitate or provide training and supervision for volunteers as well as training to reduce stigma for healthcare workers.
- Assist the NTP to map CBOs, assess their capacities, and the state of readiness of clinical services to engage these organizations in TB/HIV services.
- Provide technical assistance to build the capacity of CBOs in TB/HIV and mobilize funds to support this activity, if needed.
- Support efforts of the NTP and NAP to measure the quality and effectiveness of CBO engagement, balancing the need for data and overstretched health services. The CBOs should be engaged throughout this process.
- Explore with national programs the extent of stigma and how to address it.

For teams conducting similar studies

- Include on the study team members of TB and HIV programs and individuals who can influence policy so some immediate changes can be made.
- Involve team members in adapting and pilot-testing questionnaires to ensure appropriate questions are asked and ownership of the process.
- Invite major technical partners that support TB and HIV programs to a stakeholder workshop at the beginning of the study and to participate in the debriefing.
- Consider next steps that address the extent and quality of collaborative services provided by CBOs. Allocate time and resources to collecting and analyzing the data available in different sources and locations that quantify the impact of these services.
- Plan for and publish the results of the study in peer-reviewed journals. The considerable amount of collaborative activity in TB/HIV being undertaken by communities is not reflected in these publications.

Notes: Section 5

1 World Health Organization, Community involvement in TB care and prevention, op cit.

References

AVERT. HIV and AIDS in Nigeria. Horsham, UK: AVERT, 2008. <www.avert.org/aids-nigeria.htm#top#top>

Bacheller S, Coggin B, Huitema I, van Cleeff M. USAID support to the National TB and Leprosy Program in Nigeria: report evaluation, 15–26 January 2007. Unpublished paper.

Bates I, Fenton C, Gruber J et al. Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part 1: determinants operating at individual and household level. Lancet Infect Dis, 4, 5 (May 2004):267–77.

Beith A, Eichler R, Weil D. Performance-based incentives for health: a way to improve tuberculosis detection and treatment completion? Center for Global Development Working Paper No. 122, April 23, 2007. <http://ssrn.com/abstract=1003247>

Beith A, Eichler R, Sanderson J, Weil D. Can incentives and enablers improve the performance of tuberculosis control programs? analytical framework, catalogue of experiences and literature review. Paper prepared for the workshop on incentives and enablers to improve performance of TB control, IUATLD Conference, Paris, Nov. 2001.

Bond, V, Nyblade L. The importance of addressing the unfolding TB-HIV stigma in high HIV prevalence settings. J Comm & Appl Soc Psych 16, 6 (2006): 452–61 <www3.interscience.wiley.com/journal/113440475/abstract?CRETRY=1&SRETRY=0>

De Cock KM, Chaisson RE. Will DOTS do it? A reappraisal of tuberculosis control in countries with high rates of HIV infection. Int J Tuberc Lung Dis 3(1999):457–65. <www.ncbi.nlm.nih.gov/pubmed/10383056?dopt=Abstract>

Chimzizi R, Gausi F, Bwanali A, Mbalume D, Teck R, Gomani P, Zachariah R, Zuza W, Malombe R, Salaniponi FM, Harries AD. Voluntary counselling, HIV testing and adjunctive cotrimoxazole are associated with improved TB treatment outcomes under routine conditions in Thyolo District, Malawi. Int J Tuberc Lung Dis 8, 5 (2004):579–85. <www.ncbi.nlm.nih.gov/pubmed/15137534?dopt=Abstract>

Corbett EL, Marston B, Churchyard GJ, De Cock KM. Tuberculosis in sub-Saharan Africa: opportunities, challenges, and change in the era of antiretroviral treatment. Lancet 367, 9514 (Mar 18 2006): 926-937. <www.ncbi.nlm.nih.gov/pubmed/16546541>

Creese A et al. Cost-effectiveness of HIV/AIDS interventions in Africa: a systematic review of the evidence. Lancet 359, 9318 (May 11, 2002):1635-43

Family Health International/Nigeria. Draft concept paper for the engagement of community- based organizations (CBOs) for the implementation of the LGA HAST model. 2007. Unpublished.

Family Health International/Nigeria. HIV/AIDS, sexually transmitted infections, and tuberculosis (HAST) model of community TB care: Project assessment of Yakurr Local Government Area, Cross River State. 2008. Unpublished.

