

Kingdom of Swaziland

MINISTRY OF HEALTH AND SOCIAL WELFARE

**NATIONAL POLICY GUIDELINES FOR TB/HIV COLLABORATIVE
ACTIVITIES**

JUNE 2007

TABLE	OF	CONTENTS
Acronyms.....		iii
Foreword.....		iv
Acknowledgments.....		v
1.0 Introduction.....		1
1.1 Background.....		1
Geography, demography and health indicators		1
Health services		2
Burden of Tuberculosis.....		4
Burden of HIV/AIDS.....		5
Burden of TB-HIV co-infection.....		6
Control of Tuberculosis in Swaziland.....		7
Control of HIV/AIDS in Swaziland.....		9
Collaborative TB and HIV Programme Activities.....		9
Coordination of TB/HIV collaborative activities in Swaziland.		10
1.3 Purpose.....		11
1.4 Target audience		12
1.5 Policy framework.....		12
1.6 Policy guidelines formulation process.....		13
2.0 Goal and objectives of collaborative TB/HIV activities.....		14
3.0 TB/HIV Collaborative activities		15
3.1 A. Establish the mechanisms for sharing information and collaboration		16
A.1 Set up a national coordinating body for TB/HIV activities.		16
A.2 Identify TB and HIV focal persons at regional levels		16
A.3 Develop TB /HIV multidisciplinary teams at health facility level		17
(hospitals and health centers)		17
A.4 Conduct surveillance of HIV prevalence among tuberculosis patients		17
A.5 Carry out joint TB/HIV planning:.....		18
A.6 Monitoring and evaluation of TB/HIV collaborative activities.....		24
3.2 B. Decrease the burden of tuberculosis in people living with HIV/AIDS.....		25
B.1 Establish intensified tuberculosis case-finding.....		25
B.2 Introduce isoniazid preventive therapy (IPT), where feasible		26
B.3 Provide TB treatment for PLWHA's with active TB.....		27
B.4 Ensure tuberculosis infection control in health care and congregate settings.....		28
3.3 C. Decrease the burden of HIV in tuberculosis patients.....		29
C.1 Provide HIV testing and counseling		29
C.2 Introduce HIV prevention methods.....		30
C.3 Introduce Co-trimoxazole preventive therapy.....		32
C.4 Ensure HIV/AIDS care and support.....		32
C.5 Introduce antiretroviral therapy (ART).....		33
4.0 Targets for TB/HIV collaborative activities		34
REFERENCES		36
Annex 1: Monitoring and Evaluation of TB/HIV activities		37

Acronyms

AFB	Acid Fast Bacilli
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antirétroviral drug
BCG	Bacille de Calmette et Guérin
CBO	Community Based Organization
DOTS	Directly Observed Therapy Short course
EFV	Efavirenz
EPTB	Extra pulmonary Tuberculosis
FBO	Faith Based Organization
FDC	Fixed Dose Combination
HTC	HIV Testing and counseling (Initiated by provider)
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
INH	Isoniazid
IPT	Isoniazid Preventive Therapy
MDR-TB	Multi-Drug Resistant Tuberculosis
NGO	Non-Governmental Organization
NTCP	National Tuberculosis Control Programme
NNRTI	Non-Nucleoside Reverse Transcriptase Inhibitor
NRTI	Nucleoside Reverse Transcriptase Inhibitor
NVP	Nevirapine
PI	Protease Inhibitors
PLWHA	People living with HIV and AIDS
PPD	Purified Protein Derivative
PTB	Pulmonary Tuberculosis
RHM	Rural Health Motivators
RTV	Ritonavir
SCC	Short Course Chemotherapy
SS+	Sputum Smear positive
SS-	Sputum Smear negative
SNAP	Swaziland National AIDS Programme
SQV	Saquinavir
TB	Tuberculosis
THOs	Traditional Healers Organizations
USG	United States (of America) Government
VCT	Voluntary Counseling and Testing
TBM	Tuberculosis Meningitis
URC	University Research Co., LLC
WHO	World Health Organization

Foreword

The human immunodeficiency virus (HIV) pandemic presents a massive challenge to the control of tuberculosis (TB) at all levels. In Swaziland the interaction of TB and HIV is increasing the burden of both diseases. At present, an estimated 79.6% of TB patients are also co-infected with HIV. TB is a common, treatable HIV-related disease and a leading killer of people living with HIV/AIDS (PLHA). TB control will not make much headway in HIV prevalent settings unless HIV control is achieved. This calls for close collaboration between HIV/AIDS and TB control programmes so as to control the dual epidemic.

This policy document responds to a demand from service providers and other partners for guidance on TB/HIV collaborative activities to implement. It is complementary to and in synergy with the established core activities of tuberculosis and HIV/AIDS prevention and control programmes.

An open and participatory approach was followed in the development of this policy. The process was consultative involving participation of stakeholders from Ministries of Health & Social Welfare: SNAP, NTCP, NRL; Service providers in private and public sector and development partners.

This policy document provides a framework and guidance on implementation of TB/HIV collaborative activities so as to improve care for TB and HIV patients.

The gratitude of the Ministry of Health and Social Welfare is expressed to all the people and institutions listed in the acknowledgement for the selfless work they did to develop these excellent guidelines.

Principal Secretary

Ministry of Health and Social Welfare

Acknowledgments

Development of these policy guidelines was made possible from the recommendations of the TB/HIV Guidelines Development Workshop held on January 15-19, 2007 and the input of these individuals and organizations who participated in TB/HIV National Coordination Committee Policy and guidelines writing sub-committee.

The following are thanked for their time, dedication and contribution and their organizations for their input and participation in the writing subcommittee:

Ministry of Health & Social Welfare

1. Dr. Velephi Okello
2. Dr. Rosemary Mukasa
3. Ms Cindy Dladla
4. Ms Sipiwe Khumalo
5. Mr. Richard Walwema

Raleigh Fitkin Memorial Hospital

6. Dr Yohhanes Ghebrenegus

University Research Co., LLC

7. Dr. Samson Haumba
8. Mrs. Lindiwe Mkhathswa

We acknowledge the participation of the following individuals and organizations in the TB/HIV Guidelines Development Workshop:

1. Mr. Ernest Nhlengethwa- TB Coordinator
2. Mrs. Rejoice Nkambule-SNAP
3. Ms. Sipiwe Khumalo- TB Coordinator
4. Ms. Sibongile Mndzebele- SNAP
5. Ms. Lindiwe Mdluli- TB Coordinator
6. Mr. Richard Phungwayo-SNAP
7. Mr. Mfanasibili Matsenjwa- TB Coordinator
8. Ms. Andrew Jele –Good Shepherd Hospital
9. Ms. Thembisile Khumalo- MOHSW
10. Mr. Brain Cindzi- SNA

11. Mr. Themba Dlamini- NTCP
12. Dr. Cannan Mamvura- Good Shepherd Hospital
13. Ms. Bethusile Shabangu- NTCP
14. Ms. Cindy Dladla-NTCP
15. Mr. M. Mhlanga- Swaziland National Nursing Association
16. Mr. Thabo Kunene-NTCP
17. Ms. Albertina Nyatsi- PLWA
18. Ms. Agatha Tsabedze- NTCP
19. Dr. Jean Marie Rwangabwoba--WHO
20. Dr. Samson Haumba-Partner-URC
21. Ms. Doreen Dlamini- TB Centre Manzini
22. Mrs. Mkhathshwa Lindiwe- URC
23. Mrs. Julia Ziyani- TB Centre, Manzini
24. Mr. Peter Vranken-CDC
25. Dr. Rosemary Mukasa- TB Centre Manzini
26. Dr. De Louse Terlonge - Baylor College
27. Ms. Mary Ndlela- MOHSW Health Education
28. Dr. Yohannes Gherbrenegus –RFM Hospital
29. Dr. Velephi Okello- SNAP
30. Mr. Anzala Magoro-TB centre Manzini
31. Ms. Duduzile Maseko- NTCP
32. Dr. Benjamin Gama- WHO
33. Ms. Lindiwe Simelane- NTCP
34. Mr. Nhavana Masego-THOs

Finally we express our sincere thanks to Dr Samson Haumba and Mrs Lindiwe Mkhathshwa technical and editorial assistance and to the University Research Co. LLC for supporting the printing of the Policy guidelines.

