

Training Manual on Intensified *TB/HIV Package*

for Medical Officers



Central TB Division and National AIDS Control Organization

Ministry of Health and Family Welfare

Government of India

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Intensified TB/HIV package

Training Manual for Medical Officers

Index

1.	Preface	2
2.	Acknowledgements	3
3.	Introduction	4
4.	Offer of HIV counseling & testing for all TB Patients	5
5.	CPT prescription for all HIV- Infected TB Patients	7
6.	Referral of HIV- Infected TB patients to ART Center	11
7.	Role and responsibilities in comprehensive TB-HIV Care	13
8.	Annexures	16

Preface

It is estimated that 2.5 million people are infected with HIV in India and considering estimated 40% of the Indian population is infected with Mycobacterium tuberculosis, an estimated 1 million persons are co-infected with Mycobacterium tuberculosis & HIV. HIV is the most powerful risk factor for the progression of TB infection to TB disease. Active TB disease is the commonest opportunistic infection amongst HIV-infected individuals and is also the leading cause of death in PLHA (People living with HIV/AIDS). This is further substantiated by the fact that an HIV positive person has 50-60% lifetime risk of developing TB disease as compared to an HIV negative person who has a lifetime risk of 10% of developing the TB disease.

HIV survey amongst the TB patients jointly conducted by CTD & NACO has shown 1% to 13% HIV amongst TB patients. This diverse data shows us that different strategies need to be employed within the country to reach out to PLHAs and addresses their need for early diagnosis, treatment and care & support. The need of the hour is to establish an intensified package of services for TB-HIV for high HIV prevalence areas and a basic package for the rest of the country.

TB can be easily cured through the DOTS strategy provided through RNTCP; there is still no cure for HIV. With ART being provided free through NACP, HIV is now a **chronic manageable illness**.

The basic purpose of HIV-TB collaborative activity is to ensure synergy between the two programmes for the prevention and control of both diseases. National Framework for joint TB/HIV collaborative activities has been laid down by both the programmes and the collaborative activities have yielded very promising results over the last few years. In order to further strengthen the collaborative activities training of staff is very crucial. To streamline training, both the programmes have come up with joint modules which address the training needs of various categories of staff. It is envisaged, that standardized modular training shall be imparted to all the Programme and general health staff in the country.

The modules cover the relevant aspects of both the diseases comprehensively, and will be a valuable guide for the different category of health service provider towards discharging their duties optimally. We hope this module would be useful for further strengthening the TB/HIV collaborative activities in the country.



(Dr. L. S. Chauhan)
Deputy Director General (TB)



(Dr. Jotna Sokhey)
Addl. DG & APD (NACO)

Acknowledgements

This training material has been prepared jointly by Central TB Division, DGHS & National AIDS Control Organization for the training of Medical officers under the guidance of Dr Jotna Sokhey, Addl DG, NACO and Dr LS Chauhan, DDG (TB) CTD, DGHS by a writing group comprising of Dr. A. K. Khera, Dr. Devesh Gupta, Dr. Neeraj Raizada, Dr. Rahul Thakur and Dr. Puneet Dewan.

INTRODUCTION:

Active TB disease is the most common opportunistic infection amongst HIV infected individuals. From the public health point of view, the best way to prevent TB is to provide prompt effective diagnosis & treatment to people with infectious TB. This interrupts the chain of transmission. For HIV-infected patients who have TB, they will benefit from HIV-related care and treatment. Basic TB/HIV collaborative interventions are necessary across the country. These include the establishment of coordination mechanisms at all levels, service delivery coordination and cross referrals, involvement of NGOs in TB/HIV activities, and implementation of airborne infection control measures in HIV care settings.

Surveillance has shown that where HIV seroprevalence is high, HIV infection among TB patients is also common. Because of this association, in areas where HIV seroprevalence is high and HIV testing services are widely available, it is important that patients with tuberculosis have the opportunity to know their HIV status. An Intensified TB/HIV Package of Services has been established for high HIV prevalence areas. This package would facilitate early detection of HIV infection in TB patients and promote early access to HIV care and treatment, and is expected to reduce death and disease among HIV-infected TB patients.