Forum for Collaborative HIV Research, HIVMA, and Infectious Diseases Society of America. HIV/TB coinfection: Basic facts, October 2007. <www.idsociety.org/uploadedFiles/IDSA/Resources/Fact_Sheets/HIV_TB_Coinfection_Oct_2007.pdf>

Global Fund to Fight AIDS, Tuberculosis and Malaria. Grant performance report: scale up of comprehensive HIV and AIDS treatment, care and support, Nigeria, August, 2008. Geneva: GFATM, 2008. <www.theglobalfund.org/search/docs/5NGAH_1180_515_gpr.pdf>

Global Fund and International HIV/AIDS Alliance. Civil society success on the ground: community systems strengthening and dual fast-track financing: nine illustrative case studies. Geneva and Brighton, UK: Global Fund and the Alliance, 2008. <www.aidsalliance.org/graphics/secretariat/publications/Civil_society_success_eng.pdf>

Global Fund and International HIV/AIDS Alliance. Khana's Integrated Care and Prevention Program. In Civil society success on the ground: community systems strengthening and dual fast-track financing: nine illustrative case studies. Geneva and Brighton, UK: Global Fund and the Alliance, 2008, p. 10-14. <www.aidsalliance.org/graphics/secretariat/publications/Civil_society_success_eng.pdf>

International Centre for HIV/AIDS Care and Treatment Programs (ICAP). Partnerships with community-based organizations key to delivering patient support services in Nigeria. ICAP News, Jan. 2008. <www.columbia-icap.org/news/icapnews/January08ENews.html>

International HIV/AIDS Alliance. Integrating HIV/AIDS and TB service: a practical resource. Case studies and experiences from seven countries, 10–14 February 2003, Magaliesburg, South Africa. Brighton, UK: International HIV / AIDS Alliance, 2003. <www.popline.org/docs/280340>

International HIV/AIDS Alliance. Community engagement for universal access. 2007. <www.aidsalliance.org/graphics/secretariat/publications/What_is_community_engagement_for_ARV_treatment.pdf. >

International HIV/AIDS Alliance. Outcomes of the forum: HIV/AIDS and the community: the past, present and future, 31 January 2007. <www.ovcsupport.net/sw44606.asp>

International HIV/AIDS Alliance. Shift in HIV/AIDS project funding required. Press release, 6 Dec. 2007. <www.aidsalliance.org/sw51811.asp>

Kapulula, P, Banda R, Kagoli M, Kaswaswa K, Kwanjana J. Quality of care from the perspective of the TB patient in Malawi: Development of Quote TB Tool. In QUOTE-TB Measuring the quality of TB services: the patient's perspective. The Hague: Tuberculosis Coalition for Technical Assistance, 2005.

Kereta W, Gebreselassie G, Gebremedhin H, Stuer F, Waites BA. Involving HIV/AIDS volunteer home-based care providers through community-based organizations to strengthen TB control in Addis Ababa, Ethiopia. The XV International AIDS Conference, abstract no. TuPeD5213, July 2004. <www.skillsbuilding.org/Abstracts/A2169319.aspx>

Kironde S, and Klaasen S. What motivates lay volunteers in high burden but resource-limited tuberculosis

control programmes? Perceptions from the Northern Cape province, South Africa. Int J TB Lung Dis 6, 2 (2002): 104–110. <www.ingentaconnect.com/content/iuatld/ijtld/2002/00000006/00000002/art00003>

Makame MH, Ramaiya K, Munuo G. Private health-care sector involvement in the provision of TB/HIV collaborative services in Tanzania. Poster for PEPFAR implementers meeting, Rwanda. <www.path.org/files/HIV-AIDS_iualtd_poster_10-07.pdf>

Maher, D. The role of the community in the control of tuberculosis. Tuberculosis 83 (2003), 177–82. <http://bvs.insp.mx/articulos/5/12/022005.pdf>

Mathai R, Galbraith J. Faith-based leadership in effective HIV/AIDS program delivery: Improving access to treatment through church health institutions and parish networks in Africa, India and the Caribbean. 15 Int Conf AIDS (2004), abst. no. MoPeE4292. <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102280571.html>

Munga MA, Mbilinyi, DR. Non-financial incentives and retention of health workers in Tanzania. Combined evidence from literature review and a focused cross-sectional study, EQUINET Discussion Paper Series 61. <www.equinetafrica.org/bibl/docs/DIS61HRmunga.pdf>

Mugisha, F, Puta C, Ndyahikayo J, Adatu F, Matovu JB and Nkolo A. Quality of care from the perspective of the TB patient: development of Quote TB tool in Uganda. In QUOTE-TB Measuring the quality of TB services: the patient's perspective. The Hague: Tuberculosis Coalition for Technical Assistance, 2005.

