

MINISTRY OF HEALTH



*GUIDELINES FOR IMPLEMENTING TB-HIV COLLABORATIVE  
ACTIVITIES IN KENYA*

**What Health Care workers' need to know**

*June 2006*

## **Acknowledgements**

The need for a guideline to be used by health care workers for implementation of TB/HIV collaborative activities was soon realized when testing for HIV in TB patients began. This need was further compounded by the fact that this was a new area of intervention that needed clear and concise guidelines so that implementation of activities in the whole country can be well coordinated and uniform.

The amount of time spent by the following people cannot therefore go unnoticed: Dr. J Chakaya, the head NLTP for taking leadership role, Dr. J Sitienei (NLTP) who was the focal person in coordinating, collecting and collating materials from the drafting team. The team wishes to most sincerely thank all partners who were involved in the development of these guidelines including Dr J Kangangi (WHO), Dr. N Wambua (CDC), Dr. J Odhiambo (CDC) and Ms Margaret Mburu (CDC).

Special thanks must go to those who funded the printing of this document; CDC and Family Health International (FHI) and all those who have not been mentioned but gave support or encouragement to the drafting team. It is the believe of the drafting team that the document will be of much use for health care workers implementing TB/HIV activities so that patients dually infected can reap maximum benefits and that the fight against the dual epidemic will one day be won.

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## List of Abbreviations

|                |   |   |
|----------------|---|---|
| <b>ACS</b>     | - | Advocacy, Communication and Social Mobilization |
| <b>AIDS</b>    | - | Acquired Immuno-deficiency Syndrome             |
| <b>ART</b>     | - | Anti retroviral Therapy                         |
| <b>ARV</b>     | - | Anti-Retro-Viral (drugs)                        |
| <b>CB DOTS</b> | - | Community Based DOTS                            |
| <b>CBO</b>     | - | Community Based Organizations                   |
| <b>CCC</b>     | - | Comprehensive Care Center                       |
| <b>CD4</b>     | - | Cluster for Differentiation (Immune cells)      |
| <b>CPT</b>     | - | Cotrimoxazole Preventive Therapy                |
| <b>DASCO</b>   | - | District AIDS/STD coordinator                   |
| <b>DHMT</b>    | - | District Health Management Team                 |
| <b>DMS</b>     | - | Director of Medical services                    |
| <b>DOTS</b>    | - | Directly Observed Treatment Short Course        |
| <b>DTC</b>     | - | Diagnostic Testing and Counseling               |
| <b>DTLC</b>    | - | District TB and Leprosy Coordinator             |
| <b>FBO</b>     | - | Faith Based Organization                        |
| <b>HBC</b>     | - | Home Based Care                                 |
| <b>HIV</b>     | - | Human Immune Deficiency Virus                   |
| <b>HMIS</b>    | - | Health Management Information System            |
| <b>IEC</b>     | - | Information, Education and Communication        |
| <b>IPT</b>     | - | Isoniazid Preventive Therapy                    |
| <b>M&amp;E</b> | - | Monitoring and Evaluation                       |
| <b>NASCOP</b>  | - | National AIDS/STD Control Program               |
| <b>NACC</b>    | - | National AIDS Control Council                   |
| <b>NGO</b>     | - | Non-Governmental Organization                   |
| <b>NLTP</b>    | - | National Leprosy and Tuberculosis Program       |
| <b>PHMT</b>    | - | Provincial Health Management Team               |
| <b>PLWA</b>    | - | People Living with HIV/AIDS                     |
| <b>TB</b>      | - | Tuberculosis                                    |
| <b>STI</b>     | - | Sexually Transmitted Infections                 |
| <b>VCT</b>     | - | Voluntary Counseling and Testing                |
| <b>WHO</b>     | - | World Health Organization                       |

# **1 BACKGROUND**

## **1.1 Introduction**

The human immunodeficiency virus (HIV) pandemic is the world's leading public health emergency, with a particular severe impact on sub-Saharan Africa. It is destroying the health of Africans, the economies of African nations and their prospects for development. HIV infection is also fueling the tuberculosis (TB) epidemic, but TB programs have focused on TB case finding and treatment, with little attention to HIV/AIDS interventions. Although TB is the leading cause of HIV-related morbidity and mortality, HIV/AIDS programs have generally paid little attention to TB (1).