HIV counselling and testing and care and treatment services including management of OIs, Cotrimoxazole Prophylaxis and access to ART is rapidly expanding and widely available under the National AIDS Control Programme. Management of TB is provided through widely acclaimed DOTS strategy under RNTCP which now provides emphasis amongst HIV/TB patients for management of TB and early linkage to care & support services.

The expanded scope of a new approach to TB control in populations with high HIV prevalence comprises of up scaled interventions against TB and HIV. Interventions include intensified case finding at high HIV settings like ART centers, Community Care Centers (CCCs), NGO led Targeted Intervention sites (TIs). This would help in early diagnosis of HIV/TB patients and provision of care & support including DOTS treatment for TB, CPT prophylaxis and ART. Counsellors and clinicians at HIV care settings regularly interact with persons living with HIV and thus are in the key position to refer to the nearest RNTCP services when indicated. Therefore, the crucial service delivery sites of NACP i.e. ICTCs, ART centers, Community Care Centers, and Targeted Intervention sites should be effectively involved for implementation of the up scaled activities.

OFFER VCT TO ALL TUBERCULOSIS PATIENTS

HIV counseling and testing is now widely available under the National AIDS Control Programme. For persons who are HIV-infected, care and treatment services are also widely available, and access to treatment for HIV infection is rapidly expanding. Surveillance has shown that where HIV seroprevalence is high, HIV infection among TB patients is common. Because of this association, it is important that patients with tuberculosis have the opportunity to know their HIV status. This will allow appropriate prevention, care, and treatment for patients and their families.

Central TB Division (CTD) & the National AIDS Control Organization (NACO) have adopted the policy of routinely offering voluntary HIV counseling and testing to all TB patients as part of an intensified TB/HIV package of services for states with the highest HIV burden.¹ This policy will facilitate early detection of HIV infection in TB patients, and lead to early access to HIV care and treatment. These interventions are expected to reduce death and disease among HIV-infected TB patients.

In these states, providers will routinely offer voluntary counseling and testing to all TB patients, except those with an already known HIV status. “Known” HIV status means those patients with a history of positive HIV test from an ICTC or those with a negative HIV test from ICTC within the past 6 months. HIV test results from ICTCs are preferred because their HIV testing uses reliable laboratory kits, is conducted using a multiple-test algorithm to reduce false results, and is properly accompanied by counseling.

TB patients with unknown HIV status are to be referred to the nearest and most-convenient ICTC. The referral may be made any time after TB diagnosis, during or after initiation on TB treatment (preferably at the earliest). Treating physicians and paramedical workers should explain the need and importance for patients to be confident about their HIV status, and also that HIV testing is ‘voluntary’ and ‘not mandatory’. This offer should be made at least once during the course of TB treatment.

If the patient accepts the advice for VCT, then the patient is referred to the nearest ICTC using the standard “Integrated Counseling and Testing Centre referral form” (Annex 1). The counselor during the counseling session should spend adequate time with the TB patient to explain the importance of sharing their HIV test result with the treating physician, for better care.

Communication of HIV test result to treating physician: ‘Shared CONFIDENTIALITY’

ICTC Counselors will counsel patients to share their HIV result with the referring physician. In addition, unless patients object counselors should directly and confidentially share HIV test results with the referring or treating physician, to ensure optimal care & case management.

It is the responsibility of the PHI staff to maintain the confidentiality of the HIV status of the TB patients within the health system. The health care system, including the para-medical workers, are

¹ Initially: Andhra Pradesh, Goa, Karnataka, Maharashtra, Manipur, Mizoram, Nagaland, Pondicherry and Tamil Nadu

duty bound in maintaining the client’s privacy by restricting access to personal information and keeping client’s information confidential, especially HIV test results. The client’s information is to be kept confidential and this information is not furnished under any circumstances to any other person, except those providing health services to him, without the individual’s explicit consent. The Pharmacist / health care worker should deal with the TB treatment card in a confidential manner & not disclose any private health information, including information on HIV status, to anyone outside the health care system.

Knowledge of HIV status will enable providers to:

- Provide the correct anti-TB treatment and correctly manage other illnesses.
- Counseling to reduce risk to current and future partners
- Linkage to social support services
- Initiate Cotrimoxazole Preventive Therapy (CPT).
- Prompt referral for anti-retroviral treatment.

