

***National Framework
For Joint
TB/HIV Collaborative Activities
October 2009***



**National AIDS Control Organization
And
Central TB Division
Ministry of Health & Family Welfare
Government of India
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Foreword

The consequences of TB infection amongst HIV infected patients are well documented but it continues to gain importance because of its significant impact on the National HIV and TB programmes. The first joint National Framework (2007) expanded the basic HIV-TB activities across the country. The framework was revised in 2008 and an "*Intensified HIV-TB Package*" of services was rolled out to offer additional services in states with the higher burden of HIV-TB.

The 2009 revision of the National Framework establishes uniform activities at ART centres and ICTCs nationwide for intensified TB case finding and reporting, and set the ground for better monitoring and evaluation jointly by the two programmes. The HIV-TB performance indicators and performance targets act as a guide to channelize the HIV-TB interventions in the right direction at all the levels. In addition to this, the revised reporting formats and mechanisms have been incorporated in the National Framework to develop a common understanding on the monitoring system.

The National framework has been prepared by NACO along with Central TB Division. It is hoped that this framework will act as a guidance tool for the state/district programme managers for planning and implementing activities for strengthening HIV-TB collaboration. The overall purpose is thus to reduce the burden of HIV Infected TB patients in the country.

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Acknowledgement

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NATIONAL FRAMEWORK FOR JOINT TB/HIV COLLABORATIVE ACTIVITIES

(OCTOBER 2009)

INTRODUCTION

As per NACO sentinel surveillance report of 2007, the prevalence of HIV infection is estimated to be 0.34 % of the population, which translates to 2.31 million people living with HIV/AIDS in India. Tuberculosis (TB) continues to be a public health challenge in India and is estimated that 1.9 million new cases of TB occur in India annually. Active TB disease is the commonest opportunistic infection amongst HIV-infected individuals. High-quality diagnosis and treatment for TB is provided nationwide under the Revised National TB Control Programme (RNTCP). RNTCP anti-TB regimens have been shown to be effective in TB patients with or without HIV infection.

TB-HIV collaborative activities between RNTCP and NACP started initially in the year 2001, in the six states with high prevalence of HIV/AIDS i.e. Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu. The collaborative activities were extended to 8 additional states in 2004.

The National Framework for Joint TB/HIV Collaborative Activities was first developed in 2007, with a revision in February 2008. The 2007-2008 National Framework extended basic TB-HIV activities nationwide. An intensified TB/HIV package of services was developed to offer additional services in States with the higher burden of HIV-TB.

This 2009 revision of the National Framework establishes uniform activities at ART centres and ICTCs nationwide for intensified TB case finding and reporting, strengthens joint monitoring and evaluation with specified national TB/HIV programme indicators and performance targets.

The overall purpose of the National framework is to articulate the policy for strengthening TB/HIV collaborative activities between RNTCP and NACP, resulting in reduction of TB and HIV burden in India.

OBJECTIVES:

1. To strengthen the mechanisms for coordination between RNTCP and NACP at National, State and District levels.
2. To decrease morbidity and mortality due to tuberculosis among persons living with HIV/AIDS.
3. To decrease the impact of HIV in tuberculosis patients and provide access to HIV related care and support to HIV- infected TB patients

SPECIFIC TB/HIV COLLABORATIVE ACTIVITIES

1. Establish / Strengthen NACP-RNTCP coordination mechanisms at national, state and district level.
2. Scaling up of Intensified TB/HIV Package of Services across the country.
3. Joint Monitoring and Evaluation including standardized reporting shared between the two programmes.
4. Training of the programme and field staff on TB/HIV
5. TB and HIV service delivery coordination
 - 5.1. Offer of HIV testing to TB patients
 - 5.2. Intensified TB case finding at ICTCs, ART and Community Care Centres
 - 5.3. Linking of HIV-infected TB patients to NACP for HIV care and support (including antiretroviral treatment) and to RNTCP for TB treatment
 - 5.4. Provision of Cotrimoxazole Prophylactic Treatment (CPT) for HIV-infected TB patients
6. Implementation of feasible and effective infection control measures
7. Involvement of NGOs/CBOs and affected communities working with NACP and RNTCP for all activities on TB/HIV collaboration.
8. Operational research to improve the implementation and impact of TB/HIV collaborative activities.

1. NACP-RNTCP COORDINATION MECHANISMS AT NATIONAL, STATE AND DISTRICT LEVEL

I. National Technical Working Group (NTWG)

At the National level a technical working group is in place, comprising of key officials from NACO and CTD dealing with TB/HIV Collaborative activities and experts from WHO. The purpose of the TWG, which meets at least quarterly, is to review, optimize and plan for future TB/HIV Coordination activities. The function of National TWG also includes supervision of TB/HIV collaborative activities by officials of both programmes, including joint field visits.

II. State Level:

A. State Coordination Committees (SCC)

To ensure smooth implementation and regular review of TB/HIV Collaborative activities, State Coordination committees chaired by Principal Health Secretary are established at the State level. These coordination committee meetings should be organized by SACS on bi-annual basis. The composition and proposed TOR of State Coordination Committees are annexed (**Annex 1**). The SCC can be used to obtain administrative approvals for the TB-HIV activities guided by the SWG recommendations. Minutes of SCC meetings should be sent to NACO and CTD at tbhiv@rntcp.org.

B. State Working Group (SWG)

At the State level, SWG is composed of key officials from SACS (PD and APD) and State TB Cell (STO, second MO if present), along with other officials dealing with TB/HIV collaborative activities and consultants involved in HIV/TB collaborative activities. The SWG would be organized by SACS at-least once in a quarter to review and streamline the collaborative activities. In these quarterly meetings of SWG, apart from a review of the on-going TB/HIV collaborative activities, the key issues emerging from the district coordination meetings and reports are to be discussed. Based on the discussions, feedback should be sent to the districts on their performance and identified issues. Follow up action taken should be monitored and minutes of the meetings forwarded to NACO and CTD at tbhiv@rntcp.org.