1.0 Introduction

The age group 20-49 years old is one of the highly affected age groups by TB and HIV co-infection. This is also the most economically active and productive group. Unless halted, the TB/HIV co-infection will lead to serious negative socio economic impact on the country. By implication, the situation dictates that TB and HIV/AIDS be seriously considered not only as health issues but also as development agenda.

1.1 Background

Geography, demography and health indicators

Swaziland has a population of about 1.1 million with an area of 17 373 Km². The country is divided into 4 regions which are Hhohho, Lubombo, Shiselweni and Manzini. Seventy eight percent (78%) of the Swazi population live in rural Swaziland. The population is evenly distributed with the largest population of 30% in Manzini and the least 20.9% in Lubombo. The population of the country is generally young, with children under the age of 15 years accounting for 46 % and persons who are aged 65 years and above accounting for 3% of the total population. The last national census (1997), estimated the population to be growing at a rate of 2.8% in 1997 compared to 3.2% in 1986. Prior to the demographic impact of the AIDS epidemic, the quality of life of people living in the country had improved significantly from a life expectancy at birth of 44 years in 1966 to 60 years by 1997 with females (63 years) living slightly longer than males (58 years). The Crude Death Rate was on the decline from 18.5 per 1,000 in 1976 to 7.6/1000 in 1997. Infant mortality had dropped to 78 /1000 live births in 1997 compared to 99 in 1986, while Under-five mortality had decreased to 106/1000 live births in 1997 from 140 in 1986.

Economic indicators

The economy of the country is primarily agrarian even though the manufacturing sector has grown over the years. While the country experienced high economic growth levels of

9% on average in the late 1980s, in recent years the economic growth has seriously slowed down reaching an average rate of 3.4% in the period 1990-1992. The World Bank classifies the country as a lower middle income country with a GDP per capita income of US\$1,387 (1999), despite the majority of people (69%) in the country classified as poor. There is no doubt that economic achievements are being curtailed by the effects of the HIV/AIDS pandemic.

Health services

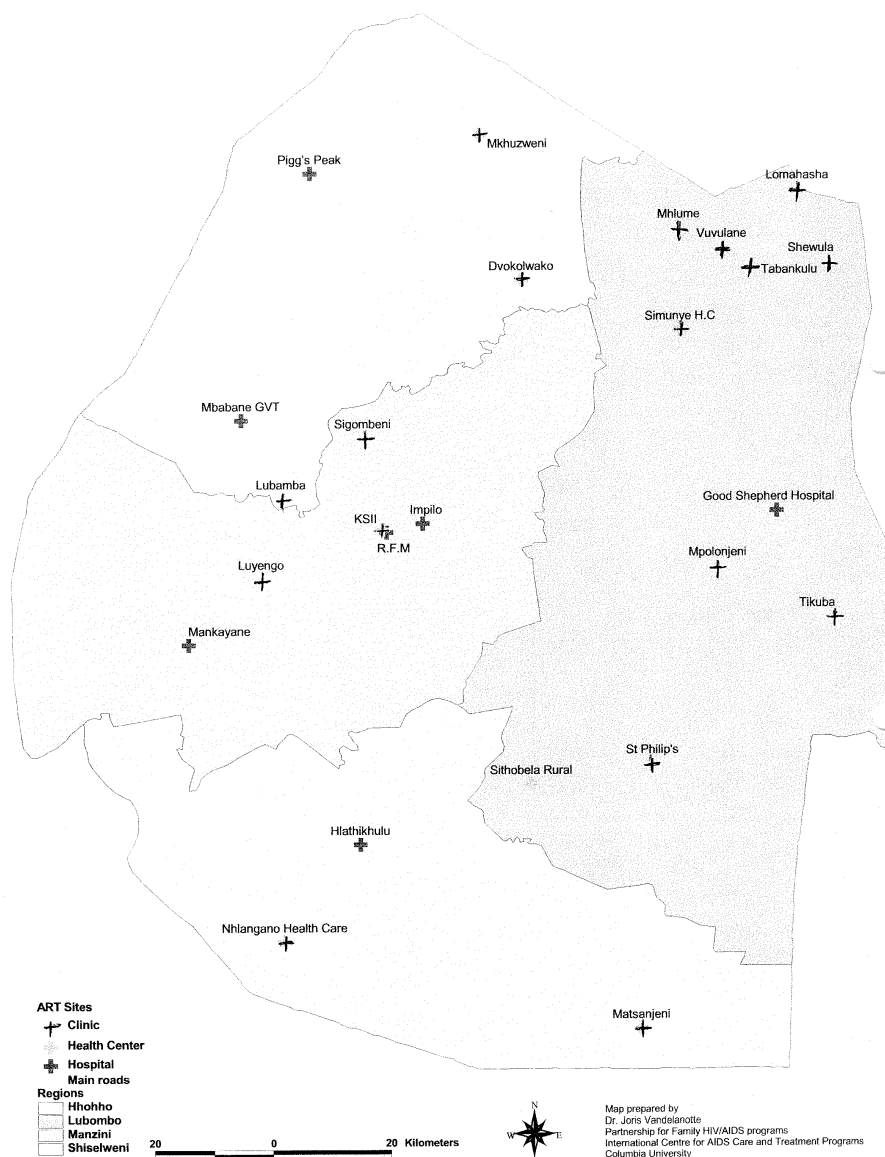
The National Health System is made up of 7 Hospitals, 8 Public health Units, 12 Health Centers, 170 Clinics and 187 outreach sites for a population of about 1 million; however, human resources constraints continue to be a challenge severely impacting on quality, timeliness and universal access to services. This acute shortage of human resources in the National health system at all levels severely affects TB services delivery as well in laboratory support, programme supervision, case management and health information system.

Table 1: Distribution of Hospitals and Health Centers by Regions

Regions	Manzini	Lubombo	Hhohho	Shiselweni
Site	1.TB hospital	4.Good Shepherd hospital	9.Mbabane government hospital	13.Hlathikhulu
	2.RFM hospital	5.Simunye	10.Piggs Peak	14.Nhlangano
	3.Mankayane hospital	6.Ubombo sugar	11.Mkhuzweni	15.Matsanjani
		7.Sithobela 8.Mhlume	12.Dvokolwako	

- Majority of TB services at health centers and clinics are managed by nurses or nurse assistants. The TB services, mostly screening and referrals, are provided by the lower level health units. The referrals are often made to regional level hospitals or TB treatment sites.
- Currently 21 sites offering ART - 6 hospitals, 5 health centers, 1 PHU, 9 private clinics. An ART Site is a health care facility that has ARV drugs, a full time doctor and 2 nurses on site to manage people on ART in addition to the necessary support infrastructure like laboratory services.

ART sites Swaziland, March 2007

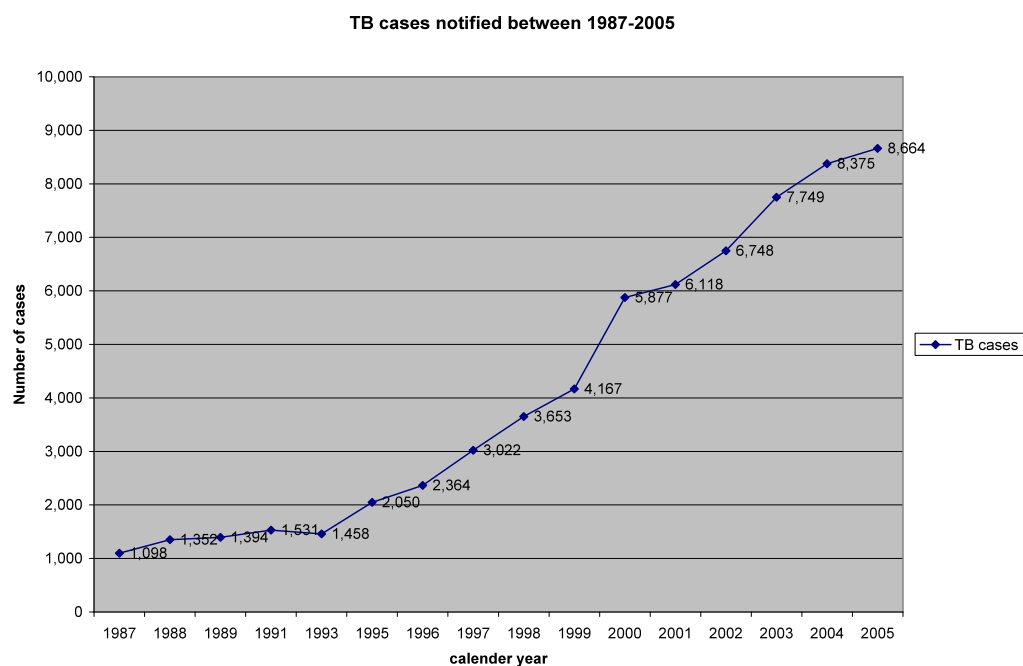


Burden of Tuberculosis

Mycobacterium tuberculosis infects a third of the world's population. In 2003 there were an estimated 8.8 million new cases of tuberculosis (TB) worldwide. The African region (24%), South-East Asia region (35%), and Western Pacific region (22%) together accounted for 82% of all notified cases and similar proportions of new smear positive cases. Developing countries had 95% of TB cases and 98% of TB deaths (WHO, 2005).