Mukadi YD, Maher D, Harries A. Tuberculosis case fatality rates in high HIV prevalence populations in sub-Saharan Africa. AIDS 15, 2 (Jan 26 2001):143–52. <www.ncbi.nlm.nih.gov/pubmed/11216921>

National Intelligence Council. The next wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China. Intelligence community assessment, Sept. 2002. <www.dni.gov/nic/PDF_GIF_otherprod/HIVAIDS/ICA_HIVAIDS20092302.pdf>

Nigeria. National Action Committee on AIDS. HIV/AIDS national strategic framework for action (2005–2009). Abuja: Government of Nigeria, 2005. <www.naca.gov.ng/index.php?option=com_content&task=view&id=80&Itemid=118>

Nigeria. Federal Ministry of Health and National TB/HIV Working Group. Draft report on 2007 TB/HIV collaborative activities in Nigeria, 2007. Unpublished.

Nigeria. Federal Ministry of Health. National Tuberculosis and Leprosy Control Programme. Guidelines for community tuberculosis care, 2008. Unpublished

Nigeria Federal Ministry of Health. Guidelines for clinical management of TB and HIV/AIDS related conditions in Nigeria. Unpublished

Nsutebu EF, Walley JD, Mataka E, Simon CF. Scaling-up HIV/AIDS and TB home-based care: lessons from Zambia. Health Policy Plan 16, 3 (2001): 240–47. <www.ingentaconnect.com/content/oup/heapol/2001/00000016/00000003/art00240>

Nunn P, Reid A, De Cock K. Tuberculosis and HIV infection: the global setting. J Infec Dis 196, Suppl 1 (2007): S5–S14 <www.journals.uchicago.edu/doi/abs/10.1086/518660>

Ogden, Jessica. Integrating TB and HIV diagnosis, treatment and care from facility to community in Nampula Province, Mozambique. International Center for Research on Women (ICRW) <www.icrw.org/html/projects/projects_hivaids.htm#TB>

Onyango-Ouma, W, Muthama D, Sitienei J, Adala S and Gacheri S. Quality of care from the perspective of the TB patient in Kenya: Development of Quote TB Tool. In QUOTE-TB Measuring the quality of TB services: the patient's perspective. The Hague: Tuberculosis Coalition for Technical Assistance, 2005.

US President's Emergency Plan for AIDS Relief. Country profile: Nigeria. Washington DC: PEPFAR, 2008. <www.pepfar.gov/documents/organization/81638.pdf>

Morrison, K. Breaking the cycle. stigma, discrimination, internal stigma and HIV. Washington DC: Policy Project and USAID, 2006. <www.policyproject.com/pubs/generalreport/Breaking_the_Cycle.pdf>

Reis C, Heisler M, Amowitz L, Moreland RS, Mafeni JO. Chukwuemeka A, Iacopino V. Discriminatory attitudes and practices by health workers toward patients with HIV/AIDS in Nigeria. PLoS Medicine 2,8 (2005). <http://medicine.plosjournals.org/archive/1549-1676/2/8/pdf/10.1371_journal.pmed.0020246-L.pdf>

RESULTS. The US President's Emergency Plan for AIDS Relief: Achieving impact through scale up of TB-HIV activities. Washington, DC: RESULTS Educational Fund, 2007. <www.results.org/website/download.asp?id=2808>

Sanderson J, Beith A. Do incentives and enablers improve TB program outcomes? Evidence from an informal survey and a literature review. Workshop on the Use of Incentives and Enablers to Improve TB Program Performance, UNION Conference, Paris, Fall 2001 www.msh.org/projects/rpmplus/Documents/upload/IE_Survey_Lit_Review_Presentation.pdf

Sinanovic E, Kumaranayake L. Sharing the burden of TB/HIV? Costs and financing of public-private partnerships for tuberculosis treatment in South Africa. Trop Med Int Health 11,9 (Sept. 2006):1466–74. <http://www3.interscience.wiley.com/cgi-bin/fulltext/118598824/PDFSTART>