III. District level

A. District Coordination Committees (DCC)

To ensure smooth implementation and regular review of TB/HIV Collaborative activities, Coordination committees are established at the District level. These coordination committees are to meet on a quarterly basis. DCCs are to be organized by DAPCU Nodal officers or DTOs (in districts where there is no DAPCU).The composition and proposed TOR of District Coordination Committees are annexed (**Annex 2**). Minutes of DCC meetings should be sent to SACS and State TB Cell. Whenever possible, the meetings

should be attended by a representative from the STC/SACS so as to streamline the discussions for the HIV-TB linkages and to raise the district specific issues.

B. Monthly meeting at the District level

A monthly meeting of the DTO and the DNO should be held with the participation of key staff from both the programmes. Monthly key staff meetings for RNTCP are already being conducted at the district level. It is envisaged that during these monthly key staff meetings, additional session be organised for TB/HIV which should be attended by the key district staff of NACP. In these monthly meetings a review of the on-going TB/HIV collaborative activities and discussion on key issues emerging from the field should be done. Based on the discussions, feedback should be sent to the service delivery centres on their performance and on any identified issues. Follow-up action taken should be monitored and minutes of the meetings forwarded to SACS and STC.

IV. Annual Review of TB/HIV Collaborative activities at National and State level

RNTCP conducts regular programme reviews at the National and State levels. It is planned that at one of these reviews at the National level, an annual review of the TB/HIV Collaborative activities would be held with the participation of State programme managers of both programmes. The annual review would be held in close coordination between NACO and CTD.

Similar annual reviews would be held at the State level by adding an additional day to one of the quarterly RNTCP review meetings and inviting the District Nodal Officers for HIV/AIDS and SACS officials. These State level reviews are to be organised in coordination with SACS and STC. Whenever possible representatives from CTD and NACO would be attending these State reviews.

V. Human Resources for TB/HIV collaborative activities

To facilitate coordination and successful implementation of TB/HIV collaborative activities, the following positions have been sanctioned:

- A. A full-time regular government officer would be in charge of TB/HIV Collaborative activities in the programmes at the National and State level in NACP and RNTCP.
- B. National Consultants for TB/HIV (NACP & RNTCP)
- C. Technical officers at SACS for Basic Services (including TB/HIV) are available across the country (1-2 per state).
- D. State TB/HIV Coordinators have been sanctioned by RNTCP in 15 States (Assam, Bihar, Chhattisgarh, Delhi, Gujarat, Himachal Pradesh, Jharkhand, Kerala, Madhya Pradesh, Orissa, Punjab, Rajasthan, Uttar Pradesh, Uttaranchal and West Bengal)
- E. District level: TB/HIV and DOTS-Plus supervisors have been sanctioned, and would be implemented over 2010-2012.

2. SCALING UP OF INTENSIFIED TB/HIV PACKAGE OF SERVICES

Intensified Package of HIV/TB activities was started in 9 states (*Andhra Pradesh, Karnataka, Maharashtra including Mumbai, Tamil Nadu, Manipur, Nagaland, Mizoram, Goa and Pondicherry*) in October 2008 and has been further expanded to Gujarat and Delhi from July and October 2009 respectively. The package is designed to enhance identification of HIV-infected TB cases, linking to HIV care and support and monitoring of TB HIV collaborative activities. The table below highlights the additional activities which have been included under the Intensified HIV/TB package.

Core TB/HIV activities for all settings, and additional activities under the Intensified TB/HIV Package

All States	Intensified TB-HIV Package States
District and State-Level Coordination between NACP and RNTCP	No additional requirements
Training of programme officials and field staff on TB/HIV	Addition: Extra training on Intensified TB-HIV package for programme and field staff
Intensified TB Case Finding at all ICTCs, ART Centres, and Community Care Centres	No additional requirements
Referral of HIV-infected TB patients to NACP for additional care and support, including cotrimoxazole prophylactic treatment and antiretroviral treatment	Addition: Decentralized provision of cotrimoxazole prophylactic treatment (CPT) to HIV-infected TB patients from all peripheral health institute
Referral of TB patients for HIV-testing based on HIV risk factors (selective referral)	Addition: Routine referral of all TB patients for voluntary HIV- counselling and testing
Core TB/HIV recording and reporting from NACO MIS and RNTCP (PMR)	Addition: Expanded TB/HIV recording and reporting by RNTCP (CF and RT reports)

The expansion of the Intensified TB/HIV package to additional States would be undertaken in a phased manner, jointly determined by the National Programmes. A tool for assessment for preparedness for rolling out the Intensified TB/HIV package is given in **Annex 3**. The SACS & STC needs to jointly provide information on the tool which would be reviewed at the National level and states would be provided feedback on the level of preparedness and starting the intensified package as jointly determined by the national programmes.

3. TB/HIV REPORTING, MONITORING AND EVALUATION

Reporting of TB-HIV collaborative activities can be expected to be somewhat complex, as two programmes with separate reporting systems are involved. The following table clarifies reporting responsibilities.