Tuberculosis in Swaziland accounts for more than 20% of all hospital admissions (MOH Annual Health Statistics Reports) and an estimated 50% deaths of HIV infected patients is attributed to tuberculosis. The annual case notification rate has risen from 236 per 100,000 population in 1996 to 781 per 100,000 population in 2005 (WHO report, 2006). In 2006 Swaziland reported 9048 cases equivalent to over 800 cases per 100,000 and case detection rate of 50%. WHO estimates show a prevalence of 1120 cases per 100,000 (WHO Global TB Report of 2006). During the 1997 to 2000 period, the TB mortality increased by more than 100% with 411 deaths reported in 1997 as compared to 1106 deaths in 2000 (WHO report). According to WHO 2007 report mortality stands at 301 deaths per 100,000. Treatment success for smear positives increased from 42% in 2003 to 50% in 2004 cohorts respectively (WHO report 2007). Available evidence indicates that the current TB epidemic, both in terms of morbidity and mortality, is fuelled by the widespread of HIV infection in the general population.

According to the case notifications, all population segments are affected and susceptible to TB. According to the 2006 case notifications Hhohho region contributed 24.6%, Manzini Region 27.1%, Lubombo 28.3% and Shiselweni region 19.8% of the national TB cases.

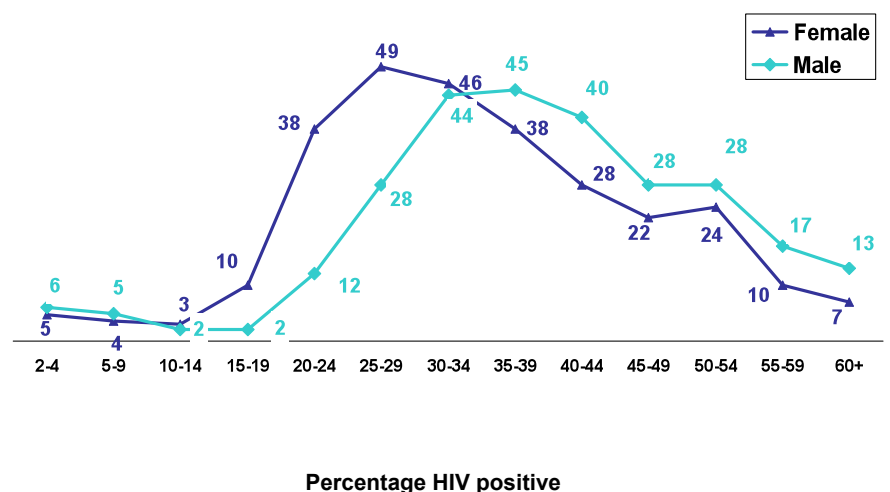


Burden of HIV/AIDS.

Globally there are 44 million people living with HIV/ AIDS and 70% are in the sub Saharan Africa. (UNAIDS/WHO, 2004). Swaziland has a population of about 1.1million people and it is estimated that 220,000 people are living with HIV and AIDS. It is also estimated that 30,000 are in need of ART and 20,530 people have been treated with ARVs by the end of September 2006. Swaziland is among the countries most severely hit by the HIV epidemic. has a high HIV prevalence among ANC clients (39.2%). According to the 10th HIV sentinel surveillance the age group of women age 25-29 have the highest HIV infection rate of 49.8% followed by the age group 30-34 the HIV prevalence is 45.8%. A sign of hope is noted among women 15- 19 years where HIV prevalence has decreased from 29.3% (2004) to 26% (2006). The age group 20 -24 years decreased from

46.3% (2004) to 40 % (2006). There is no significant difference in HIV prevalence between married/cohabiting (56.6%) and single/never married/ never cohabiting (54.5%).