Thus, despite close epidemiological links between HIV and TB, the public health responses have largely been separate, and have so far had little success in interrupting the sequence of events by which HIV infection fuels the TB epidemic (1)(2). Better coordination of HIV and TB program activities may lead to more effective implementation of interventions to decrease HIV transmission and the burden of TB. The time is ripe for TB and HIV programs to collaborate in carrying out activities as widely as possible (1).

## **1.2 Tuberculosis situation**

In countries with advanced HIV epidemics, particularly in sub-Saharan Africa, the majority of TB patients are also infected with HIV (3). In Kenya, there has been a steady increase in the number of tuberculosis patients particularly since the early 90's. This rising number of tuberculosis cases poses a major threat to the health and the economy of this country. The case notification rate has steadily increased from 54 per 100,000 in 1991 to 320 per 100,000 in 2004 (4). The peak age group for both males and females in 2004 was 25 – 34, the economically productive and sexually active age group with a male to female ratio of 1.4.

Currently, the HIV sero-prevalence among the tuberculosis patients is not known in Kenya, although it is estimated to be 50-60% (6). The survey conducted among the sputum smear positive TB cases in 1994, showed that at least 40% of TB patients were also HIV positive. The annual increase in TB case notification rate is about 16%. By the end of 2004, all forms of TB cases notified in the public sector were 105,736. WHO estimates that only 47% of the TB cases are being detected in Kenya, indicating that the remaining 53% undetected cases continue to transmit TB. This increasing number of TB cases is thought to be largely associated with the growing HIV epidemic.

The Kenya government released guidelines for HIV testing in clinical settings in November 2004. Diagnostic HIV testing is provided by health workers as part of the diagnostic work – up of patients, in the context of provision of medical care.

In settings of high HIV prevalence the majority of medical and tuberculosis patients may be HIV infected, and it is appropriate to conduct diagnostic HIV testing on all medical patients including those who have tuberculosis (5). Testing of Tuberculosis patients (being one of the opportunistic infections in HIV infection) will offer an entry to comprehensive care, treatment and support.

In this region, tuberculosis is the most common opportunistic infection for the people living with HIV/AIDS and contributes to the high mortality rates. Majority of the patients who have completed TB treatment still die due to HIV related illnesses and a good number develop tuberculosis within a year of treatment completion (6). The DOTS strategy has been effective in controlling TB in the pre HIV era. However, in this dual epidemic era, TB cases notified have continued to increase despite all efforts in TB control: it is clear that tuberculosis is difficult to control without addressing the issue of HIV/AIDS epidemic (1) (2). It is therefore becoming apparent that DOTS alone may not suffice and there is need for newer and more innovative methods including fostering partnerships in order to address renewed challenges.

### **1.3 The HIV/AIDS situation**

Over the last decade, HIV/AIDS has become the world's most devastating epidemic, particularly in developing countries, and many governments have declared it an emergency. In 2001, the United Nations Secretary General declared HIV/AIDS a global emergency (8). But of all regions of the world, sub-Saharan Africa is worst hit, with two-thirds of all HIV infected people. Out of 42 million HIV infected people in the world currently, 29 million of them live in sub-Saharan Africa (7).

It is estimated that 1.2 million Kenyans are now living with HIV infection, but few know whether they are infected or show outward symptoms of the disease (13). Only about 200,000 have AIDS, and it is estimated that altogether 1.5 million people have died of AIDS since the epidemic began in the early 1980's. Because of these large numbers of AIDS deaths, life expectancy in Kenya has dropped from 65 years in the 1970's to 46 years currently (8).

The HIV prevalence among antenatal clinic attendees is 7.5% (NASCO, 2004), while that of STI patients is 23% (NASCO, 2002). This information is obtained from sentinel sites spread across the entire country. The prevalence is generally higher in urban than in rural areas, but because a bulk of the population resides in rural areas, there are cumulatively more HIV infected people in rural Kenya (10). The HIV prevalence rate in the country currently stands at 6.7% (KDHS, 2003).

The National AIDS Control Council (NACC), housed in the Office of the President, coordinates the fight against the HIV/AIDS pandemic. This is in recognition of the multi-sectoral nature of the disease and the need for multi sectoral approach in the fight against it. NASCOP, as a unit within the Ministry of Health, coordinates all the technical issues including ARVs, STI treatment and blood safety.