	Essential recording and reporting for all States	<i>Additional</i> reporting for States implementing Intensified TB/HIV package
Coordination committee meetings	<ul style="list-style-type: none"> • Minutes of District meeting sent to State TB Cell and SACS and reported on RNTCP District PMR • Minutes of State Coordination Committee sent to Centre (tbhiv@rntcp.org) and reported on RNTCP State PMR 	No additional requirements
Intensified TB case finding at ICTCs	<ul style="list-style-type: none"> • Monthly line-list of ICTC referrals of TB suspects and TB diagnostic outcomes jointly prepared by ICTC counselors and STS (Annex 6) • Monthly ICTC TB-HIV Report (Annex 7) 	No additional requirements
Intensified TB case finding at ART centres	<ul style="list-style-type: none"> • Monthly line-list of ART referrals of TB suspects and TB diagnostic outcomes jointly prepared by ART counselors and STS, (Annex 8) • Monthly ART center TB-HIV report (Annex 9) 	No additional requirements
HIV-testing of TB patients	Monthly ICTC TB-HIV Report (Annex 7)	Routine RNTCP Quarterly Report (Case Finding Report)
Provision of CPT to HIV-infected TB patients	ART Centre TB-HIV register (Annex 10)	Routine RNTCP Quarterly Report (Results of Treatment Report)
Provision of ART to HIV-infected TB patients	ART Centre TB-HIV register (Annex 10)	Routine RNTCP Quarterly Report (Results of Treatment Report)

- All reporting from NACP is to be done through the MIS system for ICTCs and ART centers. TB-HIV reports have been added for the same.
 - PPTCT data is not to be included in the report of TB suspects referred from ICTCs, as pregnant women attending antenatal clinics have a risk of TB similar to the general population.
 - In order to allow TB suspects time for diagnosis and TB registration, reporting on TB-HIV is done for a month previous to the current regular NACP reporting period. For example, the ICTC report submitted to NACP for the month of March would have, the data in TB-HIV section for the month of February.
- All TB-HIV reporting from RNTCP is to be done through the existing system (RNTCP Epi-Centre), which already includes TB-HIV in routine reporting formats for Programme Management (PMR), Case Finding (CF), and Results of Treatment (RT).

Joint TB/HIV monitoring and evaluation

In order to strengthen the field level collaborative activities joint field visits would be undertaken by the National level team (NACO & CTD) to at least one state every quarter and similarly state level team (SACS & STC) to at least one district every quarter. These states and districts are to be prioritized on the basis of key HIV/TB performance indicators. The observations made in these joint field visits should be discussed in the State level review & SWG and submitted to NACO and CTD.

Routine monitoring, performance indicators and targets have been developed jointly by RNTCP and NACP in the Table below and are critical to successful implementation of collaborative activities. Data sources for each indicator and annual targets are detailed in Annex 4.

Table: Key TB/HIV Performance Indicators

State and district-level coordination	Data source
a. Proportion of TBHIV SCC/SWG meetings held at state level over past 4 quarters	RNTCP State PMR
b. Proportion of Districts with at least 2 DCC Meetings over past 4 quarters	RNTCP District PMR
Intensified Case Finding (reported separately for ICTC and for ART centres)	
a. Proportion of ICTC/ART centres reporting on TB/HIV ICF activities	NACO MIS
b. Number of ICTC/ART clients referred to RNTCP as TB suspect	NACO MIS
c. Out of (b) number diagnosed with TB	NACO MIS
d. Among (c), number/percentage of diagnosed TB patients put on RNTCP treatment	NACO MIS
Detection of HIV in TB patients, & HIV treatment	
a. Number of TB patients HIV-tested by NACP	NACO MIS
b. Number/ percentage of registered TB patients with known HIV status †	RNTCP Case Finding Report
c. Number of registered TB patients found to be HIV-positive †	RNTCP Case Finding Report
d. Number/ percentage of HIV-positive TB patients receiving CPT during TB treatment † ‡	RNTCP Results of Treatment Report
e. Number/ percentage of HIV-positive TB patients receiving ART during TB treatment † ‡	RNTCP Results of Treatment Report

†For settings implementing the 'Intensified TB/HIV Package' only

‡‡ For previous year's TB patient cohort

4. TRAINING OF PROGRAMME AND FIELD STAFF ON TB/HIV

Trainings on TB/HIV are an integral part of NACP and RNTCP activities. Budgets for the training of staff of the individual programmes are to be borne by SACS and STC, for their respective programme personnel. Detailed guidelines for trainings on TB/HIV Collaborative activities are annexed (**Annex 5**).

Standardized training modules on TB/HIV have been jointly prepared by NACO and CTD for training of all field staff. The contents of these modules have been integrated into the Revised RNTCP Modules. For existing field staff that has not yet undergone training on Revised RNTCP modules, stand alone TB/HIV training should be conducted. However, these stand alone trainings on TB/HIV should gradually be phased out and would be held in exceptional cases, based on specific identified retraining needs or when new activities in TB/HIV are introduced leading to revision of existing modules. In states implementing the intensified TBHIV package, additional training will be required for staff at all levels.

To ensure quality of training on standardised modules for the field staff, state-level master trainers for TB/HIV would be trained at the national level. A group of experts/officials from SACS, STC, STDC and other Institutions should be selected by the States. These trainings for the Master Trainers would be organized as per the programme requirement by CTD and NACO, at the national level. The State is responsible for holding TB/HIV training of DNOs and DTOs, and should intimate CTD and NACO when these trainings are held. The trainings on TB/HIV at the State and District level are to be facilitated by the State-level Master Trainers in TB/HIV from both the programmes and are to be organised in close coordination. When possible, trainers from National level would co-facilitate these trainings at State level.

Given the exceptionally high burden of TB in ART centres, the ART medical officers should be well trained in tuberculosis diagnosis, care, and RNTCP procedures using the standardised RNTCP modular training material at the State level. In addition, all ART centre staff should be trained on TB/HIV using the TB/HIV Module for ART Centres. In case of turn over of staff at the ART Centre, the medical officers may be trained at the State level during the periodic routine RNTCP trainings.

5. TB AND HIV SERVICE DELIVERY COORDINATION

5.1 HIV testing of TB patients

In states implementing Intensified TB-HIV Package, the policy of routine offer of HIV counselling and voluntary testing to all TB patients has been adopted. This referral should be done as soon as possible after diagnosis, and results should be communicated back to the referring provider in order to provide better patient management.

Eventually all the states would be covered under the Intensified Package. In settings not yet implementing the intensified package, Medical Officers should conduct an appropriate and detailed clinical history on all TB patients to determine the need for HIV testing. All TB patients with a history of any HIV risk factors, with a history of present or past STI, or any clinical signs/symptoms concerning for other HIV-related opportunistic infections should be offered HIV counselling and voluntary testing.