Swannepha, TN. Promoting implementation of WHO's Policies on collaborative TB/HIV activities. Lessons learned from PLWH Groups in Côte d'Ivoire, Nigeria, Swaziland and Uganda. Presented on behalf of partners in RCI, Nigeria and Uganda, HIV/AIDS Implementers meeting. Uganda, June 6, 2008. <www.hivimplementers.com/pdf/H6/H6_515_PEREZ%20SUE.pdf>

Torres, Mercedes. Advance Africa Project: best practices final report. Arlington, Va.: Management Sciences for Health, 2005. <http://pdf.usaid.gov/pdf_docs/PDACF704.pdf>

Tsiouris SJ, Gandhi NR, El-Sadr WM, Friedland F. Tuberculosis and HIV—needed: a new paradigm for the control and management of linked epidemics. Med Gen Med 9(3) 2007: 62. <www.iasociety.org/Web/WebContent/File/Tuberculosis%20and%20HIV.pdf>

UK Department for International Development. Country profile: Nigeria. 2008 <www.dfid.gov.uk/countries/africa/nigeria.asp>

UK Department for International Development. Nigeria fact sheet (last updated June 2008). <www.dfid.gov.uk/pubs/files/nigeriaFactsheet2008.pdf>

UK Department for International Development. Nigeria. Key facts. 2008. <www.dfid.gov.uk/countries/africa/Nigeria-facts.asp>

UNAIDS. UNAIDS acts to strengthen 'GIPA' with new policy. Geneva: UNAIDS, 2007. <www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2007/20070330_GIPA_Policy_Brief.asp>

UNAIDS. Country responses: Nigeria. Geneva: UNAIDS, 2008. <www.unaids.org/en/CountryResponses/Countries/nigeria.asp>

UNAIDS. Nigeria UNGASS report 2007. Geneva: UNAIDS, 2008. <http://data.unaids.org/pub/Report/2008/nigeria_2008_country_progress_report_en.pdf>

UNAIDS and Stop TB Partnership. Fight AIDS, fight TB, fight now. TB/HIV information pack. Geneva: UNAIDS, 2004. <http://www.stoptb.org/news/archives/iacxv/TBHIVInformationPack.asp>

US Agency for International Development. USAID assistance to Nigeria. Fact sheet. Washington, DC: USAID, 2008 <www.usaid.gov/press/factsheets/2003/03fs_nigeria.html>

US Agency for International Development. Infectious diseases. Nigeria. Washington, DC: USAID, 2008. <www.usaid.gov/our_work/global_health/id/tuberculosis/countries/Africa/nigeria_profile.html>

van der Grinten E, Oyama E. A desk study TB-CAP. Nigeria. September 2008. Unpublished

Wandwalo E, Kapalata N, Tarimo E, Corrigan CB, Morkve O. Collaboration between the national tuberculosis programme and a non governmental organisation in TB/HIV care at a district level: experience from Tanzania. African Health Sciences 4, 2 (August 2004): 109–14. <www.cababstractsplus.org/google/abstract.asp?AcNo=20053191790>

World Bank. Country brief: Nigeria. Washington, DC: World Bank, 2008. <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/NIGERIAEXTN/0,,menuPK:368906~pagePK:141132~piPK:141107~theSitePK:368896,00.html>

World Health Organization. Community contribution to TB Care: practice and policy: review of experience of community contribution to TB care and recommendations to national TB programmes. Geneva: WHO, 2003. <http://whqlibdoc.who.int/hq/2003/WHO_CDS_TB_2003.312.pdf>

World Health Organization. Community involvement in tuberculosis care and prevention: towards partnerships for health. guiding principles and recommendations based on a WHO review. Geneva: WHO, 2008 <http://whqlibdoc.who.int/publications/2008/9789241596404_eng.pdf>

World Health Organization. Community TB care in Africa. Report on "lessons learned" meeting in Harare, Zimbabwe, 27-29 September 2000. Geneva: WHO, 2001 <http://www.afro.who.int/tb/res-pub/community_tb_care_in_africa.pdf>

World Health Organization. Interim policy on TB/HIV collaborative activities. Geneva: WHO, 2004 <http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330.pdf>

World Health Organization. Report of a "lessons learnt" workshop on the six ProTEST pilot projects in Malawi, South Africa and Zambia, 3-6 February 2003. Geneva: WHO, 2004 <http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.336.pdf>