Figure 3: HIV Prevalence among Population Age 2 and Older by Age and Sex



Swaziland DHS 2006-07

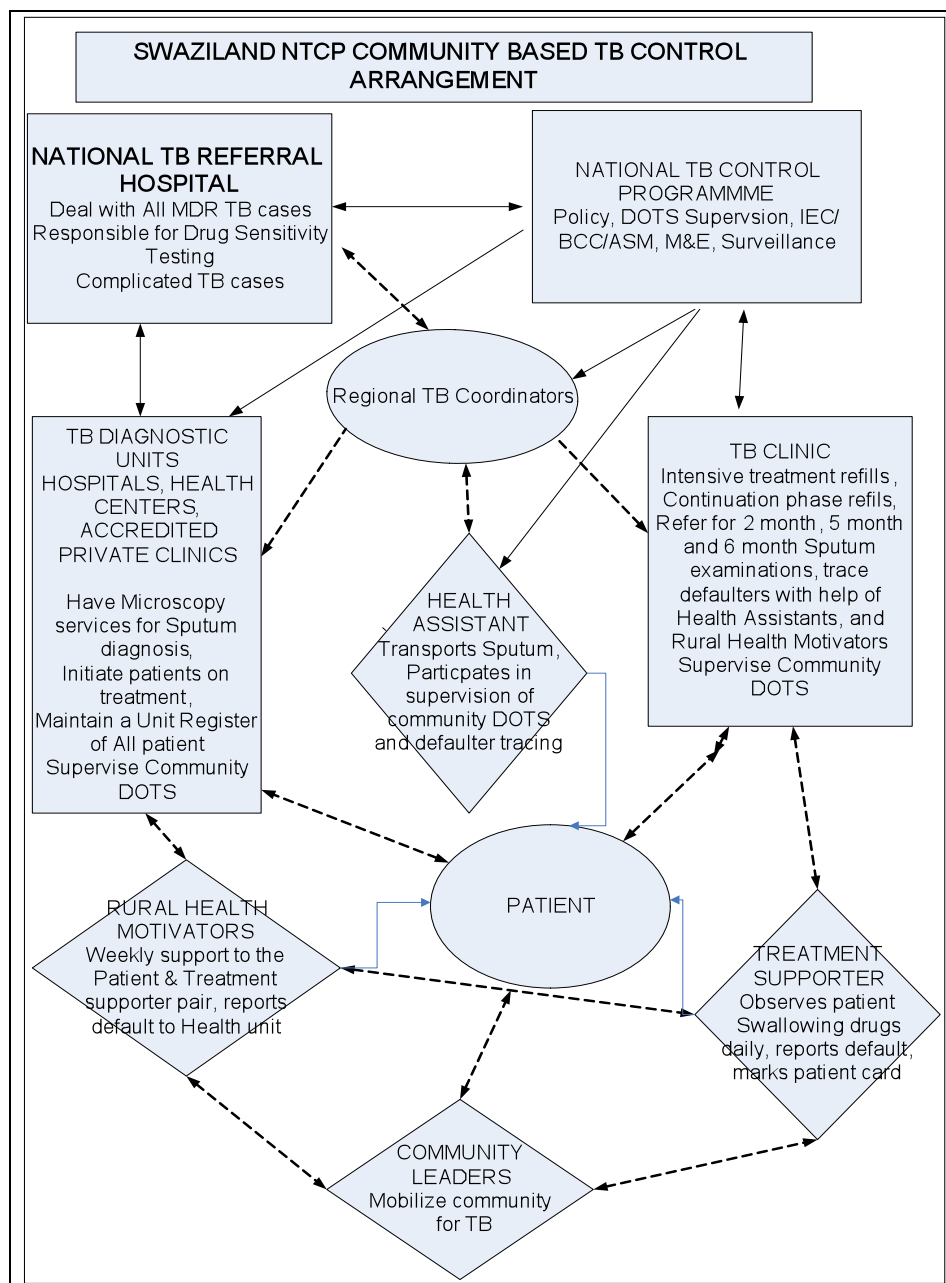
Burden of TB-HIV co-infection

The human immunodeficiency virus (HIV) pandemic presents a massive challenge to the control of tuberculosis (TB) at all levels. Tuberculosis is also one of the most common causes of morbidity and the leading cause of mortality in people living with HIV/AIDS (PLWHA). By the end of 2000, about 11.5 million HIV-infected people worldwide were co-infected with *M. tuberculosis*. 70% of them were in sub-Saharan Africa, 20% in South-East Asia and 4% in Latin America and the Caribbean, (WHO, 2004). According to the 10th HIV sentinel surveillance among TB patients, 79.6% of TB patients are also co infected with HIV. Male TB patients have the highest co infection rates of TB and HIV of 83.2% and females 74.7%. The distribution of by type of TB demonstrates that

pulmonary TB is the most common type and HIV prevalence was the highest in this category 80.5%. There is no difference in HIV prevalence among TB patients residing in the rural (79.7%) and urban area (79.5%). It is not possible to control the current TB epidemic without paying attention to HIV. There is a need for a strong TB/ HIV control programme. The age group 20-49 is one of the highly affected age groups by TB and HIV co infection and yet it is the most economically active and productive group ,which will lead to negative socio economic impact on the country. This threat, therefore, dictates that TB and HIV/AIDS be seriously considered not only as health issues but also as development agenda.

Control of Tuberculosis in Swaziland

Community based TB care (CBTBC) with direct observed therapy (DOTS) was adopted by the MOHSW in Swaziland as the best strategy for controlling TB. To date, this strategy has been expanded to all regions in the country. Swaziland implements a treatment regime according to the WHO recommended short course chemotherapy strategy. The initial phase consists of Rifampicin, Isoniazid, Ethambutol and pyrazinamide for category one patients for duration of 2 months in a fixed-drug combination (RHZE). The continuation phase has duration of 4 months of daily rifampicin and isoniazid in fixed-dose combination. The duration of treatment for TB Meningitis, Miliary TB and TB of the Bones and Joints is 9 months. In the context of HIV, Central nervous TB is treated for 9 – 12 months. Treatment Regimen for Category II Patients is 2S (RHZE)/1(RHZE)/5(RH) E and the Category III patients, the treatment regimen is 2(RHZ), 4RH. For category IV patients, a standardized regimen is used.



Control of HIV/AIDS in Swaziland

In the past few years government focused on mainstreaming HIV/AIDS into all sectors. A comprehensive patient care package was developed which included the management of opportunistic infections (including TB), palliative care, and the provision of antiretroviral drugs. The home based care approach has been adopted to care for the persons living with AIDS at the community level and this has the advantage of relieving the already over strained health care facilities. Challenges in the control of HIV/AIDS in Swaziland include inadequate access to behavior change communication ,condoms, safe blood, HIV testing and counseling PMTCT, clinical, palliative, home based care, , as well as supply of drugs for opportunistic infections and highly active ant retroviral therapy (HAART) especially in the rural areas. In addition, human resource capacity in terms of numbers and skills poses a special challenge especially in the areas of counseling, laboratory and clinical management for patients on ART. Anecdotal reports indicate increasing number of HIV positive patients that do not use condoms because they are on ART, a behavior that puts many people at risk of acquiring new HIV infection as well as HIV drug resistant strains.

Collaborative TB and HIV Programme Activities

Although some collaborative activities have been implemented in a few public facilities and NGOs, these have not been standardized and depend largely on the knowledge and motivation of an individual health care worker. A WHO- led external evaluation of the TB Program that was carried out in March 2007 revealed that a number of activities with regard to TB-HIV collaboration were taking place and partners were engaged though following individualized approaches. Collaboration between the Swaziland National AIDS programme and Swaziland National TB Control Programmes is weak. However, there has been some collaboration between the two programmes in training some TB nurses in HIV testing and Counseling (HTC). In addition, the environment for service delivery has not provided much opportunity for a wider number of TB patients to benefit from HTC, ART and other related HIV care and support services. More collaboration between the two programmes is needed to improve diagnostic, treatment, preventive,

KHAIRU 6/7/11 8:47 PM

Comment: How many nurses and training in what exactly? What was the impact of this training?

care, and support services for people living with HIV and TB. This will improve synergies, avoid overlaps and maximize service delivery. TB/HIV co-infection programs are patient centered and aim to decrease the burden of disease in populations.

Coordination of TB/HIV collaborative activities in Swaziland.

To coordinate the national response to the intersecting epidemic of TB and HIV, the Ministry of Health and social Welfare instituted the National Coordination Committee for TB/HIV collaborative activities (NCC-TB/HIV). The NCC-TB/HIV is charged with the overall coordination of TB/HIV collaborative activities in the country. The NCC is co-chaired by the Programme Managers for TB and HIV. It is comprised of representatives from Swaziland National TB Control Programme (NTCP), Swaziland National AIDS Programme (SNAP), WHO, development agencies, Civil Society Organizations (CSO), nongovernmental organizations, academic institutions, special groups (army, police etc), PLWHA, activists, patient-support groups and regional representatives.

The NCC is divided into three working groups;

- Policy, Guidelines and implementation
- Advocacy, Communication and Social mobilization
- Monitoring and Evaluation.

For day to day running of the NCC -TB/HIV the chair person will be nominated from SNAP and NTP. Similarly, working groups will be chaired by representatives of either of the two programmes, vice chairs or other position maybe created and any member of the working group may be nominated by the group to take up the position.

1.2 Rationale

The above background information demonstrates that HIV prevention and care should be a priority concern of the National TB Control Programme (NTCP) and TB prevention and care should be a priority concern of Swaziland National HIV/AIDS Programmes (SNAP). Whereas previously TB programmes and HIV/AIDS programmes have largely pursued separate courses, they need to exploit synergies in supporting health service

KHAIRU 6/7/11 8:49 PM

Comment: Which CSOs and which activist and patient support groups?

providers to deliver collaborative interventions. Some of the TB/HIV interventions described later clearly fall under the responsibility and expertise of the NTCP (such as sputum microscopy), while others fall under the responsibility and expertise of the SNAP (such as HIV testing and counseling services, ART). However, most activities fall in the middle of the spectrum with much potential overlap between the programmes e.g. increased community involvement can benefit both TB diagnosis and treatment as well as HIV/AIDS prevention, treatment care and support; Isoniazid Prevention Therapy (IPT) is a concern of both TB services (which are likely to supply and monitor the isoniazid) and of SNAP services (whose patients/clients will benefit). At the service delivery level it can be seen that many potential reciprocal synergies exist between different service providers e.g. HIV-positive clients/patients have a high rate of TB (and therefore benefit from TB screening and treatment) and TB patients have a high rate of HIV (and therefore benefit from HTC and associated services).

This document will assist policy-makers and health managers at all levels of service delivery to understand what should be done to decrease the joint burden of tuberculosis and HIV. It is designed to be used in conjunction with other existing policies on community based TB care (CB-DOTS), HIV/AIDS Care, ART, Cotrimoxazole prophylaxis, and HIV testing and counseling.

1.3 Purpose

This policy responds to a demand from regions, health units, development partners, NGOs and special groups for immediate guidance on implementation of TB/HIV collaborative activities in Swaziland. It is complementary to and in synergy with the established core activities of tuberculosis and HIV/AIDS programmes. This policy promotes enhanced collaboration between tuberculosis and HIV/AIDS programs in the provision of a continuum of quality care at service-delivery level for people with, or at risk of, tuberculosis and people living with HIV/AIDS. It also provides a consistent framework for implementers to use in expanding TB/HIV collaborative activities.

While there is good evidence for the cost effectiveness of the CB-DOTS strategy and several HIV prevention measures this policy will require updating to reflect new evidence and best practices.