HIV testing should be done by NACP at ICTCs (or any PHI where NACP HIV counselling and testing is offered). Patients who are screened for HIV through NACP whole-blood testing and are found to be HIV-negative do not require further testing. If whole blood testing results are reactive/positive, then the patient should be referred on priority to an NACP ICTC for confirmatory diagnosis.

5.2 Intensified TB case finding at ICTCs, ART, and Community Care Centres

ICTCs

All ICTC clients should be screened by the ICTC Counsellors for the presence of the symptoms of TB disease (at pre, post, and follow-up counselling). All clients who have symptoms or signs of TB disease, irrespective of their HIV status, should be referred to the nearest facility providing RNTCP diagnostic and treatment services. For better coordination in the field between the two programmes it is suggested that when the network of ICTC facilities is being expanded, consideration should be taken of establishing the new ICTCs in sites which already have an RNTCP designated microscopy centres in the respective site.

In all ICTCs in all States, referrals of TB suspects should be recorded on the ICTC line list (**Annex 6**) to facilitate coordination with RNTCP to determine TB diagnosis and initiation of DOTS of the referred patients. It is crucial that the ICTC counsellor attends the RNTCP monthly meeting for coordination with RNTCP Programme Staff to keep a track of the referrals. Recording and reporting formats have been standardized for use nationwide (**Annex 7**).

ART Centres

HIV-infected persons attending ART centres for pre-ART registration have a high prevalence of TB disease. The incidence of TB disease among ART clients is also very high, even among clients taking ART. While ART reduces the risk of TB disease, this risk is still remains many times higher than the general population. HIV-infected clients with undiagnosed and untreated TB can be expected to seek care in ART or Community Care

centres, posing the risk of exposing other HIV-infected persons to TB. Hence intensified TB case finding at ART centres is very important for early suspicion and diagnosis of TB disease, and for the prevention of transmission of TB infection to other clients. ART guidelines clearly state that all patients coming to ART centres should be screened for opportunistic infections, particularly TB. The TB suspects identified at ART centers/CCCs should be prioritized and fast tracked for evaluation by the SMO/MO in order to minimize opportunities for airborne transmission of infection to the other PLHIV at the facility.

In all ART Centres in all States, referrals of TB suspects should be recorded on the ART TB-HIV line list (**Annex 8**) to facilitate coordination with RNTCP to determine TB diagnosis and DOTS initiation. It is crucial that an ART Centre staff member attend the RNTCP monthly meeting for coordination with RNTCP Programme Staff. Recording and reporting formats have been standardized for use nationwide (**Annex 9**).

Patients diagnosed with TB should be recorded on the ART Centre TB-HIV register to facilitate coordination with RNTCP reporting on ART for HIV-infected TB patients (**Annex 10**). It is crucial that the ART centre staff attends the joint monthly meeting of the RNTCP & NACP staff for review of the TB-HIV register and updating of ART treatment status information for HIV-infected TB patients into their TB registers. Patients diagnosed with TB should be managed in accordance with RNTCP guidelines, which will entail referral for treatment by DOTS at place convenient to the patient. RNTCP DOT Centres in facilities housing ART centres can assist with the coordination of referrals and provision of feedback to the ART Centre on the same.

Community Care Centres / Link ART Centres

As with any facility caring for large numbers of HIV-infected persons, Community Care centres / Link ART Centres should 1) implement intensified TB case finding by symptom screening on a regular basis as per guidelines for ART centres, 2) promptly refer TB suspects to RNTCP diagnostic facilities, and 3) provide appropriate supportive counselling for both HIV and TB treatment. Community Care Centres / Link ART Centres are to be treated as ART centres for recording and reporting purposes (Annexes 8-10).

All these centres should have provision of RNTCP DOT services in their premises, and have effective linkages with RNTCP diagnostic services (sputum collection and transportation or referral of patients for diagnosis). The concerned STOs and DTOs should also explore the possibility of opening an RNTCP DMC at these facilities if the respective facility fulfils the relevant criteria.

5.3 Referral of HIV-infected TB patients to NACP for care and support, including antiretroviral treatment

The treatment of HIV-infected TB persons should be done using RNTCP DOTS as per national policy. All known HIV-positive TB patients are considered seriously ill regardless of sputum smear results, and are offered either RNTCP Category I or Category II treatment, depending on their previous history of TB treatment.

In addition to TB treatment under RNTCP, all HIV-infected TB patients must be provided access to care and support for HIV/AIDS, including antiretroviral therapy. ART

reduces TB case fatality rates and the risk of recurrent TB. ICTC counsellors and the treating physicians should counsel these patients on the importance of ART and on the free availability of ART evaluation and treatment.

HIV-infected TB patients should be promptly referred to the nearest ART centre by the treating physicians and ICTC counsellors. This visitation of the ART centre, however, should preferably occur at least two weeks after initiation of TB treatment; to ensure that at least some reduction in TB transmission potential occurs among these patients prior to visitation of a clinical setting with large numbers of HIV-infected persons. TB patients referred to ART centres should be carefully educated on cough hygiene.

For details on ART eligibility, reference ART guidelines (available at www.nacoonline.org). NACO recommends that ART be given to:

- All patients with extrapulmonary TB (stage 4) and
- All those with pulmonary TB (stage 3) with CD4 count is < 350 cells/mm³.

5.4 Provision of cotrimoxazole preventative treatment (CPT) for HIV-infected TB patients

CPT has been shown to reduce mortality among HIV-infected TB patients, and is recommended by NACP for all HIV-infected patients.

All HIV-infected TB patients should therefore be provided CPT. At a minimum, monthly provision of CPT should be available at all ART centres for the benefit of those patients who are able to return to the ART centre on a monthly basis.