The **mechanisms** for sharing the HIV status of referred TB patient, by the counselor with the treating physician are as under:

1. **Through the patient: via ICTC referral form (Annex 1), asking** patients to share his/her HIV test report with the treating physician.
2. **By the counselor:** Directly or by telephone, the counselor can, after advising the patient, communicate the HIV test result to the treating physician

In case the TB patient raises his/her objection to the direct communication of the HIV test result from the ICTC to the medical officer, his objection should be honoured and the HIV test result should not be communicated directly by the counselor to the referring physician.

Recording of HIV status on PHI-held TB treatment Cards

Treating physician shall record the HIV status of the TB patient on the original TB treatment card in the provided space, along with date of testing (Figure 1). The HIV status should not be recorded on the duplicate treatment card, held by community DOT provider.

Figure 1: Back of TB treatment card, and space for recording HIV status and additional treatment

II Continuation Phase

Prescribed regimen and Dosages: Category I 3 times / week, Category II 3 times / week, Category III 3 times / week

Enter X on date when the first dose of drugs has been swallowed under direct observation and draw a horizontal line (x _____) to indicate the period during which medicines will be self-administered.

Month / Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

Treatment outcome with date: _____ Signature of MO with date: _____

Details of X-ray / EP tests: _____ Remarks: _____

Retrieval Actions for Missed Doses					Household Contacts (Children < 5yrs)	
Date	By whom	Whom contacted	Reason for missed doses	Outcome of retrieval action	No.	Chemoprophylaxis

Additional Treatments

HIV status: Unknown Pos Neg (date) _____

CPT delivered on (date): (1) _____ (2) _____ (3) _____ (4) _____ (5) _____

Pt referred to ART centre (date): _____

Initiated on ART: No Yes (date) _____

- If HIV status of the patient is known, tick the appropriate box ('Pos' or 'Neg') and record the date of test. For patients who decline HIV testing, tick 'Unknown'
- Patients should not be required to show proof of HIV test results for the purpose of recording on treatment cards. (However, patients who are HIV-infected and are referred for ART should be aware that documentation of HIV test results from an ICTC will be required by the ART centre.)
- If the HIV status is ascertained during the course of TB treatment, the latest information should be updated on the treatment card.
- If HIV status of the patient remains unknown at the end of the treatment, tick the appropriate box ('unknown'), at the time of declaring treatment outcome for the patient.

PRESCRIBE CPT TO ALL HIV-INFECTED TB PATIENTS

Co-trimoxazole is a fixed dose combination of sulfamethoxazole and trimethoprim; it is a broad spectrum antibiotic that kills a range of gram-positive and gram-negative organisms, fungi, and protozoa. Co-trimoxazole can also be given routinely for the prevention of opportunistic infections in HIV-infected persons; this strategy is called **Cotrimoxazole prophylaxis therapy**.

Why provide CPT?

- Reduces morbidity and mortality of HIV-infected patients
- All HIV-infected TB patients registered under RNTCP are eligible for CPT, irrespective of their CD4 counts.

Eligibility

- All adults who are HIV-infected with tuberculosis disease on RNTCP treatment
- Pregnant patients are also eligible, regardless of foetus gestational age.
- No history of a serious drug allergy to sulpha drugs
- No history of glucose-6 phosphate dehydrogenase (G6PD) deficiency.

Prescribing CPT

- CPT is provided to patients in monthly packets.
- CPT can be prescribed at any point during TB treatment, whenever HIV-infection is determined.
- No baseline laboratory investigations are required to initiate CPT
- Dose for prophylaxis (adults and adolescents): 960 mg (800 mg sulfamethoxazole + 160 mg trimethoprim) daily.
- CPT is self-administered by the patient on a daily basis, and not under direct observation.
- Taken alongside anti-tuberculosis treatment (ATT) and ART

Duration of treatment

CPT is to be given for the entire duration of TB treatment. After TB treatment, CPT should be continued from the patients' ART centre. Patients should continue on CPT from the ART centres till

discontinued by a physician.

Treatment interruptions

Patients who do not take CPT do not get the prophylactic benefits. If patients are noted to have interrupted CPT, counseling by the health staff (including medical officer) is recommended to promote adherence at the next available opportunity. There is no “Default” in CPT; the treatment is voluntary. Patients who have interrupted CPT may choose to re-start and continue later.