#### **1.4 Relationship of TB and HIV/AIDS**

In the decades leading up-to 1980, Tuberculosis was in decline throughout the world, and there was reason to believe that if control efforts were maintained, and where necessary strengthened, TB would be driven steadily towards elimination (7). This scenario has changed with the advent of the HIV/AIDS pandemic, to the extent that even good control programs have not been sufficient in containing TB where HIV infection rates are high.

TB is the leading cause of death among PLWAs (1) and in countries with advanced epidemics; particularly those in sub-Saharan Africa, the majority of TB patients are also infected with HIV. In some countries the proportion of TB patients dually infected with HIV is as high as 70% (11). HIV is also the most powerful known risk factor for reactivation of latent TB infection to active disease. HIV positive individuals have a 50% lifetime risk of developing tuberculosis and the annual risk of developing tuberculosis is 5-15% (2). This risk has been shown to increase with declining CD4+ counts (11). The incidences of TB recurrence have also been shown to be high in HIV/AIDS patients, which may be due to endogenous reactivation or exogenous re-infection (2).

These statistics show that there is a strong epidemiological justification for TB and HIV programs sharing mutual concerns. TB and HIV programs need to exploit synergies in supporting health service providers to deliver joint interventions. In fact, the burden of TB is so closely linked to the HIV epidemic that prevention of HIV must become a priority for TB programs. TB care and prevention should also be a major concern for HIV/AIDS programs (2). Currently, the implementation of basic essentials for control of HIV-related TB is generally at low level in most high prevalence countries (2). Moreover, majority of TB suspects delay seeking care due to the fear of the strong association with HIV (stigma) hence increasing the infectious pool within the community and delaying initiation of effective treatment.

#### **1.5 Combating the dual epidemic of tuberculosis and HIV/AIDS**

Because of the impact of HIV on the TB epidemic, additional measures beyond TB case finding and treatment are necessary to control TB. These measures

should not replace but complement and strengthen ongoing efforts to improve TB control (1).

In Kenya two separate vertical programs coordinate prevention and control of HIV/AIDS and TB. The National Leprosy and Tuberculosis Program (NLTP) coordinates TB program activities, while the National AIDS and STIs Control Program (NAS COP) coordinates HIV/AIDS programs. But it is clear that TB and HIV programs share mutual concerns and they need to exploit synergies. TB control will not make much headway in high HIV prevalence settings unless HIV control is achieved (2). Lack of collaboration also leads to duplication of activities and wastage of the resources.

This is by no means an attempt to develop another program, but an opportunity for the two programs to collaborate in an effort to give quality and comprehensive care to dually infected patients that is acceptable, accessible and affordable. Each program should continue to pursue their goals and objectives, but they should also make provision for joint activities.

### **1.6 Functions of the National TB and Leprosy program**

NLTP was launched by the Kenya government in 1980 combining TB control activities started in 1956 and several leprosy control projects which existed since early seventies in western, coast and eastern provinces.

The TB control program is a unit in the Ministry of Health and functions as an integral part of the general health system (4). It is charged with the responsibility of setting policy guidelines for TB and Leprosy control. This is done in close collaboration with international organizations such as Stop TB partnership.

NLTP offers technical support to the general health system in the day-to-day care of tuberculosis patients. It has technical officers at every level, but patient management is handled within the general health care system (PHC). Part of this supportive role has to do with development of policies and guidelines for health providers in the general health system. NLTP also coordinates operational research, undertakes surveillance activities, carries out advocacy at national level and coordinates mobilization of resources.

Currently the NLTP is supported by the GOK, multilateral and bilateral donors such as CDC, WHO, USAID and CIDA through KNCV.