In States implementing Intensified TB/HIV package, CPT should also be made available for HIV-infected TB patients at all peripheral health institutions having a Medical officer and an institutional DOT centre, using RNTCP mechanisms. The supply of CPT should be procured and packaged into monthly pouches by SACS and the local distribution should be carried out by RNTCP in coordination with NACP. In this mechanism, CPT is delivered by the peripheral health institute staff, and not community DOT providers, to maintain confidentiality regarding HIV status within the health-care system.

6. INFECTION CONTROL PRACTICES

6.1 Prevent spread of TB in facilities caring for HIV-infected persons

In health care settings frequented by high numbers of HIV-infected persons, measures to reduce airborne tuberculosis transmission should be undertaken. These include simple administrative and environmental measures aimed at generally reducing exposure of HIV-infected patients to *M. tuberculosis*.

Administrative measures should first include early recognition, diagnosis and treatment of tuberculosis cases under RNTCP, particularly those with smear positive pulmonary tuberculosis. These steps should also include separation of pulmonary tuberculosis suspects from HIV-infected patients e.g. in patients waiting areas, until a TB diagnosis is excluded or confirmed and effective TB treatment initiated. Environmental protection should include maximizing natural ventilation. General guidelines for infection control have been prepared. These guidelines are summarized below:

1. ART centres should not be co-located with DMC/DOT centers, and should not share waiting areas.
2. ART centres should have a well ventilated waiting & seating area.
3. Screening of patients for respiratory symptoms & TB diagnosis would be done as soon as possible in the ART centres for early referral for diagnosis and initiation of treatment.
4. Fast-tracking of chest symptomatic should be done to ensure that there are minimum chances of contact of these patients with healthy ones.
5. Separate, well-ventilated waiting area for respiratory symptomatic should be made available wherever possible.
6. Health education on cough hygiene should be stressed upon.
7. Ventilation standards for specialized care environments (e.g., airborne infection isolation rooms, protective environments, or operating rooms) should be adhered to.
8. As far as possible, use of re-circulating air conditioners in the waiting area should be avoided as these have been found to leading to no air exchange.
9. Display of IEC material reminding the patients to follow cough hygiene practices

6.2 Prevent spread of HIV through safe injection practices in facilities providing RNTCP services.

Measures to reduce parenteral HIV transmission include the use of sterilized injection and surgical equipment in medical settings. Steps should be undertaken by concerned authorities (SACS, State and District administration) to ensure the availability at all times and all facilities, of sterilized disposable needles and syringes and needle destroyers.

7. ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION, AND INVOLVEMENT OF NGO / CBO WORKING IN NACP AND RNTCP IN TB/HIV COLLABORATIVE ACTIVITIES

7.1 Involvement of affected communities

The empowerment of communities in the response to TB and HIV/TB is crucial; there is a great role for HIV activists to play in addressing the challenge of HIV/TB co-infection. PLHA networks should regularly distribute TB treatment literacy information, so that TB can be suspected early whenever a community member suffers from persistent cough or unexplained illness. Particularly in HIV care settings, community volunteers may make important contributions to TB screening and advocacy for improved TB infection control. The PLHA community needs to increase knowledge and literacy about TB in order to maximize their contribution. Where possible, RNTCP should include PLHA groups in social mobilization activities.

7.2 Involvement of NGOs and CBOs

There are a large number of NGOs and CBOs working with both NACP and RNTCP. These organizations play an important role in programme implementation by increasing the out reach of the individual programmes and the provision of a package of services to difficult to reach populations like migrant populations, truck drivers, tribal populations, commercial sex workers, etc.

NACP is including TB-HIV activities in the minimum set of activities required for NACP-supported Targeted Intervention (TI) NGO and CBOs. Till that time, a “TB-HIV Scheme” has been made available by RNTCP to promote provision of essential TB screening and referral services by organizations dealing with high-HIV prevalence populations. Eligibility for the scheme is outlined in RNTCP Guidelines “Revised Schemes for NGOs and Private Providers, 2008” (available at www.tbcindia.org). Specific TB-HIV training material for peer educators has been developed and can be used for NGO/CBO staff.

Components of “Comprehensive TB Care for high-HIV risk populations

1. Intensified TB Case Finding:
 - a. TB symptom screening through outreach workers and peer educators at the time of each interaction with the member of target population & referral of suspects for diagnosis & treatment
 - b. TB symptom screening for clients attending these NGO clinics
2. Patient friendly approach for Diagnosis and treatment categorization:
 - a. Sputum collection & transportation or Facilitated referrals
 - b. NGO staff to coordinate with the existing government health facilities for the diagnosis of smear negative pulmonary TB (for X-Ray) and Extra-pulmonary TB (for FNAC, etc)
 - c. TB treatment categorization by NGO clinic medical officer
 - d. Undertake address verification before initiation of TB treatment
3. Treatment provision:
 - a. Treatment delivery to be organized by NGO by identification of appropriate community DOT provider in consultation with the diagnosed client/ DOT provision through NGO staff if convenient to the TB patient
4. Adherence:
 - a. NGO staff to ensure timely follow up of the patient and also undertake patients retrieval action in case of treatment interruption;
 - b. Coordinate with local RNTCP programme staff to ensure smooth transfer, in case of anticipated migration of patient
 - c. Monitoring, Supervision & Recording (on treatment cards) by NGOs
5. Monthly meeting: DTO/DNO and NGOs
6. Outreach activities by NGOs, out reach workers to include ACSM
 - a. Increase visibility of RNTCP for HRG (High Risk Group).
 - b. Community capacity building/CBO/community involvement in TB services
 - c. Advocacy with PLHA networks for TB control

7.3 IEC & BCC activities

- RNTCP and NACP IEC material should be displayed at the ICTCs, ART centres, CCCs, Link ART Centres, TI sites, DMCs and other facilities providing care and support to PLHA and TB patients. Specifically, pictorial IEC on symptoms of TB and cough hygiene should be prominently displayed in all ICTC/ART registration and waiting areas. Health care providers including counsellors should educate all their HIV-infected clients on the risk of TB, concerning signs and symptoms, and what to do when such signs and symptoms occur.
- Counselling at ICTCs and ART centres should specifically include counselling on TB. A “Counselling tool on TB-HIV” has been developed for use by the counsellors in the ICTCs and ART centres. The tool must be made available at all ICTCs and ART Centres, and should be routinely used.
- Efforts must be made by key RNTCP field staff and all general health care providers to generate awareness amongst all patients about HIV infection and the availability of services for HIV care and support.