World Health Organization. The Stop TB Strategy. Building on and enhancing DOTS to meet the TB-related millennium development goals. Geneva: WHO, 2006 <http://whqlibdoc.who.int/hq/2006/WHO_HTM_STB_2006.368_eng.pdf>

World Health Organization. Taking stock. Task shifting to tackle health workers shortages. Geneva: WHO, 2007. <www.who.int/healthsystems/task_shifting_booklet.pdf>

World Health Organization, Task shifting to tackle health worker shortages. Geneva: WHO, 2007. www.who.int/healthsystems/task_shifting_booklet.pdf

World Health Organization. WHO report 2005. Global tuberculosis control: surveillance, planning, financing. Geneva: WHO, 2005. <www.who.int/tb/publications/global_report/2005/en/index.html>

World Health Organization. WHO report 2006: global tuberculosis control: surveillance, planning, financing. Geneva: WHO, 2006. <www.who.int/tb/publications/global_report/2006/en/index.html>

World Health Organization. WHO report 2008: Global tuberculosis control: surveillance, planning, financing. Geneva: WHO, 2008. <www.who.int/tb/publications/global_report/2008/en/index.html>

World Health Organization. The World Health Report 2007—A safer future: global public health security in the 21st century. Geneva: WHO, 2007. <www.who.int/whr/2007/whr07_en.pdf>

World Health Organization. 10 essential actions for effective TB infection control. Safety without stigma. Geneva: WHO, 2008 <www.who.int/tb/en/>

Zachariah R, Spielmann MP, Harries AD, Buhendwa L, Chingi C. Motives, sexual behaviour and risk factors associated with HIV in individuals seeking voluntary counselling and testing in a rural district of Malawi. Trop Doct 33 (2003): 88– 91. <www.ncbi.nlm.nih.gov/pubmed/12680541>

Zachariah R, Teck R, Buhendwa L, Labana S, Chinji C, Humblet P, Harries AD. How can the community contribute in the fight against HIV/AIDS and tuberculosis? An example from a rural district in Malawi. Trans R Soc Trop Med Hyg 100 (2006): 167–75. http://fieldresearch.msf.org/msf/bitstream/10144/17717/1/trans%20buhendwa%20labana%20HIV.pdf

ANNEX 1

CBOs Selected for the Case Study

CROSS RIVER STATE

Good Shepherd Initiative, CBO

Health Foundation, CBO

Positive Development Foundation, NGO providing consultative services

Presbyterian Community Development Services (Presbycom), umbrella FBO

KANO STATE

Fortress for Women, CBO

Participatory Learning Action and Community Ownership (PLACO), CBO

Society for Women and AIDS in Africa, Nigeria (SWAAN), CBO

Youth Society for Prevention of Infectious Diseases and Social Vices (YOSPIS), umbrella CBO

OSUN STATE

Living Hope Care, CBO

OYO STATE

Divine Emission Initiative (DEMI), NGO

Hope for Positive Couples, NGO

Network on Ethics/Human Rights, Law, HIV/AIDS, Prevention, Support, and Care (NELA), umbrella NGO

ANNEX 2

QUESTIONNAIRE FOR CBOs ENGAGED IN HIV ACTIVITIES • Page 1 of 5	
Date (dd/mm/yyyy)	
Name of interviewer	
Name of organization	
Location	
Name of respondent	
Respondent's occupation/position	
Respondent's address/contact information	
Population of community, in thousands, based on last census	
Please review registers and collect information on patients seen and services provided during the last fiscal year and/or quarter.	# clients diagnosed with HIV____ # HIV patients screened for TB ____ # HIV clients on ART ____ # clients diagnosed with TB ____ # TB patients screened for HIV ____ # TB/HIV co-infected, total ____ # co-infected patients on ART ____
Characteristics	
How long has the organization been working in this community?	
Is this an umbrella organization with networks that you support? If yes, describe your network	☐ Yes ☐ No
If you are part of a network, please list the names of other organizations that belong to it.	
Does organization have representation and/or activities that are international, regional, national, or local?	
Is your organization registered at the national, state, or LGA level?	
What is your organizational coverage?	☐ National ☐ State: How many?____ ☐ LGA only: how many? ____
At what level of the health system do you mostly work?	☐ Primary ☐ Secondary ☐ Tertiary
Does your organization work with health facilities? If yes, what type?	☐ Yes ☐ No ☐ Primary ☐ Secondary ☐ Tertiary
Is your organization involved in institutional health services?	☐ Yes ☐ No ☐ Workplace ☐ Prisons ☐ Other
Is a written profile of your organization available? If yes, please provide a copy.	☐ Yes ☐ No
Paid staff and volunteers	
How many of your staff are paid workers?	
What are the roles and responsibilities of your paid staff?	
Do you work with volunteers? If yes, how many?	☐ Yes ☐ No Number _____
What are the roles and responsibilities of your volunteers?	
How are volunteers recruited, trained, and supervised?	
Do you provide incentives for volunteers? If yes, please describe.	☐ Yes ☐ No
Do you have a workplace HIV/AIDS program in place? If so, does it include provision of IEC on HIV, anti-discrimination policies, access to HCT, treatment of opportunistic infections, and ART?	