Children

Paediatric HIV patients are to be immediately referred to the most convenient ART centre for CPT and ART evaluation and initiation. HIV-infected children are recommended to be provided lifelong CPT.

Clinical and laboratory monitoring of patients on CPT

- No baseline laboratory investigations or laboratory monitoring of CPT is required.
- Drug-related side effects to Cotrimoxazole are uncommon and usually occur within first 2 weeks of starting treatment.
- Clinical monitoring should be carried out regularly, at least once every three months. During clinical monitoring visits, adherence should be encouraged.
- Although Cotrimoxazole can induce haemolytic anaemia in patients with G6PD, routine testing for G6PD deficiency is not indicated.

Side effects

- Severe side effects (rare): exfoliative dermatitis, erythema multiforme (Stevens Johnson Syndrome), severe anaemia, and pancytopenia.
- Minor side effects: Loss of appetite, joint pains, nausea and vomiting.
- Because patients are usually taking other medications with similar side effects (e.g. isoniazid, pyrazinamide, efavirenz), care must be taken during clinical evaluation.
- Patients with serious side effects should discontinue CPT immediately and be promptly referred to a higher level centre, for evaluation and treatment. Desensitization is possible by experienced physicians.

Decentralized CPT delivery through RNTCP mechanisms

Any HIV infected TB patient can get CPT from any PHI. In the case of patients getting TB treatment from community DOT provider, monthly CPT supply would come from PHI/institutional DOT centre. Patients should continue regular TB treatment from community DOT provider.

The treating physician should:

- a. Initiate him/her on CPT from the institutional DOT centre, while also assessing the relevant history of adverse reaction to sulpha drugs.
- b. The treating physician prescribes CPT by ticking the relevant cell on the TB patient identity card (**Figure 2**). This will facilitate communication with the institutional pharmacist.
- c. Records the prescription of CPT on the TB treatment card (PHI-held, original treatment card) (**Figure 1**). Record dates of each monthly delivery in the space provided. In case the TB patient is already on CPT before the initiation of TB treatment, tick, record most recent date of CPT provision.
- d. Asks these clients to report to the PHI in case of any adverse drug reaction

Figure 2: TB Patient Identity Card, with CPT box

Tuberculosis Identity Card																																	
Front	Back																																
<p style="text-align: center;">Revised National Tuberculosis Control Programme IDENTITY CARD</p> <p>Name of Patient: _____ Complete address: _____ TU / district name _____ Ph _____ Sex: M <input type="checkbox"/> F <input type="checkbox"/> Age: _____ TB No. _____ PHI: _____</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;"> Disease Classification <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-pulmonary Site: _____ </td> <td style="width: 50%; padding: 2px;"> Treatment Started on Date Month Year _____ </td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;"> Type of Patient • New • Relapse • Treatment after default • Failure • Transfer In • Other-Specify _____ </td> <td style="width: 50%; padding: 2px;"> Category of Treatment <input type="checkbox"/> Category I <input type="checkbox"/> Category II <input type="checkbox"/> Category III <input checked="" type="checkbox"/> CPT </td> </tr> </table>	Disease Classification <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-pulmonary Site: _____	Treatment Started on Date Month Year _____	Type of Patient • New • Relapse • Treatment after default • Failure • Transfer In • Other-Specify _____	Category of Treatment <input type="checkbox"/> Category I <input type="checkbox"/> Category II <input type="checkbox"/> Category III <input checked="" type="checkbox"/> CPT	<p style="text-align: center;">Follow up sputum examination</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Time point</th> <th style="width: 15%;">Date</th> <th style="width: 15%;">Lab No.</th> <th style="width: 45%;">Result</th> </tr> </thead> <tbody> <tr> <td>Pretreatment</td> <td></td> <td></td> <td></td> </tr> <tr> <td>End of IP/extended IP</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2 months in CP</td> <td></td> <td></td> <td></td> </tr> <tr> <td>End of treatment</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p style="text-align: center;">Appointment dates</p> <table style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">IP</td> <td style="width: 50%; text-align: center;">CP</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table> <p>Treatment outcome with date: _____ Signature and stamp of MO with date: _____</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p style="text-align: center;">REMEMBER</p> <ol style="list-style-type: none"> 1. Keep your card safely 2. You can be cured if you take treatment as advised. 3. You may infect your near and dear if you do not take your medicines as advised </div>	Time point	Date	Lab No.	Result	Pretreatment				End of IP/extended IP				2 months in CP				End of treatment				IP	CP	_____	_____	_____	_____	_____	_____
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- e. Counsels the patient on the importance of regular follow-up examination and advice the client to come for monthly examination to monitor the progress of treatment.
- f. Refers the client to the nearest ART centre using ART centre referral form. (**Annex 2**)