### **Aims of NLTP**

- For the nation - That TB is no longer a public health
- For the community - To reduce the number of infectious cases in the community and hence reduce the disease burden
- For the individual patients - to cure their disease, quickly restore their health so as to resume their daily normal activities and preserve their position in the family and society

### **Objectives of NLTP**

- To interrupt transmission of infection
- To reduce morbidity mortality and disability
- To prevent drug resistance

### **Activities of the program**

- Early case detection of TB
- Treatment of the detected cases
- Health education to the Health workers, community and the patient
- Invite contacts of patients for screening and offer necessary assistance
- Recording and reporting for monitoring and evaluation purposes
- Training of health workers and the community
- Tracing of patients who have defaulted from treatment
- Supervision of the health workers
- Conduct operation research

The Kenyan TB program adheres to the DOTs strategy as the most cost effective strategy to address the problem of tuberculosis and has used the DOTS strategy since 1993 when the DOTs program was piloted and implemented in the whole country by 1997.

The strategy embraces the following 5 key elements:

- Sustained political commitment to increase human and financial resources and integrating TB control into the national health system.
- Access to quality assured TB sputum microscopy
- Standardised short course chemotherapy to all diagnosed cases of TB and case management under direct observation of treatment (DOT).
- Uninterrupted supply of quality assured drugs with reliable procurement and distribution systems.
- Recording and reporting system enabling outcome assessment of each and every patient and overall assessment of the program.

## **1.7 The functions of the National AIDS/STD control program**

The National AIDS Control Program was established in 1987, for the purpose of coordinating all HIV/AIDS prevention and control activities in Kenya. This unit was later merged with the National STD Control Program in 1992 to form the National HIV/AIDS and STD Control Program (NASCOP), with a stronger coordinating role. In 1999, the Government declared HIV/AIDS as a national disaster, following which the National AIDS Control Council (NACC) was established in the office of the president (12).

The goal of NACC is to halt the escalation of HIV/AIDS and to reduce its impact on the society by achieving the following targets:

- Reduce the prevalence of HIV among people aged 15-24 years by 20-30 % by 2005
- Increase access to care and support for people infected with, and affected by, HIV/AIDS
- Strengthen the institutional capacity and improve coordination to respond to HIV/AIDS epidemic at all levels

The Strategic Plan identifies key priority areas in the response to the epidemic as being (12):

- Prevention and advocacy
- Treatment, continuum of care and support
- Mitigation of the socio-economic impact
- Monitoring, evaluation and research
- Management and coordination

NASCOP coordinates the technical issues in the fight against HIV/AIDS. Towards this end, it has two main objectives, namely:

- To increase access to care and support for the infected and affected
- To reduce national prevalence of HIV

## **2 OBJECTIVES OF TB-HIV COLLABORATION<sup>1</sup>**

### **2.1 Overall goal**

*To decrease the burden of TB and HIV in populations that are affected by both diseases*

### **2.2 Objectives**

The objectives of TB – HIV collaboration are:

- *To establish mechanisms for collaboration between TB and HIV programs*
- *To decrease the burden of tuberculosis amongst PLWHA*
- *To decrease the burden of HIV amongst TB patients*

The implementation of the following 12 activities will lead to achievement of these three objectives:

### **2.3 Activities of TB HIV collaboration**

1. Set up a coordinating body for TB/HIV activities at all levels: Nationally, Province and Districts
2. Conduct surveillance of HIV prevalence amongst TB patients
3. Carry out joint TB/HIV planning
4. Conduct monitoring and evaluation
5. Establish intensified TB case finding
6. Introduction of IPT in settings where this is feasible like in research, prisons etc
7. Ensure infection control in health care and congregate settings
8. Provide HIV testing and counselling (DTC)
9. Introduce HIV prevention methods
10. Introduce cotrimoxazole preventive therapy (CPT)
11. Ensure HIV/AIDS care and support
12. Introduce ART to HIV infected TB patients

### **2.4 Aim of the guidelines**

The purpose of this guideline is to give direction to implementers of TB-HIV collaborative activities. In essence it seeks to show how, where, what, and who will implement TB-HIV activities.