QUESTIONNAIRE FOR CBOs ENGAGED IN HIV ACTIVITIES Page 2 of 5	
Organization and management	
Is there a description of your organization's governance structure (board of directors, management team); administrative structure; mission statement; goals; and objectives? If no, please describe.	☐ Yes ☐ No
Do you have a strategic plan? If yes, please provide a copy.	☐ Yes ☐ No
Are you involved in any HIV/AIDS coordinating bodies and/or technical groups? If yes, please indicate at which levels, such as NACA, SACA, and LACA.	☐ Yes ☐ No
Does your organization receive external supportive supervision?	☐ Yes ☐ No
Do you have an internal mechanism for supervision?	☐ Yes ☐ No
What technical assistance do you receive to support your organization's development and management?	
Funding	
What are your sources of funding for your HIV/AIDS activities?	
If you need funding for a new initiative, how do you go about it?	
What innovative approaches have you adopted to access funding for HIV and AIDS programs?	
Capacity building	
What is your organization doing to build the capacity of staff and other stakeholders?	
In HIV/AIDS prevention	
In advocacy and social mobilization for prevention of HIV/AIDS	
In care and treatment services for PLWHA	
Monitoring and evaluation	
What M&E systems are you using?	
Do you have an M&E plan?	☐ Yes ☐ No
Do you have an M&E officer?	☐ Yes ☐ No
What indicators do you use?	
How are you reporting?	
To whom?	
How often?	
Have your staff participated in any capacity building on M&E?	☐ Yes ☐ No
Engagement in TB/HIV collaborative activities	
Which statement best characterizes your organization's role in TB/HIV collaborative activities? Please describe any interventions and activities that you are undertaking.	
☐ My organization is currently not working in TB, and we have no plans for involvement.	
☐ Although we are not working in TB, we wish to be involved in TB activities.	
☐ We have a few interventions in TB, but we have not scaled up these activities.	
☐ We are working in HIV, and we undertake TB/HIV collaborative activities.	
☐ Other (please specify)	
Core competencies	
What are your organization's core competencies?	
☐ Advocacy	
☐ Clinical care	
☐ Patient support	

QUESTIONNAIRE FOR CBOs ENGAGED IN HIV ACTIVITIES Page 3 of 5		
Core competencies (continued)		
☐ Prevention		
☐ Social mobilization		
☐ Training		
☐ Other		
Have you done, are you doing, or do you intend to carry out any research activity? If yes, please describe.	☐ Yes ☐ No	
Does your organization focus on special or hard-to-reach populations? If yes, please specify (e.g., prisoners, migrant populations, truck drivers, uniformed personnel)	☐ Yes ☐ No	
HIV/AIDS activities and services		
How did you become involved in HIV/AIDS services? Please describe the process.		
Does your organization undertake HIV prevention activities? If yes, please indicate which.	Since when?	Target populations?
☐ Advocacy		
☐ Communications (radio, campaigns)		
☐ Condom distribution		
☐ IEC development		
☐ OVC support		
☐ Peer education		
☐ Social mobilization		
☐ Support groups		
☐ Other		
If your organization undertakes advocacy and social mobilization activities relating to HIV prevention, please indicate the groups targeted and describe any results		
☐ Policymakers	☐ Yes ☐ No Results _____	
☐ Community leaders	☐ Yes ☐ No Results _____	
☐ Youth	☐ Yes ☐ No Results _____	
☐ General population	☐ Yes ☐ No Results _____	
☐ Other (please specify)	☐ Yes ☐ No Results _____	
If your organization is engaged in HIV/AIDS care and treatment activities, please indicate which ones.	Since when?	Target populations?
☐ ART		
☐ HBC		
☐ HCT		
☐ PMTCT		
☐ Psychosocial support (e.g., crisis counseling, adherence)		
☐ Treatment for opportunistic infections (please state which ones)		
☐ Other		
Is your organization involved in advocacy and social mobilization activities relating to care, treatment, and support for PLWHA? If yes, please describe results.	☐ Yes ☐ No Results _____	