At the PHI, institutional DOT provider (pharmacist/ health worker) should:

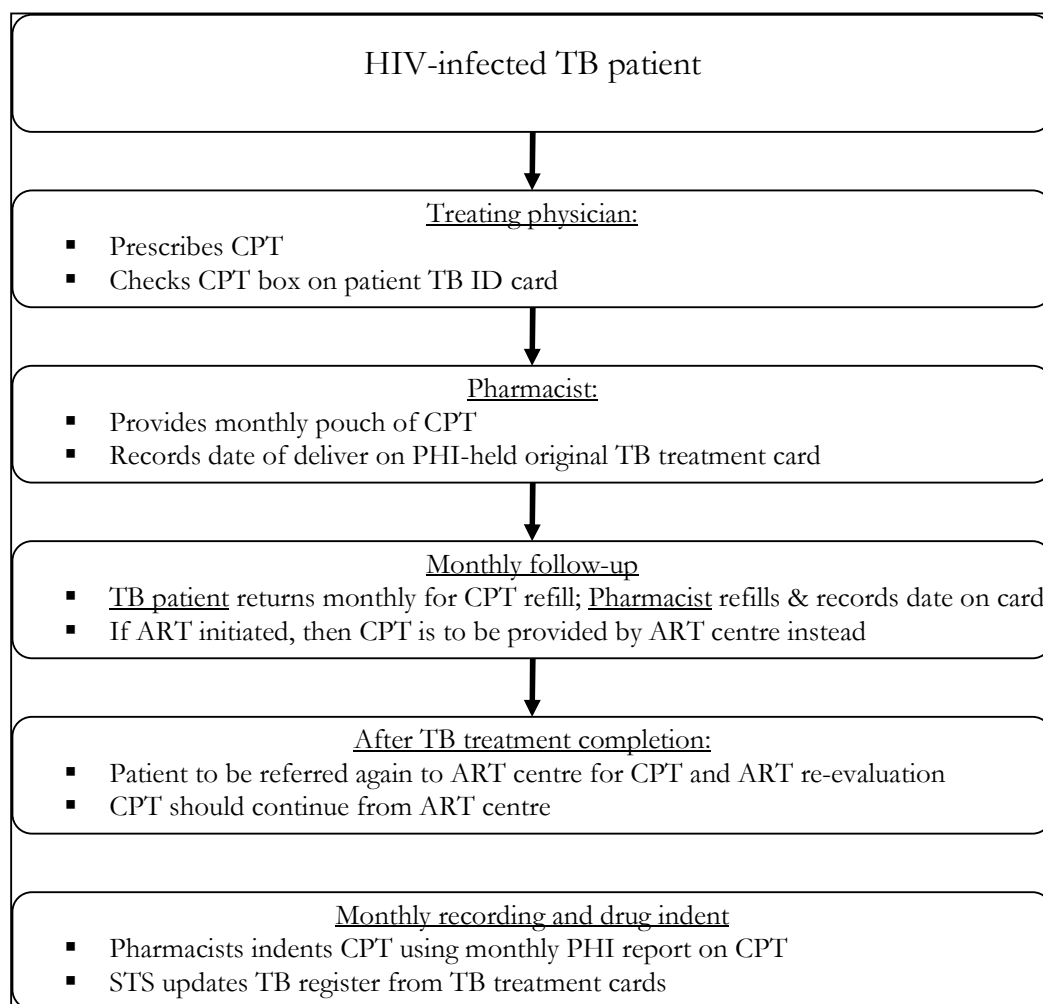
- a. Provide a monthly supply of CPT on seeing the TB identity card.
- b. Record the date of delivery of CPT on the space provided on TB treatment card
- c. Ask the client to come on a monthly basis to collect the monthly supply of CPT.
- d. Encourage the patient to meet the MO for clinical evaluation, at time of these monthly visits to the PHI.