1.4 Target audience

This document is intended for decision-makers in the field of health, civil society organizations, Non Governmental Organizations (NGOs), Faith Based Organizations (FBOs), Community Based Organizations (CBOs) and informal organizations like traditional healers organizations, academia, Private sector, special groups (military, police, prison etc) including employers and workers' Organizations and other ministries with TB and HIV/AIDS programs.

1.5 Policy framework

- These policy guidelines are in support and operationalise principles outlined in the following legal and policy documents:
- Swaziland Constitution, 1995.
- The Workers' Compensation Act.
- National Health Policy (2006)
- The Health Sector Response to HIV and AIDS plan in Swaziland 2006 – 2008
- Poverty Eradication Action Plan
- National Multisectoral HIV/AIDS policy 2006
- National strategic HIV/AIDS Plan 2006-2008
- National Tuberculosis Strategic Plan, 2006-2010
- National Tuberculosis Control Policy guidelines

1.6 Policy guidelines formulation process

A Policy, guidelines and Implementation working group was formed out of the National Coordination Committee for TB/HIV to develop policy guidelines on TB/HIV collaboration. The documents outlined above were reviewed during the process. The final draft is to be circulated to National Coordination Committee for comments and presented to the stakeholders for adoption.

2.0 Goal and objectives of collaborative TB/HIV activities

The overall goal of the policy is to decrease the burden of tuberculosis and HIV in Swaziland through improved TB and HIV/AIDS collaborative interventions.

The policy objectives are to:

1. Establish the mechanisms for sharing information and collaboration in planning, implementation, monitoring and evaluation of tuberculosis and HIV/AIDS programmes at all levels of health services.
2. To screen all PLWHA for TB and provide preventive and curative care for those with latent and active TB respectively.
3. To provide HIV screening to all TB patients and comprehensive HIV care services to those co-infected with HIV.

3.0 TB/HIV Collaborative activities

This document focuses on collaborative activities that address the interface of the tuberculosis and the HIV/AIDS epidemics and that should be carried out as part of the national response to the intersecting tuberculosis and HIV epidemics. The following table summarizes the TB/HIV collaborative activities to be carried out at various levels of health services.

Table 2 TB/HIV Collaborative activities

A. Establish the mechanisms for sharing information and collaboration
A.1 Set up a national coordinating body for TB/HIV activities.
A.2 Identify TB and HIV focal persons at regional levels
A.3 Develop TB /HIV multidisciplinary teams at facilities
A.4 Conduct surveillance of HIV prevalence among tuberculosis patients.
A.5 Carry out joint TB/HIV planning (resource mobilization, capacity building, Advocacy, communication & social mobilization)
A.6 Conduct monitoring and evaluation for TB/ HIV collaborative activities
A.7 Coordinate research activities on HIV and TB.
B. Decrease the burden of tuberculosis in people living with HIV/AIDS
B.1 Establish intensified tuberculosis case-finding.
B.2 Provide isoniazid preventive therapy, where feasible.
B.3 Provide TB treatment to those PLWHA with active TB.
B.4 Ensure tuberculosis infection control in health care and congregate settings
C. Decrease the burden of HIV in tuberculosis patients
C.1 Provide HIV testing and counseling to all TB suspects
C.2 Provide HIV prevention methods
C.3 Provide Cotrimoxazole preventive therapy
C.4 Provide HIV/AIDS care and support
C.5 Provide antiretroviral therapy if eligible

3.1 A. Establish the mechanisms for sharing information and collaboration

A.1 Set up a national coordinating body for TB/HIV activities.

The national coordinating body should have equal or reasonable representation of the two programmes and should include key stakeholders for tuberculosis and HIV programs.

Responsibilities for the National coordinating body include:

- Developing, reviewing, and updating policy and guidelines on TB/HIV collaboration.
- Planning, monitoring and evaluation of interventions
- Mobilization of resources for TB/HIV activities
- Advocacy and social mobilization for collaboration
- Coordination of stakeholder efforts on TB/HIV.
- Ensure that evidence from research and best practices is used to guide policy.

A.2 Identify TB and HIV focal persons at regional levels

Ministry of Health and Social Welfare/NTCP and SNAP supervision teams shall be responsible for supervising and guiding regions on TB/HIV collaborative activities. The Facility Management team will be responsible for appointing focal persons to ensure collaboration between TB and HIV/AIDS programs within their hospitals. However, the Regional TB and Regional HIV coordinators shall compliment the regions in supervising and guiding on TB/HIV collaborative activities. The focal persons should articulate TB/HIV collaborative issues within the Regional Health Management Team (RHMT) meetings.

Responsibilities for the focal persons at facility level include:

- Planning, monitoring and evaluation of interventions
- Mobilization of resources for TB/HIV activities
- Advocacy and social mobilization for collaboration
- Coordination of stakeholder efforts on TB/HIV.
- Ensure that evidence from research and best practices is used to guide policy development and implementation of TB/HIV activities.
- Coordination of TB/HIV capacity-building in community including training of PLWHA's as "expert clients"
- Ensuring coherence of communications about TB/HIV
- Ensuring the participation of the community in joint TB/HIV activities

A.3 Develop TB /HIV multidisciplinary teams at health facility level

(hospitals and health centers)

The chronic care of HIV positive patients requires a concerted effort from different cadres of health care workers. As TB is the commonest opportunistic infection found in HIV positive patients the inclusion of healthcare dealing directly with TB patients is paramount in the formation of multidisciplinary teams (MDTs) in health facilities this is to ensure that the care of the TB/HIV co infected patients is provided in a holistic manner. A practical approach to the formation of MDTs is to include the TB clinic healthcare workers within the ART committee. The MDT is responsible for the overall planning and implementation of the TB/HIV activities in the facility.

A.4 Conduct surveillance of HIV prevalence among tuberculosis patients

Surveillance is essential to inform programme planning and implementation.

There are three key methods for surveillance of HIV among tuberculosis patients: periodic (special) surveys (cross-sectional HIV seroprevalence surveys among a small representative group of tuberculosis patients within a community); sentinel surveys (using tuberculosis patients as a sentinel group within the general HIV sentinel

surveillance system); and routine data for HIV counseling and testing of tuberculosis patients. The surveillance method chosen depends on the existing surveillance system and availability of resources.

In Swaziland, HIV testing and counseling for all tuberculosis patients should form the basis of surveillance because of the generalized epidemic state (Generalized epidemic state: HIV prevalence consistently > 1% in pregnant women).

Recommendations

1. There should be HIV surveillance among tuberculosis patients in all regions irrespective of region adult HIV prevalence rates.
2. Regions with unknown HIV prevalence rates among tuberculosis patients should conduct a seroprevalence (periodic or sentinel) survey to assess the situation.
3. All health facilities should offer HIV testing and counseling to all TB patients and suspects. Information on HIV testing and counseling for TB patients should be incorporated into the existing health information management systems.

A.5 Carry out joint TB/HIV planning:

The tuberculosis and HIV/AIDS programmes need joint strategic planning to collaborate successfully and systematically. They should introduce TB/HIV collaborative components in both the national TB Strategic Plan 2006- 2011 and the Health Sector Response to HIV and AIDS plan 2006- 2008. The roles and responsibilities of each program in implementing specific TB/HIV activities at national and regional levels must be clearly defined.

At the regional level, TB/HIV collaborative activities should be included in the regional strategic, development and annual plans.

Crucial elements for joint planning include the activities detailed in sections A-C (Table 1) of this document, as well as resource mobilization, capacity-building and training, TB/HIV communication (advocacy, programme communication and social mobilization), enhanced community involvement, and operational research.

A.5.1 Resource mobilization for TB/HIV

Collaborative TB/HIV activities, which build on well-resourced tuberculosis and HIV/AIDS strategies, may not require much additional financial input. If either or both programmes are under-resourced in funds or human capacity, additional resources should first be mobilized to strengthen each programme. Proposals to solicit resources for implementing collaborative TB/HIV activities should be prepared, building on the comparative strengths of both programmes and the specific needs of the nation and the regions.

Recommendations

1. Joint planning should clearly define the roles and responsibilities of each programme in implementing specific TB/HIV activities outlined in Table 1 at national, regional and facility level.
2. Ministry of Health and Social Welfare should ensure mobilization and adequate deployment of sufficient qualified human resources to implement collaborative TB/HIV activities in accordance with specific situations.
3. The national TB/HIV coordinating body and the Regional Health Management Teams (RHMT) shall be responsible for the mobilization and rational use of resources to implement collaborative TB/HIV activities, thus avoiding competition for the same resources.