QUESTIONNAIRE FOR CBOs ENGAGED IN HIV ACTIVITIES Page 4 of 5	
HIV/AIDS activities and services (continued)	
Are you engaged in any income-generation activities for PLWHA? If yes, please describe activities and results.	☐ Yes ☐ No Results _____
Do you provide incentives for clients or others affected by HIV/AIDS?	☐ Patients ☐ Families of those affected ☐ Others
TB/HIV knowledge, policies, and guidelines	
How much do you know about TB and the relationship between TB and HIV?	
Is TB a problem in your community?	☐ Yes ☐ No If yes, please explain why
Is TB a problem among those that you serve or your staff?	☐ Yes ☐ No
Is stigma around TB an issue for the clients you serve?	☐ Yes ☐ No
Is fear of transmission of TB a concern for you or your clients?	☐ Yes ☐ No
Are you familiar with the national policies for TB/HIV?	☐ Yes ☐ No
Are you aware of national guidelines for TB/HIV?	☐ Yes ☐ No
Does your organization have policies on TB/HIV? If yes, please provide a copy.	☐ Yes ☐ No
Does your organization have technical TB/HIV guidelines? If yes, please provide a copy.	☐ Yes ☐ No
Current TB/HIV collaborative activities	
Which statement best characterizes your organization's role in TB/HIV collaborative activities? Please describe any interventions and activities that you are undertaking.	
☐ My organization is currently not working in TB, and we have no plans for involvement.	
☐ Although we are not working in TB, we wish to be involved in TB activities.	
☐ We have a few interventions in TB, but we have not scaled up these activities.	
☐ We are working in HIV, and we undertake TB/HIV collaborative activities.	
☐ Other (please specify)	
Is your organization conducting monitoring and evaluation of TB/HIV activities? If yes, please describe.	☐ Yes ☐ No
Does your organization work with volunteers who are involved in the following activities?	
Advocacy	☐ Yes ☐ No
Community mobilization	☐ Yes ☐ No
Case detection	☐ Yes ☐ No
DOT	☐ Yes ☐ No
Referrals	☐ Yes ☐ No
Treatment monitors	☐ Yes ☐ No
Supervision of treatment monitors	☐ Yes ☐ No
Other (please specify)	☐ Yes ☐ No
Engagement of other CBOs and recommendations	
Why do you think that CBOs that are involved in HIV are not involved in TB?	
What possible roles could be filled by CBOs currently working in HIV to strengthen the TB program?	
What advice would you provide to the TB program so that CBOs currently involved in HIV include TB as part of their prevention or care activities?	

QUESTIONNAIRE FOR CBOs ENGAGED IN HIV ACTIVITIES Page 5 of 5	
WHO POLICY ON COLLABORATIVE TB/HIV ACTIVITIES	
Engagement in mechanisms for collaboration	
Do you work with national, state. and/or LGA levels in providing integrated TB/HIV services? Please describe these integrated services.	
Is your organization participating in a state-level coordinating body for TB/HIV activities?	☐ Yes ☐ No
Is your organization involved in joint TB/HIV planning?	☐ Yes ☐ No
Engagement in decreasing the burden of TB in people living with HIV/AIDS	
Is your organization undertaking intensified TB case-finding? If yes, please describe	☐ Yes ☐ No
Is your organization providing IPT?	☐ Yes ☐ No
Does your organization provide HIV/AIDS treatment and support? If yes, please describe.	☐ Yes ☐ No
Does your organization have a TB infection control plan for facility and/or congregate settings?	☐ Yes ☐ No
Engagement in decreasing the burden of HIV in TB patients	
Does your organization provide HIV testing and counseling for TB patients?	☐ Yes ☐ No
Is your organization implementing HIV-prevention activities, such as promotion of condom use?	☐ Yes ☐ No
Does your organization provide CPT?	☐ Yes ☐ No
Does your organization provide HIV/AIDS care and support?	☐ Yes ☐ No
Does your organization provide ART?	☐ Yes ☐ No
Are you undertaking the following TB/HIV collaborative activities?	Please describe
Community mobilization around TB, HIV, and STIs	
Information on where to seek diagnosis and treatment	
Stigma reduction	
Sputum collection for TB diagnosis	
Tracing of defaulters	
Directly observing treatment for TB and/or HIV	
Other (please describe) _____	
Does your organization provide community-based TB care?	☐ Yes ☐ No If yes, describe.
Please describe any important issue(s) not captured by these questions	