Transition of CPT for HIV-infected TB patients

During TB treatment – CPT should be made available to the patient at the PHI for the duration of TB treatment, or till the time the patient takes CPT from the ART centre. If the HIV-infected TB patient is initiated on ART during TB treatment, he is to continue CPT along with ART from the ART Centre. Feedback from the ART centre regarding initiation of CPT is essential to ensure a smooth transition. In case the HIV-infected TB patient is already on CPT before the initiation of TB treatment, CPT can be continued from that source.

After TB treatment – After the completion of TB treatment the HIV-infected client is to continue CPT from ART Centre.

Summary of mechanism for providing CPT for HIV-infected TB patients



Drug supply management

- Because of irregular duration of treatment that patients may have on CPT, the supply of CPT monthly pouches is based on consumption (similar to RNTCP prolongation pouches.)
- The CPT is stored in the Pharmacy of the PHI and the Pharmacist is asked to maintain a record of stock in the PHI Stock Register.
- At the beginning of the activity, all PHIs and TUs will be provided a buffer supply of CPT.
- Based on consumption, the PHI should indent additional CPT supply with the TU on a monthly basis using the monthly CPT request (Annex 3), to be sent to the TU along with the RNTCP PHI monthly report.
- CPT monthly pouches would be provided by the TU to the PHI routinely. The District will maintain a supply at the TUs.
- In addition, emergency indent can also be made in case of urgent requirements.

REFER HIV-INFECTED TB PATIENTS TO ART CENTRE

Anti-retroviral treatment is highly effective at reducing mortality among HIV-infected TB patients; ART reduces the risk of death about 80% during the first year. Early ART initiation offers the greatest benefit to patients. For ART to remain effective excellent adherence is required; therefore, patients need intensive ongoing counseling and support.

Linking HIV-infected TB patient with ART Centres

HIV-infected TB patients not already on ART should be referred as soon as possible to an ART centre for pre-ART registration and free CD4 testing, using the standard “ART Centre referral form” (**Annex 2**). The referral to ART centre should also be recorded on the TB treatment card. TB treatment is the priority, and should not be interrupted by ART referral. However, prompt referral and evaluation for ART are also very important.

Smear-positive TB patients should be asked to attend the ART centre only after completing at least 2 weeks of intensive phase anti-TB treatment (i.e. 6 doses), and to carefully ‘cover your cough’ with a cloth. This is to reduce the risk of TB transmission of TB to other persons seeking care in the same place.

While referring the HIV-infected TB patient to ART centre, the client must be counselled by the treating/referring physician and the ICTC counselor on:

- The importance of ART and the free availability at ART centres
- The need to take the ICTC HIV test report to the ART centre for confirmation of HIV status
- Procedure of pre-ART evaluation including CD4 testing
- The days on which the CD4 testing is available at the respective ART centre.
- To attend the ART centre only after completing 2 weeks (6 doses) of intensive phase anti-TB treatment.
- To strictly cover their mouths with a cloth every time they cough in health care facilities.

ART eligibility criteria for HIV-infected TB patients

Most TB patients will be eligible for ART. All HIV-infected TB patients are in HIV clinical stage 3 or 4 (Pulmonary TB-Stage 3 & Extra-pulmonary TB-Stage 4). NACO recommends (March, 2007) that ART be given to all patients with extrapulmonary TB (stage 4) and all those with pulmonary TB (stage 3) unless CD4 count is > 350 cells/mm³. The decision of the ART Centre Medical Officer for ART initiation should be based on NACP ART guidelines. In general, ART should be initiated for eligible HIV-infected TB patients as soon as possible as per NACP ART guidelines.

Process at ART Centre

- a. In view of advanced clinical stage of HIV disease, HIV-infected TB patients are to be evaluated for ART on priority. HIV-infected TB patients should be prioritized for CD4 testing.
- b. The ART Centre staffs are to record patients’ TB number and name of referring unit in the TB/HIV register (annex 4), pre-ART register (along with ‘entry point code’) and ART-register.