A.5.2 TB/HIV capacity-building

Capacity-building for TB and HIV interventions should include training on TB/HIV collaborative issues. Capacity should be enhanced in the health care system, for example, in the laboratory and referral systems, to enable service providers cope with the increasing demands of collaborative TB/HIV activities. However, PLWHA's could be trained as "expert clients" to support adherence to treatment. It is advisable that health workers receive training in sign language to address the needs of people with disability e.g. the deaf.

Recommendations

1. Tuberculosis and HIV/AIDS programmes should draw up a joint training plan. This should cover pre and in-service training and continuing medical education on collaborative TB/HIV activities for all categories of health care workers.
2. Tuberculosis and HIV/AIDS programmes should ensure that there is sufficient capacity (e.g. laboratory, drug and referral capacity) to effectively implement collaborative TB/HIV activities.

A.5.3 TB/HIV communication: Advocacy, Communication and Social mobilization

Advocacy targeted at influencing policy, programme implementation and resource mobilization is very important to accelerate the implementation of collaborative TB/HIV activities. Two-way communication between the programmes and the general public is crucial for ensuring that patients actively seek for services. Social mobilization that generates public will and secures broad consensus and social commitment among all stakeholders is critical for stigma mitigation and prevention of tuberculosis and HIV, as well as encouraging participation in collaborative TB/HIV activities. There is need for a joint communication strategy to guide implementation of these activities and to link the public to the program areas. However, the special needs of people with disability for example the deaf should not be forgotten.

Recommendations

1. Well designed TB/HIV advocacy activities, (jointly planned to ensure coherence between their messages) targeted at key stakeholders and decision-makers, should be carried out at national and regional levels.
2. HIV/AIDS and Tuberculosis Programs should develop a joint TB/HIV communication strategy that addresses the needs of individual clients and patients and of communities affected by HIV/AIDS and tuberculosis.
3. The joint communication strategies should ensure the mainstreaming of HIV components in tuberculosis communication and vice versa. (*national TB/HIV communication strategy to be developed*)
4. The special needs of people with disability for example the deaf should be taken into consideration when developing a communication strategy.

A.5.4 Enhance Community involvement in TB/HIV collaborative activities

Expanding TB/HIV collaborative activities beyond the health sector through involvement of communities is crucially important. Through support groups for people living with HIV/AIDS, Community based care and support groups and community-based organizations, tuberculosis prevention and care can be integrated with HIV/AIDS prevention, care and support. Communities can be effectively mobilized to advocate for resources and opportunities to implement TB/HIV collaborative activities.

Community-based organizations (such as those providing HIV/AIDS home-based care), Community Based -DOTS community volunteers and workplace managers or staff associations may also be involved in identifying people with symptoms and signs of tuberculosis or HIV/AIDS, referring them to health facilities for diagnosis and treatment and ensuring directly observed treatment. Innovative mechanisms for delivery of ART could be designed along this arrangement.

Recommendations

1. HIV/AIDS programs should ensure the inclusion of tuberculosis prevention, treatment and care in community-based HIV/AIDS prevention, care and support services. Similarly TB programs should include HIV/AIDS prevention, treatment, care and support services in TB prevention, treatment and control services.
2. All stakeholders, including HIV/AIDS and tuberculosis programmes, should ensure the involvement of tuberculosis and HIV patient support groups and their communities in the planning, implementation and advocacy of collaborative TB/HIV activities.

A.5.5 Operational research to enhance collaborative TB/HIV activities

Operational research helps to determine the most efficient means of implementing collaborative TB/HIV activities. It informs national, regional and institutional policy and strategy development, taking account of cultural, geographical and resource diversity.

Recommendation

1. All stakeholders of collaborative TB/HIV activities, including both tuberculosis and HIV/AIDS programmes, should support, budget and mobilize resources for TB/HIV operational research to develop the evidence base for efficient and effective implementation of collaborative activities.
2. The academic institutions (UNISWA, nursing colleges etc) and individuals should support and disseminate research findings that could improve implementation of TB/HIV collaborative activities.

A.6 Monitoring and evaluation of TB/HIV collaborative activities

Monitoring and evaluation provide the means to assess quality, effectiveness, coverage and delivery of collaborative TB/HIV activities. They promote a learning culture within the programmes and so ensure continuous improvement of programme performance. Monitoring and evaluation involve collaboration between the programmes and the general health system, and the development of referral linkages between different services and organizations. These linkages should be integrated with existing monitoring and evaluation systems and should ensure confidentiality.

M & E Indicators have been developed in line with the goal and objectives of TB/HIV collaborative activities within this document. The Swaziland National TB programme shall be responsible for reporting on those collected at the TB clinics while the Swaziland National AIDS Programme shall be responsible for those collected at HIV care, HTC, and PMTCT centers. It is therefore the responsibility of each national program to modify recording and reporting forms, guide regions on collection of data, analyze and disseminate information on selected indicators. It is important that both programs share information at national and regional level.

KHAIRU 6/7/11 9:41 PM

Comment: It is the responsibility of these two programs to modify, record and report forms that will have different templates? How will this information be integrated if the two programs have separate data collection templates?

Recommendations

1. The Swaziland National AIDS Programme should modify recording and reporting forms, guide regions on collection of data, analysis and dissemination on indicators. (See Annex 2)
2. The Swaziland National TB Programme should modify recording and reporting forms, guide regions on collection of data, analysis and dissemination on indicators. (See Annex 2).
3. Both programs should advocate for inclusion of indicators in the general Health Management Information Systems for Ministry of Health and Social Welfare.
4. The national guidelines for monitoring and evaluation of TB/HIV collaborative activities should be used as a basis for standardizing monitoring and evaluation of activities.

3.2 B. *Decrease the burden of tuberculosis in people living with HIV/AIDS*

B.1 Establish intensified tuberculosis case-finding

Intensified tuberculosis case-finding comprises screening for symptoms and signs of tuberculosis in settings where HIV-infected people are concentrated. Early identification of signs and symptoms of tuberculosis, followed by diagnosis and prompt treatment in people living with HIV/AIDS, their household contacts, groups at high risk for HIV and those in congregate settings (e.g. prisons, police, military barracks, HIV clinics, inpatient wards, schools, large scale factory settings, mine and plantation workers, slums and others), increases the chances of survival, improves quality of life and reduces transmission of tuberculosis in the community.

Recommendations

1. Tuberculosis case-finding should be established and intensified in all HIV testing and counseling settings using, at a minimum, a simple set of questions to identify suspected tuberculosis cases as soon as possible. The questions should be asked by the first contact health workers and counselors.
2. A referral system should be established between HIV/AIDS and TB diagnostic, treatment, and support services.
3. Tuberculosis case-finding in people living with HIV/AIDS attending care and support services should be intensified , by increasing the awareness and knowledge of interactions between tuberculosis and HIV among health care workers and the populations they serve.

B.2 Introduce isoniazid preventive therapy (IPT), where feasible

Isoniazid is given to individuals with latent infection with *Mycobacterium tuberculosis* in order to prevent progression to active disease. Exclusion of active tuberculosis is critically important before this therapy is started. Isoniazid is given daily as self administered therapy for six to nine months. Since HIV-infected people could develop tuberculosis before antiretroviral therapy is indicated, and as there is no evidence contraindicating combined use, use of antiretroviral drugs does not preclude the use of isoniazid preventive therapy. However, this therapy requires several steps to be taken, including identification of HIV-positive subjects, screening to exclude active tuberculosis and treatment adherence. In Swaziland, IPT shall be given to HIV-infected persons after the exclusion of active TB and after confirming presence of latent TB by carrying out a skin test (Mantoux). Considering that provision of IPT is labor intensive yet there is

limited human resource and limited organizational capacity to offer it, feasibility of this therapy in Swaziland is still a national challenge. The country is building capacity to provide this service as a matter of **urgency**

Recommendations

1. Only those programs or organizations that satisfy the eligibility criteria for offering isoniazid preventive therapy will be allowed by National TB Control Programme (NTCP) to offer it to PLWHA. However, all children under five years who are contacts of adults with pulmonary tuberculosis should be offer isoniazid according to the national TB guidelines.
2. HIV/AIDS programmes eligible for provision of IPT as stated in recommendation one above should provide isoniazid as part of the package of care for people living with HIV/AIDS when active tuberculosis is safely excluded.
3. Information about isoniazid preventive therapy should be made available to all people living with HIV/AIDS. TB/HIV communication strategy to address refer to national TB guidelines
4. Organizations or institutions that offer IPT should be supervised by NTCP to control development of resistance against isoniazid.