ANNEX 3

Core Competencies and Areas of Practice Reported by CBOs

ACTIVITIES/ CORE COMPETENCIES	1	2	3	4	5	6	7	8	9	10	11	12	# OF ORGS.
Referrals	1	1	1	1	1	1	1	1	1	1	1	1	**12**
Support groups	1	1	1	1	1	1	1	1	1	1		1	**11**
Home-based or palliative care	1	1	1	1	1	1	1			1	1	1	**10**
Capacity building to individuals or groups	1			1	1		1	1	1	1	1	1	**9**
Income-generation for clients	1	1	1		1	1		1	1	1	1		**9**
Work with special populations as well as PLWHA	1		1	1	1	1		1	1		1	1	**9**
Community awareness	1	1	1					1	1	1	1	1	**8**
HCT	1	1			1	1			1	1	1	1	**8**
Stigma reduction	1		1		1	1		1	1	1	1		**8**
Capacity building to other organizations	1					1	1	1	1	1	1		**7**
Impact alleviation (nutritional support)	1	1					1	1	1	1	1		**7**
Training and management of peer educators		1	1	1	1		1		1			1	**7**
IEC production and distribution	1	1	1			1	1	1					**6**
Advocacy	1	1						1		1	1		**5**
Clinical care	1	1		1			1	1					**5**
Gender and woman's rights					1	1		1	1			1	**5**
Orphans and other vulnerable children		1				1	1			1	1		**5**
Research	1	1	1		1			1					**5**
Social mobilization	1		1					1	1		1		**5**
Skill-building for PLWHA		1			1						1	1	**4**
Counseling and referral for testing			1	1				1					**3**
Legal support or advocacy	1				1			1					**3**
Small-grants management	1												**1**

ANNEX 4

Factors that May Affect CBO Engagement in TB/HIV Collaborative Activities

INTERNAL TO THE ORGANIZATION	EXTERNAL TO THE ORGANIZATION
• Mandates and governance structures	• National and local policies for TB/HIV
• Management capacity, as described in the profile, planning, staffing, internal supervision, M&E	• Policies that are specific to engagement of CBOs and FBOs
• Type of services being delivered	• Mechanisms of collaboration in TB and HIV between the NTP and NAP
• Length of time in the community	• Involvement of partners in planning and levels for such involvement
• KAP of health workers toward TB/HIV	• Training opportunities for CBOs and FBOs in TB/HIV
• Knowledge of health-seeking behavior of clients	• Access to information on stigma for health professionals and communities
• Knowledge of TB and TB/HIV	• Information on health-seeking behavior of catchment populations
• Knowledge of policies and guidelines for TB/HIV	• Knowledge of TB/HIV among health workers and communities
• Organizational policies on TB/HIV	• Opportunities to access diagnosis and/or treatment of TB and HIV programs
• Linkages with NAPs	• Delivery of health services (TB and HIV) in the community and interface between public and private mix
• Linkages with the NTP	• Quantity and quality of IEC for health workers
• Resource mobilization and sources of funding	• Availability of technical assistance for collaborative TB/HIV activities—local, national, regional, and international
• Technical capacity in TB/HIV	
• Incentives or enablers for staff and volunteers	

KNCV Tuberculosis Foundation / TBCTA

P.O. Box 146, 2501 CC

The Hague, the Netherlands

Tel: 31 (0) 70 4167222; fax: 31 (0) 70 3584004

Email: info@kncvtbc.nl

Family Health International

4401 Wilson Blvd. Suite 700

Arlington, VA USA 22203

Tel: 703.516.9779; fax: 703.516.9781

Email: publications@fhi.org

www.fhi.org