- c. If the HIV-infected TB patient is initiated on ART, they would also continue their CPT from the ART Centre.
- d. The ART Centre staffs are expected to provide feedback to the referring physician.

Mechanism for feedback from ART centres to the referring physician:

- Feedback is to be provided by the ART centre MO, preferably using the referral form received from the referring physician.
- The patient is to be counselled by the ART centre staff to share the ART patient booklet and treatment history with the TB treating physician

If the HIV-infected TB patient is not been initiated on ART after their initial referral, s/he should be *again referred* to the ART centre *after* completion of TB treatment for ART re-evaluation, and for continuation of CPT.

Recording of ART referral and provision on PHI-held TB treatment cards

- All known HIV-infected TB patients are to be referred for ART to the nearest ART Centre. For referred clients record the date of referral on the original treatment card (Figure 1).
- If patient initiated on ART, tick the “yes” box, and the date of initiation of ART, and ART registration number should be entered as remarks on the treatment card.
- In case the TB patient is already on ART before the initiation of TB treatment, tick ‘yes’ for ART initiation, and record approximate date of initiation. Such patients should return to the ART centre for ART regimen adjustments necessary for TB patients as per NACO guidelines.

ROLES AND RESPONSIBILITIES IN COMPREHENSIVE TB-HIV CARE

ROLE OF MEDICAL OFFICER

- 1. Offer VCT to all TB patients with unknown HIV status**
 - Use referral form; ICTC gives feedback on test result
 - Record HIV status on 'original' treatment card

- 2. Prescribe CPT to all HIV infected TB patients**
 - If no contraindication for CPT, prescribe CPT by ticking on TB ID card; send patient to Pharmacist
 - Provide monthly course of CPT; record delivery on orig. (PHI-held) treatment card only

- 3. Refer HIV-infected TB patients to ART Centre for ART evaluation**
 - Record referral on TB treatment card
 - Use referral form; Feedback from ART centre provided on same form

- 4. Follow up with patient to ensure optimal care and support for HIV and TB**
 - **If patient initiated on ART**
 - Record ART initiation on TB Feedback recorded on TB treatment card
 - Continues CPT at ART Centre
 - Support patient for both ART and anti-TB treatment.

 - **If patient not initiated on ART**
 - Continue CPT from DOT centre
 - After TB treatment completion, refer patient again to ART Centre for ART re-evaluation & continuation of CPT

ROLE OF MEDICAL OFFICER IN CHARGE OF TB UNITS (MO-TC)

1. Provide support to DTOs and DNOs in training of MOs, STS, Counselors and Pharmacists on intensified TB/HIV package
2. Sensitize medical officers in the implementation of routine referral of TB patients for HIV testing, CPT provision, and ART referral, and the correct updation of TB records.
3. Coordinate with all the PHIs and ensure the availability of CPT at PHI having HIV-infected TB patients
4. Indent Cotrimoxazole in a timely manner from the DTO and maintain adequate supply at TU level.
5. Facilitate the training of field staff in coordination with DTO
6. Supervise field staff and sensitize them regarding responsibilities.
7. Ensure HIV status of the TB patients remains confidential within the health system

ROLE OF ICTC COUNSELOR

1. Screen clients for TB symptoms, and refer TB suspects to the DMC, recording referrals on the TB suspect line list.
2. Record referral from RNTCP in the counseling register.
3. Record the HIV test result on the referral form and send it back to referring physician through the TB patient.
4. Communicate the HIV test result of TB patients referred for VCT, to the referring/ treating physician unless the patient has requested that the HIV test results not be shared.
5. Emphasis, while counseling clients, on the importance of sharing HIV test result with the referring/ treating physician
6. Counsel HIV-infected clients on the importance of CPT, including adherence
7. Provide information to ICTC clients having TB disease or suspected of having TB on availability of decentralized CPT through the RNTCP
8. HIV-infected clients on the importance of ART and CPT, including adherence and their free availability under the programme.
9. Counsel the clients being referred to ART centre, on the process of ART evaluation and the importance of completing the necessary steps to determine the need for ART.