KHAIRU 6/7/11 9:45 PM

Comment: Which criteria? And How can we get a hold of it?

KHAIRU 6/7/11 9:46 PM

Comment: Does NTCP have this capacity?

B.3 Provide TB treatment for PLWHA's with active TB

If the diagnosis of tuberculosis has been made, the patient should be started on treatment as soon as possible. The basis of treatment of tuberculosis is chemotherapy. It is also one of the most efficient means of preventing the spread of tuberculosis microorganisms. The requirements for adequate chemotherapy include an appropriate combination of anti tuberculosis medications to prevent the development of resistance (MDR/XDR) to those

medications, correct dosage, regular intake by the patient and a sufficient period of taking medication to prevent relapse of the disease after completion of treatment.

Treatment must be given to every patient confirmed as having tuberculosis and should be given free of charge to the patients.

Recommendations

1. All persons diagnosed with tuberculosis (including PLWHA's) should be treated with anti-tuberculosis medications according to the national TB guidelines.
2. All patients on TB treatment should be supported to complete their medications under Directly Observed Therapy (DOT).

B.4 Ensure tuberculosis infection control in health care and congregate settings

In health care and congregate settings (e.g. prisons, police, military barracks, schools and living quarters for workers especially in the Agricultural sector), where people with tuberculosis and HIV are frequently crowded together, infection with tuberculosis is increased. Measures to reduce tuberculosis transmission include administrative, environment and personal protection measures (refer to national TB infection control guidelines 2007), which are aimed at generally reducing exposure to M.tuberculosis.

Administrative measures should include early recognition, diagnosis and treatment of tuberculosis suspects, particularly those with pulmonary tuberculosis, and separation of pulmonary tuberculosis suspects from others, until a diagnosis is confirmed or excluded. Environmental protection should include maximizing natural ventilation and ultraviolet irradiation. Personal protection should include protection of the HIV-positive person from possible exposure to tuberculosis.

Recommendation

1. Each health care and congregate setting should have a tuberculosis infection control plan supported by all stakeholders, which includes administrative, environmental and personal protection measures to reduce transmission of tuberculosis in health care and congregate settings.
2. Persons in congregate settings including health care workers should be provided with information on the risk of acquiring TB among TB/HIV co infected persons. *(according to national TB/HIV communication strategy to be developed)*

KHAIRU 6/7/11 9:47 PM

Comment: A plan with no implementation is as good as no plan at all

KHAIRU 6/7/11 9:48 PM

Comment: Determine if this has been developed yet

3.3 C. Decrease the burden of HIV in tuberculosis patients

C.1 Provide HIV testing and counseling

The vast majorities of HIV-infected people do not know their HIV status and seek health care from general service providers. HIV testing and counseling for tuberculosis patients offers an entry point for a continuum of prevention, care, support and treatment for HIV/AIDS as well as for tuberculosis. Benefits accrue to the patient, the family and the community at large. The counseling and testing services should be readily available and confidentiality should be ensured according to National HTC guidelines.

Recommendations

1. HIV testing and counseling should be offered to all tuberculosis patients and suspects. Patients and suspects should be allowed to opt out in case they do not want to test.
2. NTCP should mainstream provision of HIV testing and counseling in their operations or establish a referral linkage with the HIV/AIDS programmes to do so.

C.2 Introduce HIV prevention methods

Reduction of sexual, parenteral and vertical transmission of HIV builds on broad-based programmes of education about HIV/AIDS. Measures to reduce sexual transmission of HIV include promoting safer and more responsible sexual behavior and practices in all communities including special groups like prisons, delayed onset of sexual activity, reduced number of sexual partners, systematic use of condoms (male and female) and diagnosis and treatment of other sexually transmitted infections. One of the main vehicles propagating the epidemic is HIV transmission among discordant couples and among HIV positive people. Measures to reduce transmission among these subsets are needed. Measures to reduce sexual transmission of HIV should also be extended to work settings whose environment predisposes workers to contracting HIV. Therefore workers in sectors like hotels, bars, pubs, catering industry, transport sector etc are special groups that do not only closely interact among themselves but with the general public.

Measures to reduce parenteral HIV transmission include ensuring the safety of the blood supply and use of sterilized injection and surgical equipment in medical, traditional and cultural settings. Vertical transmission of HIV can be reduced by providing antiretroviral drugs to pregnant women and their infants. Health education should form a basis for preventive measures more especially in special groups like prisons. However, positive

living among those already infected should be emphasized to prevent spread within the community.

Recommendations

1. NTCP and SNAP should develop and implement comprehensive HIV prevention strategies for their patients in all settings including special groups like prisons, targeting sexual, parenteral or vertical transmission.
2. All clients attending tuberculosis clinics should be screened for sexually transmitted infections using a simple questionnaire or other recommended approaches. Those with symptoms of sexually transmitted infections should be treated or referred to relevant services according to need.
3. SNAP and NTCP should facilitate the implementation of procedures for reduction of occupational and nosocomial exposure to HIV infection in their services.
4. SNAP and NTCP should ensure that vertical transmission is prevented through prevention of mother-to-child transmission.
5. Health workers should provide HIV prevention messages to all TB patients.

KHAIRU 6/7/11 9:52 PM

Comment: These have not been developed yet?

KHAIRU 6/7/11 9:53 PM

Comment: Screening without consent? Even with consent how reliable will this information be?

KHAIRU 6/7/11 9:53 PM

Comment: Which recommended approaches?

KHAIRU 6/7/11 9:58 PM

Comment: The policy does not give a concise outline on how these programs can facilitate this implementation

C.3 Introduce Co-trimoxazole preventive therapy

The National Multisectoral HIV/AIDS Policy 2006 states that “Cotrimoxazole prophylactic therapy shall be offered to all HIV positive persons.” Tuberculosis patients who are co-infected with HIV are eligible for this therapy. Cotrimoxazole prophylaxis should be provided daily to all TB patients co-infected with HIV.

C.4 Ensure HIV/AIDS care and support

Access to health care for people living with HIV/AIDS is a basic human right and includes the provision of clinical care as part of a continuum of a comprehensive AIDS care strategy. The strategy includes clinical management with laboratory support (prophylaxis, early diagnosis, rational treatment and follow-up care for opportunistic infections), nursing care (including promoting hygiene and nutritional support), palliative care, home care (including education for care providers and patients’ relatives, promoting universal precautions), counseling and social support. People living with HIV/AIDS who are receiving or who have completed their tuberculosis treatment should be provided with the continuum of care and support for HIV/AIDS supported by a client referral system.

Recommendations

1. All people living with HIV/AIDS who are diagnosed of having tuberculosis disease should also be provided with HIV/AIDS care and support services.
2. SNAP and NTCP should establish referral linkages to provide the continuum of care and support for people living with HIV/AIDS who are receiving or who have completed their tuberculosis treatment.

C.5 Introduce antiretroviral therapy (ART)

Antiretroviral therapy improves the quality of life and greatly improves survival for people living with HIV/AIDS. Availability of antiretroviral therapy can serve as an incentive for people to be tested for HIV. It also transforms HIV infection into a chronic condition through its positive effect on life expectancy. It is a lifelong treatment requiring a high adherence rate to achieve long-term benefits and minimize the development of drug resistance.

Recommendations

1. Antiretroviral therapy should be offered to all eligible HIV-positive tuberculosis patients following the National ART and Care guidelines for adults and children.
2. SNAP and NTCP should create a mechanism to provide antiretroviral therapy to eligible HIV-positive tuberculosis patients.

4.0 Targets for TB/HIV collaborative activities

The Millennium Development Goals embrace the WHO tuberculosis targets and also aim to decrease the prevalence and death rates of tuberculosis by 50% of the year 1990 estimates by 2015.

Under the HSRP 2006 – 2008, specific targets for Tuberculosis control in Specific are:

1. To increase the proportion of persons diagnosed with TB who are tested for HIV from below 50% in 2005 to 100% by 2008 (NSP objective 26, National TB strategic plan objective 3)
2. To establish mechanisms for collaboration of TB/HIV activities at all levels. (NSP objective 29)
3. To decrease the burden of TB of PLWHA from 50% to 35% in 2008. (NSP objective 30)
4.) To decrease the burden of HIV in TB patients from 78% to 45% in 2008 (NSP objective 31)

Effective implementation of collaborative TB/HIV activities will contribute to achieving the HIV/AIDS and tuberculosis targets. Targets will enable the country, organizations and institutions to concentrate on a problem and work towards a common goal. Targets on TB/HIV collaborative activities are needed to increase national coverage and to accelerate implementation of TB/HIV collaborative activities.

4.1 The following are targets for TB/HIV collaborative activities in Swaziland:

1. By end of 2007, a national TB/HIV coordinating body should have been established and by mid 2008, all regions should have put in place a mechanism for collaboration between tuberculosis and HIV programmes.
2. By end of 2008, all regions should have developed joint TB/HIV implementation plans.
3. By end of 2008, all regions should have established a system for HIV surveillance among tuberculosis patients.
4. By end of 2008, all regions should have established a system for TB surveillance among PLWHA.

REFERENCES

- A Guide to monitoring and evaluation for collaborative TB/HIV activities, WHO, 2004.
- Antiretroviral Treatment guidelines , Ministry of Health and Social Welfare, 2006
- Guidelines for HIV Surveillance among Tuberculosis Patients, Second Edition, WHO, 2004
- Guidelines for Implementing Collaborative TB and HIV Programme Activities, WHO, 2003
- Swaziland National Tuberculosis Control guidelines 2006
- The Health Sector Response to HIV and AIDS plan in Swaziland 2006 – 2008
- National Tuberculosis Strategic Plan, 2006-2010
- Interim Policy on Collaborative TB/HIV Activities, WHO, 2004
- Management of Tuberculosis, A Guide for low income countries, IUATLD, 2000
- Swaziland HIV and AIDS Pediatric Guidelines 2006
- National Health Policy, 2006.
- National Multisectoral HIV/AIDS policy 2006
- Annual reports on TB case finding and treatment outcome, 2006 NTCP
- WHO/ Stop TB Assessment Of the Swaziland National TB Programme Report, March 2007
- TB/HIV Clinical Manual, WHO, 2006
- National TB Strategic Plan 2006-2011
- Ministry of Health and Social Welfare, Department of Statistics,
- Swaziland HIV and AIDS sentinel Survey, 2006
- Swaziland National HIV Testing and Counseling and Testing 2006
- Swaziland National TB infection control guidelines 2007

Annex 1: Monitoring and Evaluation of TB/HIV activities

The following indicators shall be used to monitor and evaluate TB/HIV collaborative activities in Swaziland.

1. *Indicator 1: Proportion of registered TB patients tested for HIV.*

Numerator: Total number of TB patients, registered over a given time period, who are tested for HIV during their TB treatment.

Denominator: Total number of TB patients registered over the same given time period.

Purpose: To assess the uptake of HIV testing by TB patients.

Source of data:

1. TB unit register

2. *Indicator 2: Proportion of TB patients who are HIV positive.*

Numerator: Total number of newly registered TB patients (registered over a give period e.g over a quarter) who are HIV-positive.

Denominator: Total number of newly registered TB patients (registered over the same given period) who were tested for HIV and included in the surveillance system.

Purpose: The indicator measures the burden of HIV in TB patients in any given setting. It gives an indication of the contribution that HIV is making to the TB epidemic.

Source of data:

1. TB diagnostic unit registers.

3. *Indicator 3: Proportion of HTC clients, screened for TB symptoms (for the purpose of this document screening refers to the provider asking the client /patient for symptoms of TB disease, namely: cough for two or more weeks accompanied by fever, excessive night sweats, weight loss, chest pain, hemoptysis).*

Numerator: Number of HTC clients who were screened for TB symptoms, over a given time period.

Denominator: Total number of HTC clients seen, over the same given time period.

Purpose: This is a process indicator for an activity intended to reduce the impact of TB among PLWHA's.

Source of data:

1. HTC register

4. Indicator 5: Proportion of newly diagnosed HIV positive clients given treatment for latent TB infection.

Numerator: Total number of newly diagnosed HIV-positive clients in whom active TB has been excluded, who start (given at least the first dose) treatment for latent TB infection.

Denominator: Total number of newly diagnosed HIV-positive clients, eligible for treatment of latent TB.

Purpose: To ensure that eligible HIV positive individuals are given treatment for latent TB infection and thus reduce the incidence of TB in PLWHA.

Note: *This indicator applies to only those centers that qualify to treat latent TB infection according to the National Policy and applies to only children under five years.*

Source of data:

1. Data management system
2. Patient files/manual
3. Patient appointment register.

5. Indicator 5: Proportion of new smear positive pulmonary tuberculosis co-infected with HIV registered in a specified period that are successfully treated for TB

Numerator: Number of smear positive pulmonary tuberculosis patients who are co-infected with HIV registered during a specific quarter that is successfully treated for TB.

Denominator: Total number of new smear positive pulmonary tuberculosis patients who are co-infected with HIV that are registered in the same period

Purpose: evaluation of the treatment outcomes of HIV infected TB patients is used to determine the quality and effectiveness of the national TB programme in reducing the burden of TB among HIV infected patients

Sources of data:

1. TB register
2. Quarterly reports

6. Indicator 6: Proportion of PWHAs attending on ART treatment and care services, screened for TB symptoms. (for the purpose of this document screening refers to the provider asking the client /patient for symptoms of TB disease, namely: cough for two or more weeks accompanied by fever, excessive night sweats, weight loss, chest pain, hemoptysis)

Numerator: Number of PWHAs attending HIV treatment and care services who were screened for TB symptoms, over a given time period.

Denominator: Total number of PWHAs attending ART treatment and care services during the same month.

Purpose: This is a process indicator for an activity intended to reduce the impact of TB among PLWHAs.

Source of data:

1. Data management system
2. Patient files/manual
3. Patient appointment register.

7. Indicator 7: Proportion of PWHAs attending HIV treatment and care services, newly diagnosed with TB.

Numerator: Number of cases of newly diagnosed TB identified in PWHAs attending HIV treatment and care services, over a given time period.

Denominator: Total number of PWHAs attending HIV treatment and care services (who were screened for TB symptoms), over the same given time period.

Purpose: To provide information on the output of intensified TB case finding

Source of data:

1. Data management system
2. Patient files/manual
3. Patient appointments register.

8. Indicator 8: Proportion of HIV-positive TB patients who receive at least one month dose of co-trimoxazole preventive therapy during their TB treatment.

Numerator: Number of HIV-positive TB patients, registered over a given time period, who receive (at least one dose of) CPT during their TB treatment.

Denominator: Total number of HIV-positive TB patients registered over the same given time period.

Purpose: To monitor commitment and capacity of programmes to provide CPT to HIV-positive TB patients.

Source of data:

1. Diagnostic TB unit register
2. TB patient treatment card
3. ART Data management system
4. ART Patient files/manual
5. ART Patient appointment register.

9. Indicator 9: Proportion of HIV-positive registered TB patients given ART during TB treatment.

Numerator: All HIV-positive TB patients, registered over a given time period, who receive ART (are started on or continue previously initiated ART)

Denominator: All HIV-positive TB patients registered over the same given time period.

Purpose: Outcome indicator to measure commitment and capacity of TB service to ensure that HIV positive TB patients are able to access ART.

Source of data:

1. Data management system
2. Patient files/manual
3. Patient appointments register.
4. TB unit register
5. ART care register.

10. Indicator 10: Presence of TB/HIV IEC materials in TB and HIV services

Numerator: Total number health facilities where IEC materials on both HIV and TB, are available.

Denominator: Total number of TB and HIV health facilities evaluated.*

Purpose: To demonstrate the commitment and capacity at national and Regional level to creating HIV awareness among people with TB , and TB awareness among PLWHA's and to promote prevention of HIV and TB.

Source of data:
Health facilities