8. OPERATIONAL RESEARCH TO IMPROVE THE IMPLEMENTATION OF TB/HIV COLLABORATIVE ACTIVITIES

Operational research in TB/HIV would be directed towards improving the efficiency of programme policies and procedures for TB/HIV, evaluating new approaches to decrease the morbidity and mortality due of tuberculosis in people living with HIV/AIDS, improving access to HIV care and support for HIV-infected TB patients. Specific TB-HIV operational research topics have been detailed in the RNTCP Operational Research Agenda (available at www.tbcindia.org).

The priority areas for collaborative operational research with both programmes for TB/HIV include:

- Evaluation of the screening methods for TB case finding in antiretroviral treatment and Community Care Centers.
- Reasons for loss of TB suspects referred from integrated counseling and testing centers to designated microscopy centers
- Development of algorithm to exclude active TB disease among ART Clients
- Reasons for non-initiation of ART and CPT for HIV-infected TB patients
- Incidence and mortality associated with TB among patients awaiting ART and on ART.
- Causes for delay in treating HIV in TB patients, and effect of corrective actions
- Feasibility and cost-effectiveness of isoniazid preventive treatment for HIV-infected patients in ART centers
- Involvement of NGO's in TB-HIV interventions.
- Evaluation of the implementation and impact of infection control measures in ART centres.
- Risk of TB among HCWs at HIV care, support and treatment centers
- Evaluation of the impact of infection control measures on the incidence of TB infection among health care workers.
- Spectrum of Immunological and Clinical staging of HIV disease in HIV-infected TB patients.

ANNEX 1

State TB-HIV Co-ordination Committee

The proposed composition of the State Coordination Committee is as under:

1. Secretary, Health: Chairman
2. Director Health Services: Vice Chairman
3. Mission Director, National Rural Health Mission, Vice Chairman
4. Director Medical Education and Research: Member
5. Project Director, SACS: Member
6. Additional Project Director, SACS: Member, Secretary
7. State TB Officer: Member
8. Director, STDC: Member
9. Dy. Director, Surveillance, SACS: Member
10. Dy. Director, ICTC, SACS: Member
11. Dy. State TB Officer : Member
12. RNTCP and NACP consultants: Member
13. Representative of NGOs working with RNTCP: Member
14. Representative of NGOs working with NACP: Member

Scope of Work of the Committee

The State TB-HIV Co-ordination Committee will review the performance of the collaborative TB-HIV activities in the respective state, formulate strategies for strengthening the TB-HIV co-ordination activities, and provide guidance for the implementation of the National framework for TB-HIV Collaborative activities in the respective State. The committee should hold a meeting once every six months.

The Chairman of the Committee if need arises can invite a person as special invitee whenever required for the betterment of the programme. In case the Chairman is not available for the meeting, a nominee of the chairperson may preside over the deliberations.

Terms of Reference

1. To ensure co-ordination between NACP and RNTCP in the State
2. To review the status of training of health care providers in TB-HIV and formulate strategies for ensuring that all the health care providers are trained in TB-HIV
3. To review the co-ordination activities between the ICTCs / ART Centres/CCCs and the RNTCP diagnostic and treatment services, and guide the strengthening of the NACP - RNTCP coordination activities (including district wise review of the cross-referral and identification of HIV infected TB patients' data)
4. To review and further strengthen the participation of NGOs and Private Medical Practitioners implementing NACP / RNTCP in the TB-HIV co-ordination.
5. To review and ensure the participation of institutes/organizations providing care and support to HIV/AIDS patients, in the RNTCP (e.g. Community Care Centres, ART Centres, etc.)
6. To ensure that appropriate measures are taken to prevent the spread of TB in facilities caring for HIV/AIDS patients
7. To ensure the prevention of spread of HIV infection through safe injection practices in those facilities providing RNTCP treatment services
8. To take decisions for the implementation of TB-HIV activities in the State under the broad policy framework recommended by the Government of India.
9. To ensure optimal coordination in the delivery of DOTS and ART.

ANNEX 2

District TB/HIV Coordination Committee

The proposed constitution of the District Coordination Committee

1. Chairman : District Magistrate/Collector or CEO Zilla Panchayat
2. Vice Chairman : Chief Medical Officer / District Health Officer or equivalent
3. Member Secretary : DAPCU Nodal Officer/DNO AIDS or District TB Officer
4. Member : Medical Superintendent, District Hospital
5. Member : Medical Superintendent, Medical College Hospital
6. Member : City TB Officers (Where applicable);
7. Member : MS of Hospital providing ART Services (where applicable)
8. Member : ART Centre Medical Officer (where applicable)
9. Member : Representative of NGO / CBO involved in NACP
10. Member : Representative of NGO / CBO involved in RNTCP

SCOPE OF WORK OF THE COMMITTEE

District Co-ordination Committee for TB-HIV will ensure the implementation of TB-HIV collaborative activities in their District and review the performance of the same.

The Chairman of the Committee if need arises can invite a person as special invitee whenever required for the betterment of the programme. In case the Chairman is not available for the meeting, a nominee of the chairperson may preside over the deliberations.