ROLE OF STS

1. Update TB registers during monthly visits to PHIs with information on HIV status, and (for HIV-infected TB patients) provision on CPT and ART from the original TB treatment card.
2. Coordinate with MO-PHIs and pharmacist and facilitate the availability of CPT at the PHIs
3. Ensure HIV status of the TB patients remains confidential with in the health system
4. Supply cotrimoxazole to requesting PHI's on an as-needed basis.
5. Coordinate with ART centre staff during monthly meeting to ascertain ART provision to HIV-infected TB patients.

ROLE OF PHARMACIST/ INSTITUTIONAL DOT PROVIDER

1. Check the TB identity card for CPT prescription
2. Provide monthly supply of CPT to the HIV-infected TB patients, who have been prescribed CPT by the attending MO and record the date of delivering on the TB treatment card.
3. Indent (from MO-TC) and maintain stock of Cotrimoxazole for the HIV-infected TB patients prescribed CPT for the entire duration of their TB treatment
4. Encourage the HIV-infected TB patients, during their monthly visit to PHI for collecting CPT, to meet the Medical Officer for routine examination
5. Ensure confidentiality of HIV status of the TB patients remains confidential with in the health system
6. Encourage patients on CPT to continue their CPT from an ART centre after TB treatment is finished.

ROLE OF ART CENTRE

1. Evaluate HIV-infected TB patients for ART on priority, including prioritization for CD4 testing.
2. Record patients' TB number and name of referring unit in the pre-ART register (in the column 'entry point code', along with the appropriate code for RNTCP) and the ART- register.
3. Ensure CPT is provided to all HIV-infected TB patients for the duration of TB treatment from either the PHI or from ART centre.
4. Continue CPT after the end of TB treatment from ART centre as per NACP OI guidelines.

5. Provide feedback on CPT continuation and ART initiation to the referring physician, using the same ART centre referral form if received and available.

Annex 1.

Integrated Counselling and Testing Centre referral form

Referral to Integrated Counselling and Testing Centre

Dear Counsellor,

The patient with the following details is being referred for VCT to your centre:

Name _____ *age/sex*

TB Number (if available) _____

Kindly do the needful and provide me feedback on the same, in a confidential manner.

Referring Provider

Name:

Contact Phone #:

Date of referral:

Name of the PHI:

Feedback by the Counsellor to referring provider

(To be filled in duplicate by the counsellor. One copy for patient, the other for referring MO)

TEST RESULT FROM ICTC

HIV positive

HIV negative

Indeterminate

Opted out

PID Number

Date of conducting test

Additional communication to the referring physician

Signature of MO ICTC/counsellor

ANNEX 2: RNTCP TO ART CENTER REFERRAL FORM

REFERRAL TO ART CENTER	
<i>(To be filled in duplicate by PHI MO. One copy for patient, one for record)</i>	
ART Centre (location, address):	
Dear Doctor,	
I am referring _____ Age, _____ Sex, _____ who is a diagnosed HIV-infected patient to your ART centre for further evaluation.	
(If applicable: Type of TB Case _____ & TB number.....)	
<i>Referring Doctor:</i>	<i>Contact Phone #:</i>
<i>Name & signature:</i>	<i>Date:</i> _____
<i>Name & address of the PHI:</i>	<i>District:</i>
	<i>TU Name:</i>
Details regarding ART	
<i>(to be filled by the ART medical officer and sent to the referring PHI through the patient)</i>	
Pre-ART Registration Number: _____	
Patient Started On Art - Yes / No ART Reg No: _____	
If No, reason:	
Patient started on CPT - Yes / No	
If No, reason:	
Additional information:	
<i>Name & signature of the ART MO</i>	<i>Date</i>

Annex 3

Addendum to RNTCP Monthly PHI report for CPT

ITEM	Unit of Measurement	Stock on first day of month (a)	Stock received during the month (b)	Consumption during the month (c)	Closing stock on last day of the month (d) $d=(a+b-c)$	Quantity Requested (e)
Cotrimoxazole monthly pouch (960 mg Double Strength tablets)	Monthly pouch (30 tablets)					

Annex 4

HIV / TB Referral Register at ART Center

Date of referral	Name	Address	Name of the District referred from	TB Unit (TU) name & TB No.	Pre ART No.	Baseline CD4	Date of starting of ART	ART No.