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<sup>1</sup> The goal, objectives and activities of TB and HIV collaboration are adopted from the WHO guidelines for TB/HIV collaboration

### **3 TB and HIV ACTIVITIES**

#### **3.1 Coordination of TB/HIV collaborative activities.**

For effective implementation of TB/HIV collaborative activities there must be good coordination. It is recommended that every province and district should establish TB/HIV coordinating committees. The membership of these committees should include but not limited to:

##### **At the provincial level**

- PMO
- PTLC
- PASCO
- Provincial public health nurse
- Provincial public health officer
- Representatives from NGO, FBO, CBO working with TB/HIV
- Representative from PLWA, TB clubs etc
- PMLT

##### **At the district level**

- DMOH
- DTLC
- DASCO
- District public health nurse
- District public health officer
- Representatives from NGO, FBO, CBO working with TB/HIV
- Representative from PLWA, TB clubs etc
- DMLT

*Note: All stake holders within the region should be included where possible*

##### **At the health facility level**

- The health facility in charge
- TB Nurse
- PHO/PHT
- Other stake holders

#### **3.2 The role of these committees includes:**

- Planning of HIV/TB collaborative activities
- Resource mobilization for TB/HIV
- Coordinate training and other capacity building activities
- Advocacy, communication and social mobilization
- Enhancing community participation
- Oversee successful implementation of TB/HIV collaborative activities
- Monitoring and evaluation of TB/HIV activities

### **3.3 PRACTICAL STEPS TO PLANNING THE IMPLEMENTATION OF TB/HIV COLLABORATIVE ACTIVITIES AT DISTRICT**

#### **3.3.1 District situation analysis**

This includes analysis of the TB/HIV services:

- Collection of TB/HIV baseline statistics
- The identification of risk groups for TB and HIV infection
- A survey of existing district TB and HIV/AIDS service providers
- A survey of existing stakeholders in the area

This will be the responsibility of the DHMT in consultation with the DTLC and DASCO

Sources of information include:

- HMIS
- District TB register
- Laboratory, ward and OPD registers
- Surveillance results if they exist
- Morbidity and mortality records.

Situational analysis should include description of groups within the district considered to be at special risk of TB and/or HIV infection e. g. groups of people known to be infected with HIV and PLHA support groups, patients with STI's, prisoners, the military, CSW, IDU's and migrant groups like seasonal laborers.

A list of service providers should be included with an assessment of:

- Target population/catchment area
- Number of clients/patients using service
- Gender and ages of patients/clients
- HIV status of patients/clients
- Drugs available for HIV care at different clinical service providers

Trends of service use over time should also be collected and the list should include:

- Who is doing what and where in terms of provision of TB and/or HIV care
- Identification of gaps in the package of prevention and care for HIV and TB within the district
- Identification of underserved populations

### **3.3.2 Establishing a TB and HIV/AIDS coordinating committee**

The DHMT should establish one with all the relevant TB and HIV/AIDS care and support stakeholders invited to participate. The MoH in consultation with the DTLC and the DASCOS is tasked with the duty of convening the stakeholders to the first meeting. Terms of reference and reporting structure for the group should be defined. This committee should be meeting regularly to enable networking, planning and implementation of collaborative TB and HIV activities.

Formation of the steering committees should see the election of a chairman and a secretary. The elected chairman should preferably come from the other stakeholders within the district with the secretary preferably from the ministry of health (DTLC)

For purposes of proper implementation, coordination and supervision of TB/HIV collaborative activities, these committees should initially be meeting monthly and then quarterly to review implementation of activities and task officers. Minutes of the meetings should be circulated to all members before the meetings are called. Copies of these minutes should also be shared with the PHMT and the TB and HIV programs.

Where feasible, health institutions should set up health facilities committees which will offer an opportunity for these institutions to address implementation constraints and to plan for reducing transmission of both TB and HIV in the institutions. The steering committees will ultimately strengthen the delivery of quality health care services to all patients.

### **3.3.3 Diagnostic Testing and Counseling (DTC)**

This is HIV testing which is *initiated by a health worker* as part of the diagnostic work up for patients who present with symptoms or signs that could be attributable to HIV disease.

Diagnostic Testing and Counseling (DTC) will offer an entry point for all TB patients to quality and comprehensive treatment, care and support. TB patients tested for HIV and turn out to be HIV positive should for a start be put on double strength CPT at the chest clinic before being referred to the comprehensive care centre for ARVs. CPT will treat and prevent some opportunistic infections that patients succumb to. HIV is a serious problem that cannot be managed unless the diagnosis is known. Because many patients with HIV infection present with active TB, the TB clinics are a good way to identify those infected with HIV.

All TB patients should be offered rapid HIV testing as a routine investigation with detailed information on benefits of testing. TB patients needing comprehensive counseling should be referred to a trained counselor. This is NOT mandatory testing and the patient reserves the right to decline. DTC is offered in the context of consent, counseling and confidentiality (3C's). Considering that TB patients are within the health system throughout their medication period (8 months), those who decline initially should also be reminded in subsequent visits of missed opportunities.

Sites for HIV testing of TB patients will depend on several factors within the institution including but not limited to workload, space for testing and human resources available. However, the common areas where the HIV testing can be done include:

- At the chest clinic
- At the laboratory
- A side room next to the TB clinic/ward
- At the VCT site – with care being taken not to put the patient through counseling and waiting again

If testing is done at the laboratory, measures should be put in place to ensure that the TB patients are not lost during referral and also to ensure that the TB patients do not queue for long while waiting to be attended. Issues of confidentiality should always be addressed and a member of staff should be tasked to take results to the clinician.

All HIV positive patients on the other hand should be thoroughly screened for TB and those with signs and symptoms of TB investigated to rule out active TB. Clients seeking care at VCT, STI and PMTCT sites should all be screened for TB and referred appropriately. A simple job aid will be available to health care workers that will assist them to screen for TB. This will include asking for a history of chronic cough with blood stained sputum or contact with a TB patient, history of night sweats, weight loss and chest pains.

### **3.3.3 Assessing the cost of the work plan**

Some finances may be allocated to the district from TB/HIV budget. There are however other sources of funding that could be explored to keep activities going:

- Private business
- Local companies
- NGO's
- Charities
- Faith based organizations

### **3.4 Coordinating District TB/HIV activities**

The coordinating officer should be able to encourage collaborative activities and have the capacity to document and monitor such activities. The coordinating committee should identify existing resources that can be used for coordination.

#### **3.4.1 Establishing a referral system**

In many areas, a number of TB and HIV/AIDS service providers already exist but often work in isolation. The result is that a network of care and support does not exist in the district despite the presence of comprehensive TB/HIV care and support providers. One of the first priorities for the coordinating committee is to establish links between the service providers and clinics in order to create a **patient-centered referral system**. The committee should seek to strengthen existing district referral systems so that patients with other illnesses can also benefit from the improved system. Referrals within the health facility should also be strengthened and made easy for the patients. Referral forms will be placed at all sites that offer service to the TB and HIV/AIDS patients to enable tracking of these patients and enable the committees to properly plan for referrals within the health institutions and to the community where Home Based Care (HBC) is available.

#### **3.4.2 Supporting the staff**

There is need to constantly have support supervision so that mistakes can be corrected early and to motivate the staff by giving guidance. Lessons learnt in successful sites should be built upon and replicated to give the patients comprehensive care.

District TB/HIV committees should invest time and resources in training and motivating TB/HIV service providers as new activities are planned and implemented within the district. Other activities to support the staff include:

- ✓ Regular meetings to maintain and update the skills of the service providers
- ✓ Confidential staff support meetings where staff can share their own emotional responses to the occupational stress
- ✓ Regular supervision with supportive and constructive feedback to health care providers
- ✓ Exchange visits with care providers in other districts
- ✓ Strategies to reduce the risk of TB and HIV in health staff



### 3.4.3 Monitoring and evaluation

As far as possible, recording and reporting should be made routine. There shall be quarterly collection of data from partners on service use. This will allow changes in the district TB/HIV service performance to be monitored. Indicators for new activities shall also be monitored and reported quarterly. Six monthly and yearly evaluations should be undertaken including quarterly meetings where lessons learned can be exchanged and services improved. The following targets will guide the implementation

#### Targets

- 100% of all TB patients being offered DTC
- HIV status of 75% of all TB patients known
- All eligible HIV positive patients provided with ART and/or CPT
- 100% off all HIV positive clients screened for active TB

And the following need to be constantly monitored:

- ✓ Total number of TB patient registered
- ✓ Number of TB patients offered DTC
- ✓ Number of TB patients counselled and tested
- ✓ Proportion of those that were tested that tested HIV positive
- ✓ Number of HIV positive TB patients commenced on ART
- ✓ Number of HIV positive TB patients commenced on CPT
  
- ✓ Number of VCT clients/number of clients tested/number of HIV positive clients
- ✓ Number of HIV positive VCT clients screened for TB
- ✓ Number of screened VCT clients diagnosed with active TB

### 3.4.4 Documenting the process

The coordinator of the district collaborative activities should be responsible for documenting the process of planning and implementing collaborative TB/HIV activities including the resources required. The information should be shared with all stake holders during meetings.

## Annex I

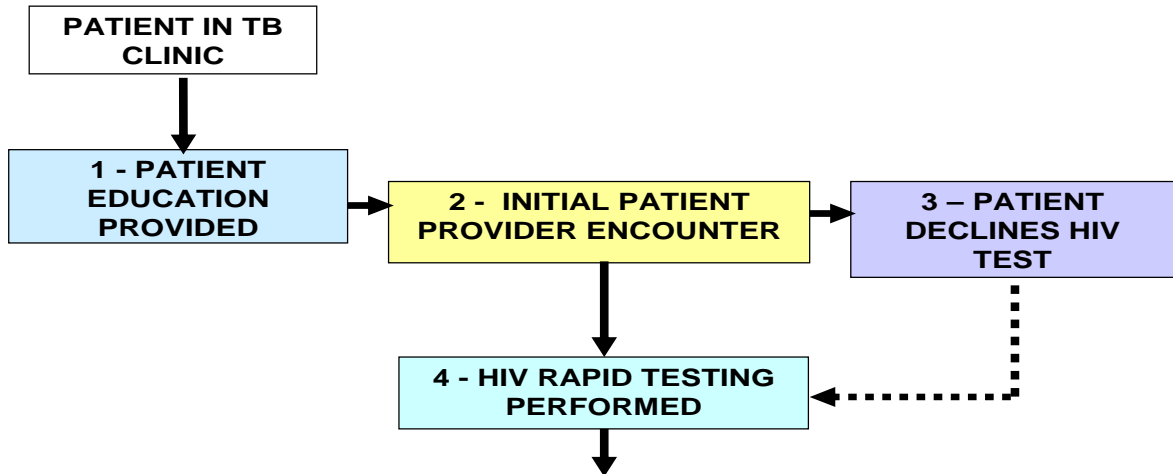
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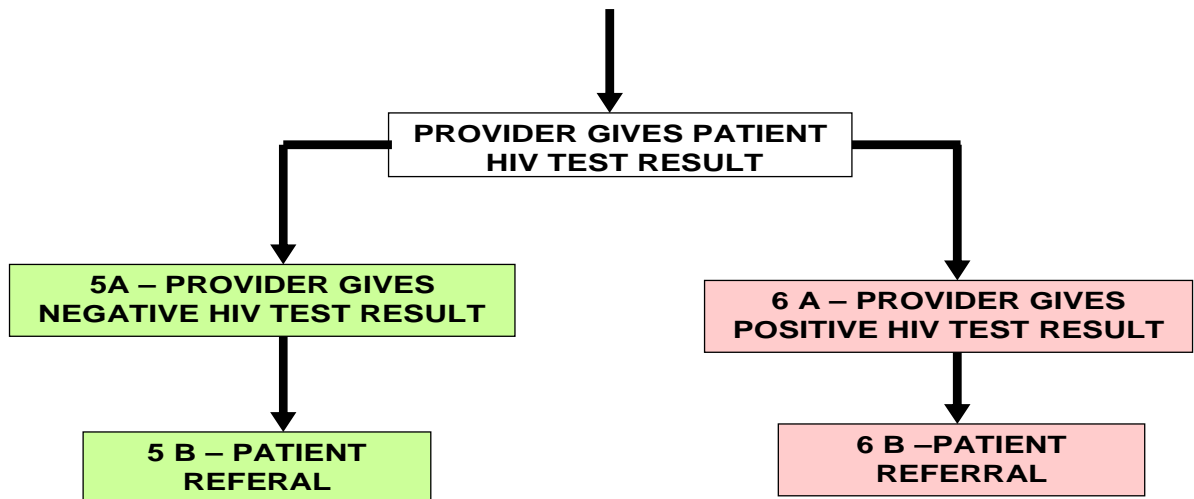
Annexes

DTC Protocol Script

### DTC Pretest Counseling



### DTC Post Test Counseling





# Routine HIV Testing and Counseling (DTC) in TB Clinical Settings Protocol

Ministry of Health