Terms of Reference

1. To strengthen the collaboration between the RNTCP and NACP in the District.
2. To review the co-ordination activities between the ICTC/ART Centre/CCC and RNTCP diagnostic and treatment services, and ART and DOT services, and overall implementation of the National framework for TB-HIV Collaborative activities, and guide the strengthening of these activities in the respective district (including review of the cross-referral data).
3. To facilitate the participation of NGOs and Private Practitioners implementing NACP/RNTCP in the TB-HIV co-ordination activities.
4. To facilitate the participation of institutes and organizations providing care and support to HIV/AIDS patient in the RNTCP (e.g. Community Care Centre, ART Centre, etc.)
5. To ensure that appropriate measures are taken to prevent the spread of TB infection in facilities caring for HIV-AIDS.
6. To ensure prevention of spread of HIV infection through safe injection practices in those facilities providing RNTCP treatment services.

The committee should hold one meeting every quarter to review the TB-HIV coordination activities.

ANNEX 3

Review of TB-HIV coordination, infrastructure, and activities before rolling out Intensified HIV/TB package

1	State and district-level coordination	Notes
1a	Whether TB-HIV SCC has been formed at the state level?	Yes/No
1b	No. of TB-HIV SCC meetings held at state level	In last 4 quarters
1c	Number of TB-HIV SWG meetings held at state level	over past 4 quarters
1d	Proportion of Districts with at least 1 DCC Meetings in each quarter	over past 4 quarters
2	Infrastructure	
2a	Total no. of stand alone ICTCs in the state	As of previous quarter
2b	Distribution of ICTCs as per the district category (A,B,C,D)	As of previous quarter
2c	No. of ICTCs in 24*7 PHCs in the state	As of previous quarter
2d	No. of ICTCs functional under PPP in the state	As of previous quarter
2e	No. of ART centers in the state	As of previous quarter
2f	No. of LAC (Link ART Centres) functional in the state	As of previous quarter
2g	No. of DMCs in the state	
2h	No. of ICTCs in the same facility as the same DMC	As of previous quarter
2i	No. of TUs in the state	As of previous quarter
2j	No (%) of TUs without any HIV counseling & testing facility	As of previous quarter
3	Intensified Case Finding for TB at ICTCs and ART Centers	
3a	Proportion of ICTCs reporting on TB/HIV	As of previous quarter
3b	Total no. of clients who attended ICTCs during the month	As of previous quarter
3c	No.(%) of ICTC clients referred to RNTCP as TB suspects	As of previous quarter
3d	No. (%) of the referred TB suspects from ICTCs who are diagnosed with TB	As of previous quarter
3e	No.(%) of diagnosed TB patients from ICTCs who are initiated on DOTS treatment	As of previous quarter
3f	No. (%) of ART patients referred to RNTCP as TB suspects	As of previous quarter
3g	No. (%) of the referred TB suspects from ART centres who are diagnosed with TB	As of previous quarter
3h	No.(%) of diagnosed TB patients from ART centre who are initiated on DOTS treatment	As of previous quarter
4	Detection of HIV in TB patients & HIV treatment	As of previous quarter
4a	Number of TB patients tested for HIV by NACP	As of previous quarter

4b	No. (%) of registered TB patients with known HIV status	As of previous quarter
4c	No. (%) of registered TB patients found to be HIV positive	As of previous quarter
4d	No. (%) of HIV-positive TB patients receiving CPT during TB treatment	As of previous quarter
4e	No. (%) of HIV-positive TB patients receiving ART during TB treatment	As of previous quarter
5	Human Resources	
5a	No. (%) of ICTCs having counsellor	As of previous quarter
5b	No. (%) of ICTCs counselors trained in TB-HIV	As of previous quarter
5c	No. (%) of ICTCs with LT	As of previous quarter
5d	No. (%) of ICTCs functional	As of previous quarter
5e	Are the counselors (ICTC and ART) attending the RNTCP monthly meeting	Yes/No
5f	Is the Health Care Provider tool being provided to all the PHIs	Yes/No
5g	Is the 10 point counseling tool for TB available at all the ICTCs?	Yes/No
5h	No. of field visits made to the districts jointly by officers from SACS and STC	No. of visits made in the last four quarters

ANNEX 4

National Framework for TB/HIV Collaborative Activities: Performance Indicators and Targets for TB/HIV Collaborative Activities

Performance Indicator	Data Source	2009	2010	2011	2012	2013	2014
Minimum Cumulative Number of States/UT implementing intensified TB/HIV package (by end of each year)	NACO/RNTCP SWG	12	18	28	35	35	35
State and district-level coordination							
a. Proportion of TBHIV SCC/SWG meetings held at state level over past 4 quarters	RNTCP State PMR Qtrly Report	100%	100%	100%	100%	100%	100%
b. Proportion of Districts with at least 2 DCC Meetings over past 4 quarters	RNTCP District PMR Qtrly Report	>80%	>90%	>90%	>90%	>90%	>90%
Intensified Case Finding (reported separately for ICTC and for ART centres)							
a. Proportion of ICTC/ART center reporting on TB/HIV ICF activities *	NACO MIS	80%	>90%	>90%	>90%	>90%	>90%
b. Number of ICTC/ART clients referred to DMC as TB suspect	NACO MIS	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers
c. Number of (b) who are diagnosed with TB	NACO MIS	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers
d. Among (c), number/percentage of diagnosed TB patients put on DOTS	NACO MIS	>80%	>80%	>80%	>80%	>80%	>80%
Detection of HIV in TB patients, & HIV treatment							
a. Number of TB patients HIV-tested by NACP	NACO MIS	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers	Increasing trend in numbers
b. Number/ percentage of registered TB patients with known HIV status	RNTCP CF Qtrly Rprts†	353,000 50%	460,000 50%	660,000 50%	900,000 60%	1,050,000 70%	1,200,000 80%
c. Number of registered TB patients found to be HIV-positive	RNTCP CF Qtrly Rprts†	21,700	25,400	29,700	37,700	44,000	50,300
d. Number/ percentage of HIV-positive TB patients receiving CPT during TB treatment ‡	RNTCP RT Qtrly Rprts†	n/a	60%	70%	80%	80%	80%
e. Number/ percentage of HIV-positive TB patients receiving ART during TB treatment ‡	RNTCP RT Qtrly Rprts†	n/a	50%	60%	70%	70%	70%

* "yes" if reports received for past 6 months. †For settings implementing the 'Intensified TB/HIV Package' only; annual target numbers reflect scale-up plan for the intensified package, 2008 TB notifications, and state-wise estimated prevalence of HIV among TB patients.‡ For previous year's TB patient cohort.

ANNEX 5

Training requirements for TB/HIV

S.No	Trainees	Trainers	Level at which training occurs	Duration of TB/HIV specific training component *	Responsibility for organizing training	Training materials
1.	State Master Trainers, STDC trainers and SACS, STC Officials	Experts from CTD, NACO, WHO, NTI and TRC	National Level	2 days	CTD and NACO	1. Revised Training modules on TB-HIV 2. HIV-TB module for ART center staff 3. Intensified Package module for Programme Managers*
2.	District TB Officers/District Nodal Officers (HIV-AIDS)	State Master Trainers	State level	2 days	STC in coordination with SACS, CTD and NACO	1. Revised Training modules on TB-HIV 2. HIV-TB module for ART center staff 3. Intensified Package module for Programme Managers*
3.	MO-ICTC/MO-TC	Officials from SACS, STC and State Master trainers	State level/ District level	2- days including visit to DTC, DMC, ICTC and DOT Centre	SACS in close coordination with STC, DTO and DNO	1.Revised Training modules for TB/HIV 2. Intensified Package for MOs*
4.	District TB/HIV & DOTS Plus Supervisors / District ICTC supervisors/ STS	DTO and DNO	District level	2- days including visit to DTC, DMC, ICTC and DOT Centre	DTO and DNO	1. Revised Training modules on TB-HIV 2. HIV-TB module for ART center staff 3. Intensified Package module for Programme Managers*
5.	ICTC Counsellors	DTO and DNO	District level	1 day	DTO and DNO	1. Revised Training modules on TB-HIV 2. Intensified Package module for Counsellors*
6.	Medical Officers- General health services	District TB officer and DNO,	District level	1 day	DNO, in coordination with DTO	1.Revised Training module TB/HIV 2. Intensified Package module for MO*
7.	ART Centre Medical Officers	CST Division at SACS/Regional CST consultant	State level	2 days	NACO & CTD/ SACS & STC	1. RNTCP PP Module 2. Module for ART staff on HIV-TB
8.	Data Entry Operator at SACS and State TB Cell	Experts from NACO, CTD and WHO	State Level	Half day	SACS & STC	Presentations & group work and Part of Training Modules on data and M&E.

*Trainings on Intensified Package to be conducted in states where the package is rolled out.

ANNEX 7

ICTC TB-HIV Report

REPORTING MONTH: _____ YEAR _____

NAME OF ICTC: _____ DISTRICT: _____

I. TOTAL NUMBER OF GENERAL CLIENTS ATTENDING ICTC:

a) Total no. of clients who attended ICTC in the month (excluding PPTCT clients)	
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II. REFERRAL OF SUSPECTED TUBERCULOSIS CASES FROM ICTC TO RNTCP

	HIV positive	HIV Negative
a) No. of persons suspected to have TB referred to RNTCP diagnostic services		
b) Of the referred TB suspects, No. diagnosed as having:		
(i) Sputum Positive TB		
(ii) Sputum Negative TB		
(iii) Extra-Pulmonary TB		
c) Out of above (b), diagnosed TB patients, number receiving DOTS		

III. REFERRAL OF DIAGNOSED TB PATIENTS FROM RNTCP TO ICTC

a) No. of RNTCP registered TB patients tested for HIV	
b) Out of above (a), No. detected to be HIV Positive	

Signature of Medical Officer – In charge ICTC

Name of Medical Officer In-charge ICTC

ANNEX 8

LINE-LIST OF PERSONS REFERRED FROM ART CENTRE TO RNTCP

MONTH/YEAR

NAME OF ART CENTRE:

NAME OF DISTRICT:

To be completed by ART/CCC Nurse										To be completed by STS				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
<i>Sr. No.</i>	<i>Pre-ART/ART Number</i>	<i>Complete Name & Complete Address</i>	<i>Age</i>	<i>Sex</i>	<i>Date of referral to RNTCP for investigation</i>	<i>Name of facility referred to</i>	<i>Is patient diagnosed as TB – Yes or No</i>	<i>If diagnosed as TB, specify whether patient is sputum positive TB, sputum negative TB or Extrapulmonary TB</i>	<i>Date of referral to RNTCP for treatment</i>	<i>Date of Starting TB Treatment</i>	<i>TB Number with TU Name</i>	<i>Is the patient referred outside district (Yes/No)</i>	<i>Is the patient initiated on Non-RNTCP treatment (Yes/No)</i>	<i>Remarks</i>
Sign of ART Nurse Date of completion		Sign of SMO/MO-ART					Sign of STS(TU where ART centre is situated) Date of completion				Sign of DTO			

ANNEX 9

ART CENTRE MONTHLY TB-HIV REPORT

REPORTING MONTH: _____ YEAR _____

NAME OF ART CENTRE: _____ DISTRICT: _____

a) Number of HIV positive patients attending ART centre during the month(Pre-ART and ART)	
b) No. of TB Suspects referred from ART to RNTCP	
c) Out of the above persons, number diagnosed as having TB :	
(i) Sputum Positive TB	
(ii) Sputum Negative TB	
(iii) Extra-Pulmonary TB	
d) Total Diagnosed TB Patients	
e) Out of (d), number of TB patients receiving RNTCP treatment within the district	
f) Out of (d), number of TB patients referred outside district for RNTCP treatment	
g) Out of (d), number of TB patients receiving Non-RNTCP treatment	

Signature of Medical Officer / In-charge of ART Centre:

Name of Medical Officer / In-charge of ART Centre:

