

Report of the workshop
to accelerate the implementation of
TB-HIV collaborative activities
in SEAR

Kathmandu, Nepal, 9-11 July 2012



**World Health
Organization**

Regional Office for South-East Asia

SEA-TB-342
Distribution: General

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Printed in India

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Abbreviations and acronyms

3Is	intensified TB case finding, INH preventive therapy and infection control
ACSM	advocacy, communication and social mobilization
AIC	airborne infection control
ART	antiretroviral therapy
ARV	antiretroviral
ATT	antiTB treatment
CBO	community-based organization
CPT	cot-rimoxazole preventive therapy
CSO	civil society organization
DMC	designated microscopy centre
DOT	directly-observed treatment
DOTS	directly-observed treatment, short-course
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
IC	infection control
ICF	intensified case finding
ICTC	integrated counselling and testing centre
IEC	Information, education and communication
IPT	isoniazid preventive therapy
M & E	monitoring & evaluation
MC	microscopy centre
MDR	multidrug resistance
MNCH	maternal, neonatal and child health
MoH	ministry of health
MoU	memorandum of understanding

NGO	nongovernmental organization
NSP	national strategic plan
NTP	national TB programme
OI	opportunistic infection
PICT	provider-initiated HIV counselling and testing
PLHIV	people living with HIV
R & R	recording and reporting
SEAR	South-East Asia Region
SSF	single stream of funding
TA	technical assistance
TB	tuberculosis
TB/HIV	the intersecting epidemics of TB and HIV
ToT	training of trainers
VCT	voluntary counselling and testing
WHO	World Health Organization

1. Introduction

1.1 Background

Tuberculosis (TB) is the most common presenting illness among people living with HIV. At least one third of the 34 million people living with HIV worldwide are infected with TB. These coinfecting persons are 21-34 times more likely to develop active TB disease than persons without HIV. TB is the leading cause of death among people living with HIV. Almost one in four deaths among people with HIV is due to TB.

Globally, of the estimated 8.8 million incident TB cases in 2010, about 1.1 million (13%) were among people living with HIV. In the South-East Asia Region (SEAR), HIV prevalence among new TB patients is 5.7%, which is equivalent to 180 000 incident TB cases living with HIV accounting for nearly 15% of the global burden of new HIV-positive TB cases.

Five out of 11 countries (Bangladesh, India, Indonesia, Myanmar and Thailand) in the Region are among the 22 high-TB-burden countries, consisting almost 40% of the global TB burden.

The overall HIV prevalence among the adult population was estimated at 0.3% in the South-East Asia Region in 2010, which is equivalent to 3.5 million people living with HIV. Sex workers and their clients, men who have sex with men, transgenders and people who inject drugs are disproportionately affected by HIV. India, Indonesia, Myanmar, Nepal and Thailand together contribute almost 99% of HIV infection in the Region.

In response to the dual (TB and HIV) epidemics, WHO published a core set of policy and programme guidance in 2004 and recommended 12 collaborative TB/HIV activities to reduce the impact of TB and HIV epidemics (WHO *Interim Policy on Collaborative TB/HIV activities*, 2004). They include activities to establish a mechanism for collaboration to

decrease the burden of TB in people living with HIV/AIDS and to decrease the burden of HIV in TB patients. In 2005, key TB/HIV elements were included in the WHO standard data collection form. The South-East Asia Region responded by adapting global strategies and guidelines to the unique needs of the Region in 2004.

In 2009, WHO published a policy on TB Infection Control in Health Care Facilities, Congregate Settings and Households. Furthermore, WHO revised its guidelines on ICF/IPT in 2010 and recommended the use of a simplified symptom-based screening algorithm to identify those people living with HIV who are unlikely to have active TB and hence eligible for IPT. The TB/HIV indicators were harmonized and the interlinked patient monitoring system now includes TB/HIV.

In early 2012, WHO updated its TB/HIV collaborative policy by consolidating the latest available evidence and WHO recommendations on the management of HIV-related TB. It follows the same framework as the 2004 interim policy document, structuring the activities under three distinct objectives: establishing and strengthening mechanisms for integrated delivery of TB and HIV services; reducing the burden of TB among people living with HIV and initiating early antiretroviral therapy; and reducing the burden of HIV among people with presumptive TB (that is, people with signs and symptoms of TB or with suspected TB) and diagnosed TB.

Although substantial progress was made in implementation of TB/HIV collaboration activities in the South-East Asia Region in 2004, many challenges still remain in expanding the coverage. They are broadly described under administrative challenges to collaboration, access to PICT, implementation of 3Is, access to CPT and ART, patient-centric approach at a unified point of care and monitoring and evaluation.

The TB/HIV working group of the Stop TB Partnership has identified 63 priority countries including India, Indonesia, Myanmar and Thailand from SEAR. Along with Nepal, these priority countries require intensified actions for TB/HIV collaboration. Full adoption and adaptation of the above-mentioned guidelines to country situations is critical in reducing the burden of TB and HIV in the Region. Other low-burden countries need to implement the basic framework to prevent an increase of HIV-related TB. Partners' support is important in resource mobilization and in the whole process of implementation of activities. The participation of civil society in

the adaptation, planning, implementation, advocacy and monitoring and evaluation of collaboration in TB/HIV control is crucial in ensuring that the WHO guidance translates from policy to action.

Considering the urgency of the need to scaleup implementation of TB/HIV collaborative activities in the Region and to provide strategic guidance for implementation, WHO-SEAR convened a workshop of TB and HIV programme managers, NGOs, CBOs and WCO staff from 10 countries in the Region in Kathmandu, Nepal from 9 to 11 July 2012.

1.2 Objective

- The overall objective of the workshop was to accelerate implementation of the TB/HIV collaborative activities through the development of national response plans.

1.3 Specific objectives

- To review the status of implementation of TB/HIV collaborative activities (establishing a mechanism for collaboration, decreasing the burden of TB in people living HIV/ AIDS and early initiation of ART, and decreasing the burden of HIV in TB patients) and challenges for nationwide scale-up.
- To share the best practices for expanding TB/HIV collaborative activities.
- To discuss the role of partners and community organizations in the scale-up.
- To identify critical areas and action points to draft a response plan to accelerate the implementation of TB/HIV collaborative activities.
- To agree on the follow-up mechanism for monitoring the implementation of the response plan.

1.4 Proceeding of the workshop

Inauguration and Introduction

The workshop began with welcome remarks from Dr Lin Aung, WHO Representative to Nepal. Dr Md. Khurshid Alam Hyder, Regional Adviser-TB, WHO-SEARO, presented the objectives of the workshop.

The Chief Guest, Dr Praveen Mishra, Secretary of Health, Ministry of Public Health, Nepal, in his address mentioned about the menace of TB and HIV in the Region and its linkage with poverty. He emphasized the need for multisectoral efforts and the primary health care approach to reduce the impact of the two diseases. He also stressed on the need for improving the coverage of TB/HIV collaborative activities in the Region and to learn from the successes of other programmes.

Dr Lin Aung delivered the message of Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia. In his message, Dr Samlee apprised participants about the burden of TB/HIV in the Region and the response from WHO in terms of providing strategic guidance to countries. He lauded countries for the substantial progress made on implementation of TB/HIV collaborative activities especially after the implementation of the regional TB/HIV collaborative activities in 2004, but also mentioned about the challenges in expanding the services. He stressed the need for full adoption and adaptation of the WHO guidelines to the country situation and participation of civil society in planning, implementation and monitoring of programmes for reducing the burden of TB and HIV. "Health system strengthening and the primary health care approach are vital to provision of equitable access to all," he said. He also mentioned that the workshop will provide an opportunity of reviewing the status, challenges and sharing best practices for reducing TB/HIV in the Region (full text in Annex).

Dr Maw Amaya Naing, Technical Officer, AIDS, WHO-SEARO, introduced the participants.

Technical sessions

The following technical sessions were conducted:

- Global and regional update on TB/HIV
- Overview of harmonized TB/HIV indicators and an introduction to the three interlinked patient monitoring systems
- Overview of new WHO guidelines on ICF/IPT for PLHIV and operational considerations
- A provisional WHO plan for TB/HIV collaboration, 2012-2015.

Country experiences

The following countries shared their experiences in implementation of various components of TB/HIV collaboration:

- All 10 participating countries exhibited their status, challenges and future plans as poster presentations.
- Role of NGOs/civil society organizations in scaling up implementation by an NGO from India.
- Success story in TB/HIV scale-up from Thailand.
- Experience in M & E of TB/HIV from Myanmar.
- Experience in implementation of 3Is and early initiation of ART from Indonesia.
- Bottlenecks in implementation of PICT, CPT and ART and uptake from India.

Group work

Countries were divided into groups for discussion and presentation of work on the following components, facilitated by WHO resource persons:

- To identify challenges and priority actions to strengthen mechanisms of collaboration including monitoring and evaluation.

- To identify challenges and priority actions to scale up 3Is and early implementation of ART.
- To identify the challenges and priority actions to strengthen PICT, HIV prevention and CPT and ART uptake among the coinfecteds.
- To prepare a draft response plan for accelerating TB/HIV collaborative activities.

Conclusions and recommendations

Following intensive discussions during the three-day workshop, WHO prepared a summary and presented the key recommendations for guiding countries in scaling up TB/HIV collaborative activities.

Wrap-up

Dr Lin Aung, in his closing remarks, expressed satisfaction at the successful completion of the workshop. He hoped that countries will finalize their response plans at the earliest and start implementation for scale up of TB/HIV collaborative activities. He reemphasized the need for incorporating health system strengthening and the primary health care approach into country response plans.

2. Global situation on TB/HIV epidemic and collaborative activities

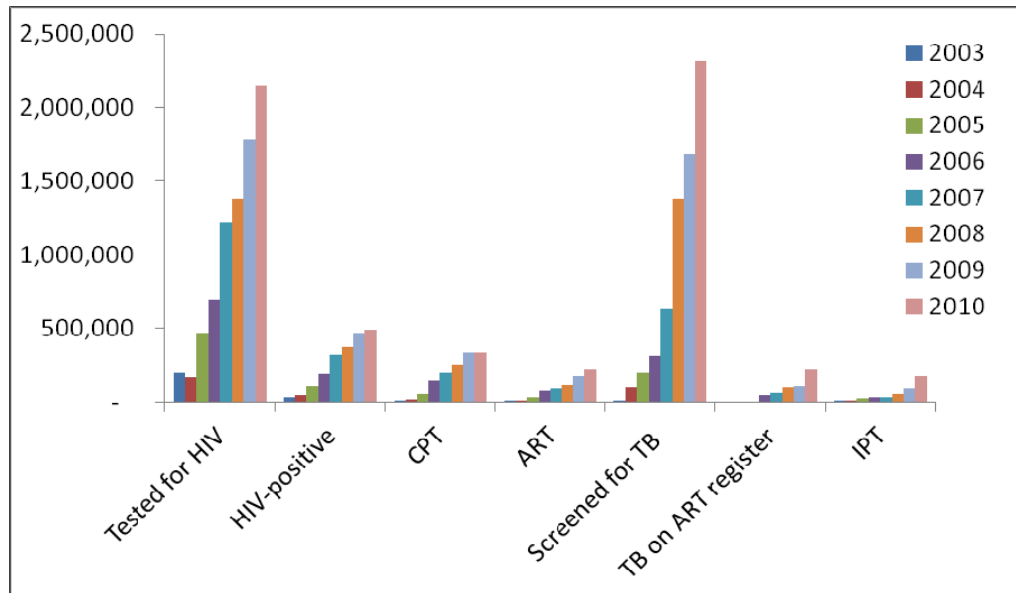
2.1 Global TB/HIV epidemiology (*WHO Global TB Report 2011*)

Globally, of the estimated 8.8 million incident TB cases in 2010, about 1.1 million (13%) were among people living with HIV. The African Region accounted for 82% of TB cases among people living with HIV.

In 2010, of the estimated 8.8 million incident TB cases, there were 1.1 million deaths from TB among HIV-negative people and an additional 0.35 million deaths from HIV-associated TB.

2.2 Global situation of TB/HIV collaborative activities

Figure 1: **Global implementation of key TB/HIV collaborative activities (2003-2010)**

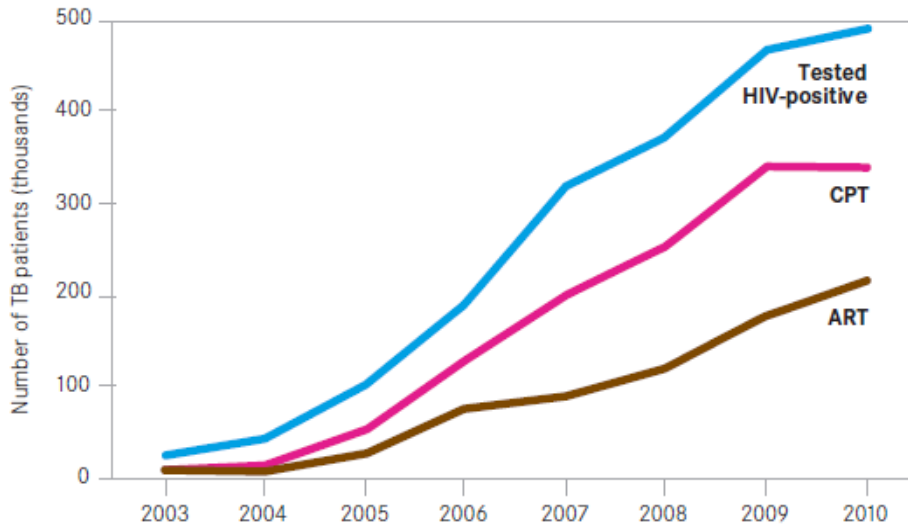


As shown in Figure 1, there has been consistent progress in implementation of TB/HIV collaborative activities since 2003.

The number of TB patients who knew their HIV status reached 2.1 million in 2010, equivalent to 35% of notified TB cases. The coverage of HIV testing of TB patients was particularly high in the African and European regions, where 59% and 80% of TB patients respectively knew their HIV status in 2010.

Among TB patients with an HIV test result in 2010, 23% were HIV positive at the global level with the highest of 44% in the African Region.

Figure 2: **CPT and ART uptake among HIV-positive TB patients**



Source : Global Tuberculosis Control : WHO Report 2011, World Health Organization, Geneva 2011

Globally, between 2009-2010, over 0.3 million TB patients living with HIV were enrolled on CPT, equivalent to 77% TB patients known to be HIV-positive. The South-East Asia Region achieved 87%, one of the highest levels of enrolment on CPT.

The number of HIV-positive TB patients on ART steadily increased and reached over 200 000 in 2010, equivalent to 46% of TB patients known to be living with HIV.

Figure 3: **PLHIV screened for TB**

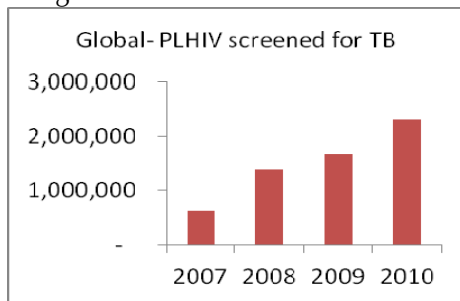
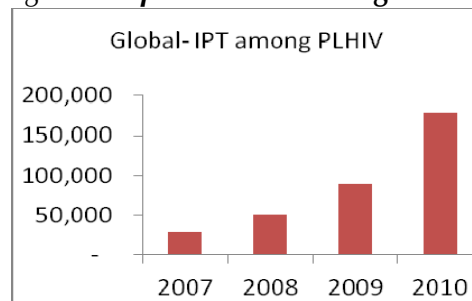


Figure 4: **Uptake of IPT among PLHIV**



As shown in Figure 4, TB screening among people living with HIV and provision of IPT have steadily increased, particularly since 2007. In 2010, 2.3 million were screened for TB, which is equivalent to 58% of the

reported number of people who were enrolled for HIV care and 178 000 of those without active TB were enrolled on IPT, equivalent to 12% of the reported number of people living with HIV, newly enrolled for HIV care.

3. Regional situation on TB/HIV collaboration

3.1 SEAR TB/HIV epidemiology

Table 1: TB and HIV situation in SEAR, 2010

Countries	Estimated prevalence of HIV in adult population %	Estimated number of people living with HIV	Estimated prevalence of all forms of TB		HIV prevalence in incident TB cases	
			Rate per 100 000 populaion	Numbers	%	Numbers
India	0.3	2 300 000	249	3 000 000	6.4	130 000
Thailand	1.2	550 000	189	130 000	17	16 000
Indonesia	0.2	340 000	285	660 000	2.8	12 000
Myanmar	0.6	230 000	595	300 000	9.2	22 000
Nepal	0.4	63 000	241	71 000	2.4	1 100
Bangladesh	<0.1	7 000	426	690 000	0.2	580
Sri Lanka	<0.1	2 800	101	20 000	0.1	32
Bhutan	0.1	1 000	179	1 300	0.1	36
Timor-Leste	<0.1	1 000	743	8 400	1.1	10
Maldives	<0.1	100	47	150	0.1	10
DPR Korea	No case reported	-		100 000	-	200
Total	0.3	3 494 900		4 980 850		181 968

Source: Tuberculosis Control in the South-East Asia Region 2012, WHO-SEARO, New Delhi 2012

Five countries (Bangladesh, India, Indonesia, Myanmar and Thailand) in SEAR are among the 22 high-TB-burden countries, accounting for nearly 40% of the global TB burden.

In the South-East Asian Region, an estimated 3.5 million people were living with HIV in 2010, with an overall HIV prevalence among the adult population at 0.3%.

Sex workers and their clients, men who have sex with men, transgenders and people who inject drugs are disproportionately affected by HIV. India, Indonesia, Myanmar, Nepal and Thailand together contribute to almost 99% of HIV infection in the Region. India, Myanmar and Thailand (9 states) have generalized HIV epidemics while Bangladesh and Indonesia have concentrated epidemics.

In the Region, HIV prevalence among new TB patients is 5.7%, which translates to ~180 000 incident TB cases living with HIV, accounting for nearly 15% of the global burden of new HIV-positive tuberculosis cases.

3.2 SEAR situation of TB/HIV collaborative activities

Figure 5: SEAR implementation of key TB/HIV collaborative activities, (2003-2010)

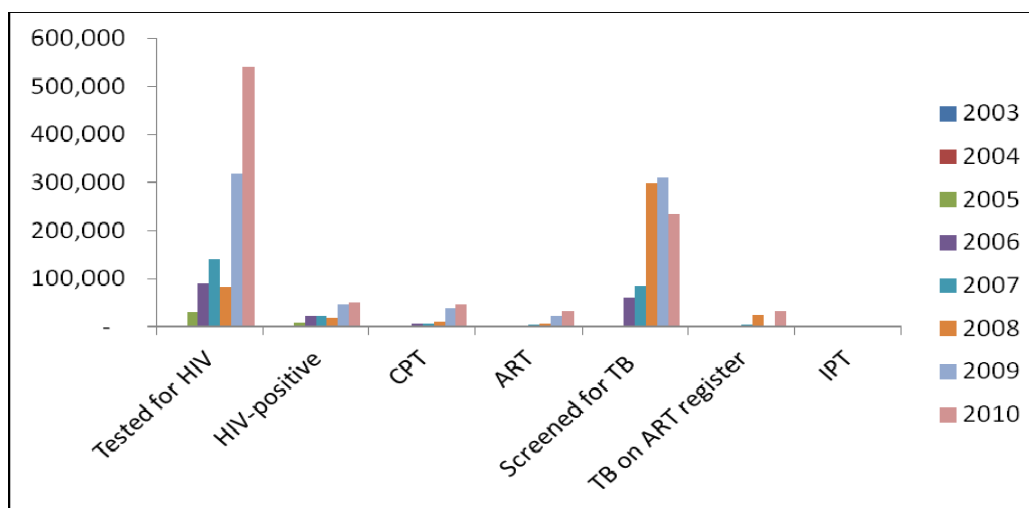


Table 2: SEAR implementation of key TB/HIV collaborative activities (2003-2010)

Year	TB patients tested for HIV	HIV positive	On CPT	On ART	HIV positives screened for TB	TB cases on ART register	New HIV positives started on IPT
2003	142	5	4	3			
2004	250	1	1				
2005	31 847	7 025	305	190			
2006	89 418	21 630	5 220	2 550	60 762	17	444
2007	139 318	22 593	6 662	3 275	85 387	3 991	1
2008	84 113	18 601	10 930	6 882	300 360	25 090	208
2009	318 237	46 089	39 360	23 174	310 412	714	467
2010	540 660	50 985	45 088	32 165	234 991	32 165	581

As shown in Figure 5 and Table 2, remarkable progress has been made in TB/HIV collaborative activities in the South- East Asia Region. In 2010, 540 660 TB patients were tested for HIV, which is equivalent to 23% of the total diagnosed TB cases. Out of HIV-tested TB cases, 50 985 (9.5%) were diagnosed as HIV positive. As shown in Table 2, 45 088 (87%) HIV-positive TB patients were put on CPT and 32 165 (57%) were put on ART. In 2010, 32 165 HIV-positives were screened for TB and 581, a small number started on IPT.

Box 3.1: Success story of scale-up of TB/HIV collaboration in Thailand

Thailand, with a population of 69 million is among the high TB and HIV burden countries. The estimated prevalence of TB was 189 per 100 000 population in 2010 and an HIV prevalence of 1.2% in the adult population. Recognizing the high TB/HIV coinfection rate (17%), Thailand piloted TB/HIV activities in 2003 and achieved nationwide coverage in 2006. TB/HIV, ICF and PICT guidelines were developed and harmonized monitoring and evaluation was established. In 2011, the country raised the CD4 level from <250 to <350 for initiating ART in PLHIV and irrespective of CD4 for TB patients living with HIV.

TB screening among PLHIV, HCT among TB patients and CPT and ART uptake improved remarkably over the years and reached 89%, 91%, 75% and 60% respectively in 2011. Moreover, TB/HIV activities are being implemented in all 141 prisons and disaggregated data are generated.

Thailand aims to improve its performance in this area further by strengthening supervision and monitoring, early initiation of ART and conducting operational research on priority TB/HIV areas.

4. WHO-SEA regional response plan for TB/HIV collaboration

In response to the dual (TB and HIV) epidemics, WHO published a core set of policy and programme guidelines in 2004 to reduce the impact of TB and HIV epidemics.

The WHO South-East Asia Region responded to the dual epidemic of TB and HIV in 2004 by adapting global strategies and guidelines to the unique needs of the Region.

In early 2012, WHO updated its TB/HIV collaborative policy by consolidating the latest available evidence and WHO recommendations on the management of HIV-related TB. The policy follows the same framework as the 2004 interim policy document, structuring the activities under three distinct objectives:

- Establishing and strengthening mechanisms for integrated delivery of TB and HIV services;
- Reducing the burden of TB among people living with HIV and initiating early antiretroviral therapy; and
- Reducing the burden of HIV among people with presumptive TB (that is, people with signs and symptoms of TB or with suspected TB) and diagnosed TB.

WHO-SEARO aims to develop a strategy for 2012- 2015 by adopting and adapting the new WHO policy on TB/HIV collaboration. The workshop has provided an opportunity to know the status, challenges and priority

areas for the expansion of TB/HIV collaboration in countries of the Region. These will be taken into consideration for development of the Regional Strategic Plan, 2012-2015.

5. Status and challenges of TB/HIV collaboration in the SEA Region

5.1 Establishing a mechanism for TB/HIV collaboration

Status and achievements

- Most countries in the Region (8 out of 11) except Bhutan, Maldives and Thailand have set up collaborative bodies at the national and subnational levels, which meet quarterly or biannually to plan and monitor TB/HIV collaborative activities in countries.
- All countries except Bhutan and Maldives have developed TB/HIV guidelines.
- Most countries (8 out of 10)* except Bangladesh and Indonesia have a routine surveillance mechanism to determine HIV prevalence among TB patients and 7 out of 10* (except Bhutan, Bangladesh and Timor-Leste) have a routine system of screening PLHIV for TB.
- Most countries (8 out of 10)* have modified TB and HIV R and R to incorporate TB/HIV information.

Box 5.1: Experience of an NGO in implementation of TB/HIV collaboration in India

Agnesh Kunze Society (AKS) is an NGO based in the Dehradun district of Uttarakhand state. Since 2004, under the Target TB project, it is involved in TB control in the Dehradun district. It works through a network of 530 DOT providers who support TB treatment and referral for HCT. AKS has also established one ICTC and community care centre for PLHIV.

* DPR Korea does not have any HIV/AIDS cases

The major achievements are: AKS treated more than 3000 TB patients on DOTS, almost all TB patients referred for HCT, TB referral to government health facilities well established at ICTC and CCC and conducted almost 400 awareness generation camps in rural communities.

AKS is a member of the state and district TB/HIV coordination bodies and State Grievances Redressal Committee. It was part of a joint monitoring mission for reviewing the National TB Programme in 2009. AKS was also awarded the Health Excellence Award for TB/HIV in 2009 from the Chief Minister of Uttarakhand.

AKS is facing some challenges in ensuring cross-referral between TB and HIV sites with government facilities, stigma of both diseases, addressing MDR and resistance to ART and dealing with other social issues like poverty and alcoholism, etc.

AKS recognizes the great potential of NGOs/ CBOs in planning and implementation, especially in hard-to-reach areas and addressing high-risk groups and monitoring of TB/HIV collaborative activities.

Box 5.2: Experience in monitoring and evaluation of TB/HIV collaboration in Myanmar

Myanmar, with a population of 50 million is one of the high TB-and-HIV burden countries. The estimated prevalence of TB is 595 per 100 000 population and 0.6% of the adult population is living with HIV. Myanmar is implementing TB/HIV collaborative activities in 18 out of 330 townships since 2005.

HIV sentinel surveillance in TB is carried out in 25 sites. Myanmar developed TB/HIV guidelines in 2005 and has since modified the R & R to capture TB/HIV indicators. Health facilities report monthly on HCT and IPT activities and quarterly on other TB/HIV indicators. Some NGOs provide single-facility services for TB and HIV. The role of TB and HIV programmes is clearly defined for reporting of specific indicators. A system has been established for joint supervision and monitoring of TB/HIV, which involves representatives from both the programmes, WHO, donors and partners.

TB/HIV technical meetings and national coordination board meetings are held annually at the central level. At the district level, the TB/HIV coordination body meets quarterly to review the programme.

The programmes have identified some challenges especially availability of skilled human resource, harmonization of R & R of all implementing partners and quality of data, etc. However, the country aims to revise M & E formats and harmonize them across the implementing partners in line with the current international guidelines.

Challenges

- Bhutan, Maldives and Thailand do not have functional TB/HIV collaborative bodies at national and subnational levels.
- In most countries, the TB/HIV collaborative bodies do not include representatives from partner organizations, NGOs/ CBOs and people affected by the two diseases, and there are challenges in conducting regular meetings of the bodies at different levels.
- Bhutan is not implementing TB/HIV collaborative activities and Bangladesh (six NGOs), Myanmar (18/330 townships) and Nepal (22/75 districts) have limited geographical coverage.
- Bhutan and Maldives do not have TB/HIV guidelines in place.
- Bhutan, Maldives, Myanmar, Nepal, Sri Lanka and Timor-Leste reported inadequate human resources and technical capacity.
- Most countries except Bangladesh reported limited involvement of NGOs/ CBOs in TB/HIV collaboration.
- In Bangladesh, Indonesia, Nepal and Sri Lanka only high-risk TB patients are screened for HIV.
- In most countries, there is a wide service gap between TB and HIV and the referral linkage is not strong.
- Bangladesh, Bhutan, Myanmar and Maldives reported inadequate funding for expansion.
- Cross-border migration is a major challenge for Nepal and Thailand.

- Very little progress is seen in addressing children, women, people who use drugs and in involving prisons.
- Harmonization of TB/HIV indicators and quality of data are a challenge in most countries.
- Except India, no other country reported implementation of regular operational research.

Box 5.3: *Experience in establishing a mechanism of TB/HIV collaboration in Nepal*

With a population of 27 million, Nepal has an estimated prevalence of all TB cases of 241 per 100 000 population; 0.3% of the adult population are living with HIV.

Nepal has a concentrated HIV epidemic and is implementing TB/HIV collaborative activities in 22 out of 75 districts. TB/HIV coordination committees have been formed at national, regional and district levels. TB/HIV is well represented in NSP. TB and HIV programmes have jointly developed TB/HIV guidelines, modified R & R format and established joint supervision and monitoring. Joint planning also includes planning for ACSM and training of health-care staff.

However, Nepal is experiencing challenges in geographical expansion of services, integration with other health services like MNCH, nutrition, involvement of private and business sectors and other line agencies and dealing with cross-border migration.

Nepal is aiming to expand the services and involve NGOs and other line agencies for effective implementation of TB/HIV collaboration in the country.

5.2 Implementation of 3Is and early initiation of ART

Status and achievements

- Most countries have a policy of screening all HIV-positives for TB at every visit to HIV services.

- All countries in the Region have a policy of initiating ART in PLHIV at <350 CD4 and in addition, Indonesia, Maldives and Thailand have a policy to initiate ART in all pregnant mothers living with HIV irrespective of the CD4 count.
- India, Indonesia, Myanmar and Thailand have reported piloting of IPT in some selected ART centres.
- Most countries (8 out of 10) have developed a TB infection control plan.

Box 5.4: *Experience in implementation of 3Is and early initiation of ART in Indonesia*

Indonesia, with a population of 236 million, is one of the high TB-and-HIV burden country in the world. The estimated TB prevalence is 289 per 100 000 population and 0.2% of the adult population are living with HIV. HIV prevalence in incident TB cases varies from 2%-17% with an average of 4%.

There is a policy of screening all PLHIV for TB using symptom-based algorithm and to treat diagnosed TB patients with standard ATT. TB patients living with HIV are started on ART irrespective of the CD4 count. IPT is in the pilot stage at four sites. Eleven hospitals in 11 provinces were developed as model hospitals for TB infection control and there is a plan to expand this model to other hospitals. Prison staff is sensitized in TB infection control. In 2011, 63% PLHIV were screened for TB symptoms.

Indonesia's programme is facing challenges of availability of skilled staff, data quality, and limited facility coverage. The country aims to strengthen M & E and plan regular training of staff.

Challenges

- Not all countries are using standard symptom complex for screening PLHIV for TB (e.g. Bangladesh still uses the three-weeks-of-cough indicator).
- There is no separate TB screening tool for screening children living with HIV.

- In India, HIV records do not include information on PLHIV screened for TB symptoms and hence the country reports only the number of PLHIV who are investigated for TB.
- Bhutan has neither implemented ICF nor its M & E; Bangladesh, Myanmar and Nepal have limited geographical coverage.
- No country in the Region is implementing IPT to PLHIV due to various reasons like:
 - Lack of policy
 - Lack of consensus among implementers on efficacy, risk of resistance.
- Maldives and Timor-Leste reported absence of a plan for implementation of TB infection control.
- No country in the Region has developed indicators for regular monitoring of IC activities.
- No country in the Region has a mechanism in place for the surveillance of TB among health-care staff.

5.3 Implementation of HCT and HIV prevention and uptake of CPT and ART

Status and achievements

- Most countries, except Bhutan, have a policy of screening TB patients for HIV.
- India has started a pilot for screening TB suspects for HIV.
- All implementing countries have a policy of starting all HIV-positive TB patients on CPT.
- Bangladesh, India, Indonesia, Maldives and Thailand have a policy of initiating ART for all TB patients diagnosed with HIV at an early stage following start of ATT, irrespective of the CD4 count. Myanmar has a policy of initiating ART among TB patients living with HIV at <500 CD4 count. Other countries have a policy of starting ART at CD4 <350 among TB patients infected with HIV.
- In all countries in the Region, HIV prevention, including for referred TB cases, is offered by the HIV programme.

Box 5.5: Experience in implementation of HCT, CPT and ART in India

India, with a population of 1.2 billion, is one of the highest TB- and HIV burden countries in the world. The estimated prevalence of TB is 253 per 100 000 population and 0.4% of the adult population are living with HIV, which is equivalent to 2.4 million.

India began piloting the basic TB/HIV collaborative activities in 2001 and achieved nationwide coverage of the intensified package in 2012.

There has been remarkable progress in HCT and CPT, and in the ART uptake over the years. In 2011, 45% TB patients were screened for HIV and among the coinfecting, 91% were started on CPT and 59% on ART.

The low uptake of HCT is mainly due to a wide facility gap between TB and HIV services, loss during referral and frequent shortage of HIV testing kits. The low uptake of ART is also the result of the same issue of a wide facility gap between TB and ART programmes (>30 000 TB treatment centres and ~1000 ART centres including link ART centres).

The HIV programme is aiming to strengthen the procurement and supply chain for HIV testing kits and CPT and ARV drugs as well as increase the number of ART centres in the country. The TB programme has implemented a scheme that provides transport support to TB patients for accessing HIV services.

Challenges

- Bangladesh, Indonesia, Nepal and Sri Lanka have a policy of offering HCT to only high-risk TB patients
- Bangladesh (six NGOs), Myanmar (18/330 townships) and Nepal (22/75 districts) have limited geographical coverage for HCT.
- There is no recording and reporting of HCT, CPT and ART in Bhutan and Sri Lanka; recording and reporting is done by the HIV department in Bangladesh, Myanmar and Nepal (no figures available).

- Most countries have an issue of a service mismatch between TB and HIV programmes, which is compounded by a weak referral and feedback mechanism.
- Some countries (Bangladesh, Myanmar) report frequent shortage of CPT/ ART.

6. Recommendations

6.1 Establishing a mechanism for TB/HIV collaboration

TB and HIV programmes

- Set up and strengthen a collaborative body for TB/HIV activities that includes representatives from other line ministries, partners, NGOs/ CBOs and people affected by the two diseases at critical levels of the health system.
- Develop/revise TB/HIV guidelines incorporating internationally recommended policies as per the country situation.
- Formulate an operational plan for implementing TB/HIV collaborative activities that includes a plan to :
 - Expand integrated TB and HIV services to improve geographical excess;
 - Reduce the service gap between TB and HIV services;
 - Ensure adequate and skilled human resources by planning jointly for training health-care staff from TB and HIV programmes;
 - Engage NGOs, CBOs (disease-affected communities);
 - Mobilize resources;
 - Strengthen linkage with MNCH, harm reduction services, and high-risk groups including migrants, etc.;
 - Implement joint ACSM activities; and
 - Conduct operational research for improving implementation.

- Advocate with policy-makers for:
 - Accelerating and scaling up the uptake of IPT, HCT of TB patients and implementation of IC measures;
 - Placement of adequate and skilled human resources in TB and HIV programmes;
 - Expanding infrastructure/geographical coverage and minimizing the service gap between TB and HIV programmes; and
 - Allocating adequate resources.
- Establish/strengthen M & E for TB/HIV
 - Develop costed M & E plan;
 - Standardize recording and reporting formats to collect data on key TB/HIV collaborative activities;
 - Establish strong referral/feedback linkages between TB and HIV programmes;
 - Ensure quality of data; and
 - Establish harmonized indicators.

Minimum recommended indicators

TB Programme	HIV Programme
<ul style="list-style-type: none"> ➤ % of TB patients tested for HIV ➤ % of HIV-positives among tested TB patients ➤ % of HIV-positive TB patients on CPT ➤ % of HIV-positive TB patients on ART 	<ul style="list-style-type: none"> ➤ % of PLHIV screened for TB ➤ % new HIV-positives starting IPT ➤ % of HIV-positive patients who received TB treatment

6.2 Implementation of 3Is and early initiation of ART

HIV programme

- Screen all people living with HIV (adults and children) for TB using a clinical symptom-based algorithm, separate for adults and children.
- Modify recording and reporting formats to capture ICF/IPT activities.
- Investigate suspected cases of TB by using appropriate, advanced tools.
- Ensure TB treatment is initiated for all diagnosed TB cases.
- Consider IPT for all adults, adolescents and children >12 months showing no TB symptoms on screening.

TB and HIV programmes

- Develop IC guidelines, IC plan and facilitate the health system to implement IC measures.
 - Designating a focal person for IC in each facility, triaging, ventilation in waiting area, medical surveillance of staff in health-care facilities and congregate settings, are the minimal IC measures required.

6.3 Implementation of HCT and uptake of CPT and ART

TB programme

- Urgently scale up HIV counselling and testing for all diagnosed TB patients.
- Provide CPT to all HIV-infected patients (children and adults) with active TB disease, regardless of the CD4 counts.
- Initiate ART for all TB patients living with HIV irrespective of the CD4 counts (children and adults).

- ART should be initiated as soon as possible after the start of ATT.
- Ensure uninterrupted availability of HIV testing kits, CPT and ART.

7. References

- (1) WHO Report 2011, Global Tuberculosis Control
- (2) WHO Policy on Collaborative TB/HIV Activities, WHO 2012
- (3) The Global Plan to Stop TB 2011-2015, WHO 2010
- (4) TB/HIV in South-East Asia Region, Status Report, WHO 2011

Annex 1

Status, achievements, challenges and priority actions for implementation of TB/HIV collaborative activities in SEAR Member States

Bangladesh

Demography

Population: **152 million**

Provinces/ States/ Divisions/ Regions: **7**

Districts: **64**

TB and HIV services

Total number of TB microscopy centres (government+ NGOs):
1069 (617+ 452)

Total number of health facilities providing HCT (government + NGOs):
100 (1+ 99)

Total number of health facilities providing ART (government+ NGOs):
11 (5+ 6)

Guidelines

Availability of TB/HIV guidelines/ Year: **Yes/ 2009**

Availability of TB infection control guidelines/ Year: **Yes/ 2012**

Policies/coverage

Active TB case-finding among PLHIV: **Yes/ implemented by six NGOs**

IPT to PLHIV without TB: **No**

HCT among TB patients: **Yes/only high-risk TB patients offered HCT**

CPT to TB patients diagnosed with HIV: **irrespective of the CD4 count**

ART to TB patients diagnosed with HIV: **irrespective of the CD4 count/implemented by six NGOs.**

Mechanism of TB/HIV collaboration

Presence of TB/HIV collaborative bodies at the national level: **Functional**

Establishment of R & R for collecting TB/HIV indicators: **Yes**

TB/HIV collaborative activities (2011)

HIV-positive patients screened for TB	HIV-positive TB patients started on ATT	Newly HIV-positive cases started on IPT	TB patients tested for HIV	TB patients found HIV-positive	HIV-positive TB patients on CPT	HIV-positive TB patients on ART
154 (1.5%)	5	NA	1900	12 (0.6%)	100%	100%

Achievements

- The National TB Strategic Plan, 2006, adopted TB/HIV as a major service delivery area and ensured funds to implement TB-HIV collaborative activities through GFATM Round 5, Round 8 and Round 10 (SSF) grants
- The National TB/HIV Coordination Committee established with approval of the Director-General of Health Services in March 2008
- NTP developed an operational guideline on management of TB/HIV collaboration in 2009
- NTP provides uninterrupted antiTB drugs and other logistics to NASP/partner NGOs on the basis of a tripartite MoU to manage TB-HIV coinfection.
- A well-structured referral network has been initiated by NTP for TB and HIV diagnosis
- Human resources of HIV programme have been strengthened

Challenges

- Ensuring sustainability of funding
- No coordination structure below national level
- Limited expansion – only by NGOs
- Recording and reporting formats not standardized
- There is no policy of IPT
- Erratic ARV drug supply
- Lack of CD4 testing facilities (only three)
- No surveillance of TB among health-care staff and no R & R on infection control activities

Priority actions

- Secure funding and plan for nationwide expansion
- Establish coordination structure below national level
- Standardize and harmonize recording and reporting formats to collect TB/HIV data
- Expand HIV services and ensure uninterrupted supply of ART
- Advocacy with policy-makers regarding IPT as a strategy
- Training on IC

Bhutan

Demography

Population: **0.7 million**

Provinces/ States/ Divisions/ Regions: **3**

Districts: **20**

TB and HIV services

Total number of TB microscopy centres (government+ NGOs): **32 (32+ 0)**

Total number of health facilities providing HCT (government + NGOs): **46 (46+ 0)**

Total number of health facilities providing ART (government+ NGOs): **5 (5+ 0)**

Guidelines

Availability of TB/HIV guidelines/ Year: **No**

Availability of TB Infection control guidelines/ Year: **Yes/ 2009**

Policies/coverage

Active TB case-finding among PLHIV: **Yes/No recording and reporting of ICF**

IPT to PLHIV without TB: **No**

HCT among TB patients: **Yes/ No recording & reporting of HCT**

CPT to TB patients diagnosed with HIV: **irrespective of the CD4 count**

ART to TB patients diagnosed with HIV: **<350 CD4/No recording and reporting**

Mechanism of TB/HIV collaboration

Presence of TB/HIV collaborative bodies at the national level: **No**

Establishment of R & R for collecting TB/HIV indicators: **No**

TB/HIV collaborative activities (2011)

HIV-positive patients screened for TB	HIV-positive TB patients started on ATT	Newly HIV-positive cases started on IPT	TB patients tested for HIV	TB patients found HIV-positive	HIV-positive TB patients on CPT	HIV-positive TB patients on ART
NA	NA	NA	NA	NA	NA	NA

Achievements

- Referral of TB patients for VCT started
- Plan to develop TB/HIV collaborative policy
- HIV patients screened for TB along with other conditions
- Study on HIV prevalence among TB patients -STAC supported
- CPT provided for children born to HIV-positive mothers and others requiring it
- Availability of infection control guidelines/plan

Challenges

- No coordination structure at any level
- Absence of separate TB/HIV guideline and R & R
- Lack of funds for training, development of guidelines and M & E
- Suboptimal technical/ programme implementation capacity
- Service gap between TB and ART services
- Poor awareness among health workers

Priority actions

- Establish TB/HIV collaborative body at the national level
- Develop TB/HIV guidelines/plan and establish joint M & E
- Secure funding for implementation of TB/HIV collaborative activities
- Strengthen ACSM, training of staff

India

Demography

Population: **1225 million**

Provinces/ States/ Divisions/ Regions: **30 States and 5 Union Territories**

Districts: **640 (663 TB Districts)**

TB and HIV services

Total number of TB microscopy centres (government+ NGOs):
13 039 (12 548+ 491)

Total number of health facilities providing HCT (government + NGOs):
10 515 (9551+ 964)

Total number of health facilities providing ART (government+ NGOs):
1090 (345+ 735 Link ART+ 10 NGOs)

Guidelines

Availability of TB/HIV guidelines/ Year: **Yes/ 2009**

Availability of TB Infection control guidelines/ Year: **Yes/ 2010**

Policies/coverage

Active TB case-finding among PLHIV: **Yes/ nationwide**

IPT to PLHIV without TB: **No/ pilot under way at 12 ART sites**

HCT among TB patients: **Yes/ nationwide**

CPT to TB patients diagnosed with HIV: **irrespective of the CD4 count/ nationwide**

ART to TB patients diagnosed with HIV: **irrespective of the CD4 count/ nationwide**

Mechanism of TB/HIV collaboration

Presence of TB/HIV collaborative bodies at the national level: **Functional**

Establishment of R & R for collecting TB/HIV indicators: **Yes**

TB/HIV collaborative activities (2011)

HIV-positive patients screened for TB	HIV-positive TB patients started on ATT	Newly HIV-positive cases started on IPT	TB patients tested for HIV	TB patients found HIV-positive	HIV-positive TB patients on CPT	HIV-positive TB patients on ART
132832 (43%)- investigated	8069/ 10 691	NA	688 530 (45%)	44 702 (6%)	40 853 (91%)	26 165 (59%)

Achievements

- Nationwide coverage of intensified TB/HIV package was achieved in 2012
- In the first quarter of 2012, 55% TB patients knew of their HIV status in the country
- Among TB-HIV coinfecting patients, 95% are on CPT and 67% are on ART
- ICF at ICTC and ART centres contribute close to 6%-7% TB cases to the overall TB notification in the country
- Operational research for IPT, screening TB suspects for HIV under way

Challenges

- Suboptimal involvement of HIV NGOs
- Low uptake of HIV testing in several states:
 - Infrastructure gap - DMC: ICTC ratio is less than 0.5; patients have to travel long distances
 - Less than 50% DMCs have co-located HIV testing services
 - Frequent shortage of HIV test kits
 - Non-referral by health-care providers

- Low levels of ART among HIV-TB:
 - Infrastructure gap – 300+ ART centres and 400 000+ DOT centres
 - Long distances to travel and lack of finances
 - Operational losses in ART evaluation process
- Late diagnosis of HIV-TB and increased severity lead to high mortality:
 - Sputum microscopy has poor sensitivity, especially among PLHIV
 - Many PLHIV still do not know their HIV status; late diagnosis of HIV (median CD4 <150)
 - Low CD4 counts at the time of HIV-TB diagnosis
- Minimal activities in addressing high-risk groups
- No implementation of IPT
- No documentation and reporting of AIC activities from HIV care
- No surveillance mechanism for TB among health-care staff

Priority actions

- TB programme:
 - Ensure linkage of HIV/TB cases to ART
 - Ensure HIV testing of all notified TB cases
 - Strengthen the uptake of TB/HIV scheme for NGOs
 - Early diagnosis of TB and DR-TB –use of newer diagnostics
- HIV programme
 - Early initiation of ART
 - Enhance HIV testing facilities
 - Ensure uninterrupted supply of HIV test KITS
 - Strengthen the implementation of ICF at all HIV-care facilities

- Implementation of ICF activities at targeted intervention projects (HRG, specially IDU)
- Decisions on HIV testing of presumptive TB cases (TB suspects)
- Decisions on IPT implementation
- Joint responsibility:
 - Strengthening coordination mechanisms at all levels
 - Strengthening monitoring and evaluation
 - Strengthening joint ACSM
 - Supervision and monitoring of AIC

Indonesia

Demography

Population: **236 million**

Provinces/ States/ Divisions/ Regions: **33**

Districts: **502**

TB and HIV services

Total number of TB microscopy centres (government+ NGOs):
4981 (4866+ 115)

Total number of health facilities providing HCT (government + NGOs):
524 (437+ 87)

Total number of health facilities providing ART (government+ NGOs):
322 ((196 referral+ 70 satellite)+ (41 referral+ 15 satellite))

Guidelines

Availability of TB/HIV guidelines/ Year: **Yes/ 2010**

Availability of TB Infection control guidelines/ Year: **Yes/ 2010**

Policies/ coverage

Active TB case-finding among PLHIV: **Yes/ nationwide**

IPT to PLHIV without TB: **No/pilot in 4 sites**

HCT among TB patients: **Yes/only high-risk TB patients offered HCT/ nationwide**

CPT to TB patients diagnosed with HIV: **irrespective of the CD4 count/ nationwide**

ART to TB patients diagnosed with HIV: **irrespective of the CD4 count/ nationwide**

Mechanism of TB/HIV collaboration

Presence of TB/HIV collaborative bodies at the national level: **Functional**

Establishment of R & R for collecting TB/HIV indicators: **Yes**

TB/HIV collaborative activities (2011)

HIV-positive patients screened for TB	HIV-positive TB patients started on ATT	Newly HIV-positive cases started on IPT	TB patients tested for HIV	TB patients found HIV-positive	HIV-positive TB patients on CPT	HIV-positive TB patients on ART
63%	73.3%	NA	3511	1280	1182 (92%)	544 (43%)

Achievements

- TB-HIV collaborative activities implemented in all 33 provinces since 2008
- Establishment of TB-HIV working group at national, provincial, municipality and health facilities levels
- TB-HIV training has been carried out in 33 provinces (not all health facilities)
- Sensitization of health workers on TB/HIV collaboration in 20 prisons

- Agreement letter on TB-HIV Infection Control and Prevention in penitentiary and prisons for officers, residents and visitors, was signed between Ministry of Health and Ministry of Law and Human Rights (25 February 2010)
- TB-HIV service is part of standard requirements for hospital accreditation (2011)
- Developed ToT modules for TB-HIV, TB-HIV training modules, TB-HIV IEC materials, TB-HIV guideline for IDU, TB-HIV National Strategy (2010-2014) and TB Infection Control Guideline
- Also developed guideline for Clinical Management of TB-HIV coinfection, Management Guideline for TB-HIV Collaboration, Guideline for TB-HIV Infection Control in Health Care and Prisons, and IPT Initiation Manual (draft)
- Implementation of rapid diagnostic tools (Xpert MTB/RIF) for TB-HIV and MDR TB suspects at four sites
- Implementation/pilot of IPT in PLWHA (four hospitals in DKI Jakarta and West Java)

Challenges

- Coordination
 - Lack of commitment from local government
 - Suboptimal collaboration between TB and HIV control programmes in most health facilities (suboptimal internal and external linkage)
 - Lack of coordination at district and province levels (impact from decentralization policy)
- Health service
 - Misperception of confidentiality vs secrecy among health officers
 - Limited number of health facilities conducting TB-HIV collaborative activities
 - Limited number of HCT sites

- Human resources
 - Few trainers for TB-HIV training
 - Small number of trained health workers
 - Uneven distribution of skilled health workers
 - High turnover of skilled health workers
- Funding
 - Limitation of local funding
 - Donor dependence
- Community
 - Limited number of CSOs involved in TB-HIV programme
- Strategic information
 - Lack of database

Priority actions

- Strengthen collaboration at all levels
- Plan regular training/ mentoring of staff
- Secure funding for sustenance and scale-up
- Enhance and support CSOs especially PLHIV PSG
- Strengthen referral system
- Consider implementation of IPT

Maldives

Demography

Population: **0.3 million**

Provinces/ States/ Divisions/ Regions: **7**

Districts: **NA**

TB and HIV services

Total number of TB microscopy centres (government+ NGOs): **20 (20+ 0)**

Total number of health facilities providing HCT (government + NGOs):
9 (8+ 1)

Total number of health facilities providing ART (government+ NGOs):
1 (1+ 0)

Guidelines

Availability of TB/HIV guidelines/ Year: **No**

Availability of TB infection control guidelines/ Year: **No**

Policies/ coverage

Active TB case-finding among PLHIV: **Yes/ nationwide**

IPT to PLHIV without TB: **No**

HCT among TB patients: **Yes/ nationwide**

CPT to TB patients diagnosed with HIV: **irrespective of the CD4 count/ nationwide**

ART to TB patients diagnosed with HIV: **irrespective of the CD4 count/ nationwide**

Mechanism of TB/HIV collaboration

Presence of TB/HIV collaborative bodies at the national level: **non-functional**

Establishment of R & R for collecting TB/HIV indicators: **Yes**

TB/HIV collaborative activities (2011)

HIV-positive patients screened for TB	HIV-positive TB patients started on ATT	Newly HIV-positive cases started on IPT	TB patients tested for HIV	TB patients found HIV-positive	HIV-positive TB patients on CPT	HIV-positive TB patients on ART
3	0	NA	5	0	0	0

Achievements

- Testing of all TB positive patients above the age of 15 started on 1 December 2011
- Awareness session conducted for expatriate workers on TB through HIV peer educators to mark World TB Day 2012
- IEC materials developed in four languages to mark World TB Day

Challenges

- Lack of human and financial resources
- M & E of TB/HIV not integrated
- Lack of NGO/ CBO involvement in TB/HIV

Priority actions

- Throughout the country three NGOs are providing VCT services and formal discussions held and finalized to integrate TB screening and DOTS services
- National TB Strategic Plan to be developed through consultation with the HIV programme
- Encourage more NGOs to work with TB/HIV services delivery
- Establish harmonized M & E for collecting TB/HIV indicators

Myanmar

Demography

Population: **50 million**

Provinces/ States/ Divisions/ Regions: **14**

Districts: **67 (330 townships)**

TB and HIV services

Total number of TB microscopy centres (government+ NGOs):
395 (335+ 60)

Total number of health facilities providing HCT (government + NGOs): **484
(336+ 148)**

Total number of health facilities providing ART (government+ NGOs):
96 (42+ 54)

Guidelines

Availability of TB/HIV guidelines/ Year: **Yes/ 2005**

Availability of TB infection control guidelines/ Year: **No**

Policies/coverage

Active TB case-finding among PLHIV: **Yes/18 out of 330 townships
implementing**

IPT to PLHIV without TB: **Yes/pilot in 12 out of 330 townships**

HCT among TB patients: **Yes/ 18 out of 330 townships implementing**

CPT to TB patients diagnosed with HIV: **irrespective of the CD4 count/18
out of 330 townships implementing**

ART to TB patients diagnosed with HIV: **CD4 < 500/ 18 out of 330
townships implementing**

Mechanism of TB/HIV collaboration

Presence of TB/HIV collaborative bodies at the national level: **Functional**

Establishment of R & R for collecting TB/HIV indicators: **Yes**

TB/HIV collaborative activities (2011)

HIV-positive patients screened for TB	HIV-positive TB patients started on ATT	Newly HIV-positive cases started on IPT	TB patients tested for HIV	TB patients found HIV-positive	HIV-positive TB patients on CPT	HIV-positive TB patients on ART
12 120 (100%)	NA	361	7464	1257	4862?	3109?

Achievements

- Central TB/HIV coordination body – NAP, NTP, partners established in 2005, including CSO
- TB/HIV sentinel surveillance
 - Five townships in 2005, 20 townships in 2010 and 25 townships in 2012
- Isoniazid preventive therapy (IPT) for PLHIV – 15 tsps:
 - Pilot project started in 2009 (seven townships in Mandalay, Lashio and Tachileik)
 - Expanded to Monywa, Magwe and Pathein in 2011
 - Then to Mawlamyaing, Pyay and Dawe in 2012
- Expansion of VCT centres at TB clinics:
 - Ten sites in 2010
 - Continue seven sites in 2012 after collaborative activities expanded to Pyay, Mawlamyine and Monywa

Challenges

- Severe limitation of ART – only 30% patients in need are on treatment
- Decentralization of care and treatment services including ART at township level. Now it is mainly at state/region and district levels

- Lack of commodities such as HIV test kit, OI drug
- Less space for ART quota for TB/HIV coinfection
- Slow scale-up for IPT as part of TB/HIV plan
- Inadequate human resources at all levels
- Budget constraint for expansion of new townships
- Infection control improvement needed in all health-care facilities
- Lack of resources and capacity to roll-out Xpert MTB/RIF for more sensitive diagnosis of TB in people living with HIV/AIDS
- Poorly defined TB/HIV indicators
- Insufficient coordination among partners providing TB/HIV services (eg. CoC)

Priority actions

- Implementation of national TB/HIV strategic plan (2012-2015)
- Expand implementation of TB/HIV collaborative activities to cover all 330 townships
- Simplify and strengthen the M&E system aimed at data quality assurance
- Strengthen coordination among two programmes and other partners, especially CSOs
- Mobilize financial resources for TB/HIV scale-up (e.g. future Global Fund Rounds, 3 MDG Fund)
- Training of staff, TA for guidelines development
- Establishment of harmonized indicators for M & E and corresponding changes in TB and HIV R & R

Nepal

Demography

Population: **27 million**

Provinces/ States/ Divisions/ Regions: **5**

Districts: **75**

TB and HIV services

Total number of TB microscopy centres (government+ NGOs): **NA**

Total number of health facilities providing HCT (government + NGOs): **NA**

Total number of health facilities providing ART (government+ NGOs): **NA**

Guidelines

Availability of TB/HIV guidelines/ Year: **NA**

Availability of TB Infection control guidelines/ Year: **NA**

Policies/ coverage

Active TB case-finding among PLHIV: **Yes/22 out of 75 districts are implementing**

IPT to PLHIV without TB: **No**

HCT among TB patients: **Yes/ only high-risk TB patients offered HCT/22 districts implementing**

CPT to TB patients diagnosed with HIV: **irrespective of the CD4 count/22 districts implementing**

ART to TB patients diagnosed with HIV: **irrespective of the CD4 count/22 districts implementing**

Mechanism of TB/HIV collaboration

Presence of TB/HIV collaborative bodies at the national level: **Functional**

Establishment of R & R for collecting TB/HIV indicators: **From HIV side**

TB/HIV collaborative activities (2011)

HIV-positive patients screened for TB	HIV-positive TB patients started on ATT	Newly HIV-positive cases started on IPT	TB patients tested for HIV	TB patients found HIV-positive	HIV-positive TB patients on CPT	HIV-positive TB patients on ART
30%	NA	NA	NA	NA	NA	NA

Achievements

- National coordination committee and TB/HIV technical sub-committee established
- National, regional and district-level committees formed
- In national strategic plan, TB/HIV component with budget and human resources addressed
- TB/HIV-related manuals, guidelines, policy documents and IEC materials published and updated
- TB/HIV-related basic training, refresher training, orientation, ToT to community, district-level health workers and PLHIV group conducted
- TB/HIV surveillance being conducted on a regular basis
- DOTS in ART centre established
- TB/HIV register, form and format up to periphery level HF supplied
- IPT implementation from third quarter
- Joint policy formulated with supervision and monitoring
- Programme to avoid duplication of districts selected (with AIDS control programme) for TB/HIV operationalized
- Cross-referral and integrated reporting system established

Challenges

- Limited geographical coverage and poor health sector response to TB/HIV
- Funding after 2013
- Poor integration of other health services: reproductive health, nutrition, IEC, training
- Involvement of private sector and business houses and line agencies inadequate
- Only HIV programme records and reports on TB/HIV activities
- Inadequate training status
- Cross-border issues

Priority actions

- Scale up services in 43 districts by 2015
- Identify source for sustained funding of TB/HIV
- Integrate with other programmes
- Involve other sectors and NGOs/ CBOs for TB/HIV collaboration
- Establish harmonized indicators and revise TB and HIV R & R accordingly
- Plan for regular training of staff
- Plan meetings with cross-border districts/states for addressing the migrants issue.

Sri Lanka

Demography

Population: **20 million**

Provinces/ States/ Divisions/ Regions: **9**

Districts: **25 (26 RDHS divisions)**

TB and HIV services

Total number of TB microscopy centres (government+ NGOs): **NA**

Total number of health facilities providing HCT (government + NGOs): **NA**

Total number of health facilities providing ART (government+ NGOs): **NA**

Guidelines

Availability of TB/HIV guidelines/ Year: **Yes/ 2011**

Availability of TB infection control guidelines/ Year: **NA**

Policies/ coverage

Active TB case-finding among PLHIV: **Yes/nationwide**

IPT to PLHIV without TB: **No**

HCT among TB patients: **Yes/ only high-risk TB patients offered HCT**

CPT to TB patients diagnosed with HIV: **irrespective of the CD4 count**

ART to TB patients diagnosed with HIV: **irrespective of the CD4 count**

Mechanism of TB/HIV collaboration

Presence of TB/HIV collaborative bodies at the national level: **NA**

Establishment of R & R for collecting TB/HIV indicators: **NA**

TB/HIV collaborative activities (2011)

HIV-positive patients screened for TB	HIV-positive TB patients started on ATT	Newly HIV-positive cases started on IPT	TB patients tested for HIV	TB patients found HIV-positive	HIV-positive TB patients on CPT	HIV-positive TB patients on ART
NA	NA	NA	NA	NA	NA	NA

Achievements

- Management guidelines of TB/HIV coinfection printed and disseminated to focal points in 2011
- Formats for a TB /HIV coinfection reporting system developed in May 2012; printed and disseminated in July 2012

Challenges

- Difficulties in cross-screening of TB and HIV/AIDS patients
- Delay in integration of new diagnostic technologies

- Constraints in human resources including respiratory physicians, venerologists, medical officers and paramedical staff for both sectors
- Inadequate social benefits and nutritional support for TB/HIV patients and their families
- Social stigma related to tuberculosis and HIV/AIDS

Priority actions

- Establish a strong referral system between TB and HIV programmes
- Plan training of relevant staff in TB/HIV
- Plan for ACSM activities to address stigma due to TB and HIV
- Establish harmonized M & E system for TB/HIV

Thailand

Demography

Population: **69 million**

Provinces/ States/ Divisions/ Regions: **77**

Districts: **878**

TB and HIV services

Total number of TB microscopy centres (government+ NGOs): **1100**

Total number of health facilities providing HCT (government + NGOs): **905 (868+ 37)**

Total number of health facilities providing ART (government+ NGOs): **937 (899+ 38)**

Guidelines

Availability of TB/HIV guidelines/ Year: **Yes/ 2007**

Availability of TB infection control guidelines/ Year: **Part of TB guidelines**

Policies/ coverage

Active TB case-finding among PLHIV: **Yes/nationwide**

IPT to PLHIV without TB: **No**

HCT among TB patients: **Yes/nationwide**

CPT to TB patients diagnosed with HIV: **irrespective of the CD4 count/nationwide**

ART to TB patients diagnosed with HIV: **irrespective of the CD4 count/nationwide**

Mechanism of TB/HIV collaboration

Presence of TB/HIV collaborative bodies at the national level: **Functional**

Establishment of R & R for collecting TB/HIV indicators: **Yes**

TB/HIV collaborative activities (2011)

HIV-positive patients screened for TB	HIV-positive TB patients started on ATT	Newly HIV-positive cases started on IPT	TB patients tested for HIV	TB patients found HIV-positive	HIV-positive TB patients on CPT	HIV-positive TB patients on ART
20 515 (89%)	3053 (13%)	NA	57 292 (91%)	7546 (16%)	5680 (75%)	4516 (60%)

Achievements

- HIV testing is included as a package of TB care
- Guidelines such as TB/HIV collaborative activities, provider-initiated HIV testing and counselling (PITC) and intensified case finding (ICF), as well as the recording and reporting system, were revised
- Increasing trend of HIV testing, CPT and ART over the years
- Implementing pilots of IPT in five ART centres and 41 sites reporting on process indicators of infection control

- TB/HIV activities are implemented in all 141 prisons and disaggregated data are generated

Challenges

- High death rates among TB patients with HIV infection
- Reluctance of physicians for early initiation of ART among HIV-infected TB patients
- Sustenance of training status of health-care staff
- Cross-border issues
- Quality of data
- No surveillance system in place for health-care staff

Priority actions

- Training of staff in M & E tools
- Advocacy with policy-makers regarding IPT as a strategy
- Establishment of clinical consultants' panel at national level to facilitate early ART initiation
- Planning for regular training of staff
- Strengthening M & E
- Planning for meetings with cross-border districts/states for addressing the migrants issue
- Development of M and E tools for AIC activities and TB among health-care staff

Timor-Leste

Demography

Population: **1.1 million**

Provinces/ States/ Divisions/ Regions: **13**

Districts: **65**

TB and HIV services

Total number of TB microscopy centres (government+ NGOs): **19 (17+ 2)**

Total number of health facilities providing HCT (government + NGOs): **19 (18+ 1)**

Total number of health facilities providing ART (government+ NGOs): **7 (6+ 1)**

Guidelines

Availability of TB/HIV guidelines/ Year: **Yes/ 2011**

Availability of TB Infection control guidelines/ Year: **No**

Policies/ coverage

Active TB case-finding among PLHIV: **Yes/ nationwide**

IPT to PLHIV without TB: **No**

HCT among TB patients: **Yes/ nationwide**

CPT to TB patients diagnosed with HIV: **irrespective of the CD4 count**

ART to TB patients diagnosed with HIV: **<350 CD4/ nationwide**

Mechanism of TB/HIV collaboration

Presence of TB/HIV collaborative bodies at the national level: **Functional**

Establishment of R & R for collecting TB/HIV indicators: **Yes**

TB/HIV collaborative activities (2011)

HIV-positive patients screened for TB	HIV-positive TB patients started on ATT	Newly HIV-positive cases started on IPT	TB patients tested for HIV	TB patients found HIV-positive	HIV-positive TB patients on CPT	HIV-positive TB patients on ART
1	1	NA	276 (6%)	4 (1.4%)	4 (100%)	4 (100%)

Achievements

- TB/HIV collaboration body established in early 2009; it is conducting quarterly meetings
- national TB-HIV collaborative framework developed and joint training conducted
- Timor-Leste has 19 microscopy centres with 17 having co-located VCT in 13 districts
- Cross-referral initiated in several public and private health facilities
- In 2011, a total of 276 i.e. 6% of total TB patients knew their HIV status and four were having coinfection.

Challenges

- Limited human resources with lack of expertise in both programmes
- Lack of skills and capacity of TB and HIV staff at all levels
- TB/HIV collaboration body not established yet at district level
- Limited VCT centres at peripheral level considering country geographical situation; TB patients residing in remote villages have problem in accessing VCT services
- Stigma and discrimination present in several institutions
- No IC plan/ guidelines

Priorities

- Plan for regular training of staff
- Establish collaborative bodies at subnational levels
- Advocacy with HIV programme to increase access to HIV services
- Plan for joint ACSM
- Development of IC plan/ guidelines

Annex 2

Agenda

- (1) Opening, introduction and objectives.
- (2) Overview of global and regional updates on TB/HIV collaboration.
- (3) Review the evidence of decreasing burden of TB in people living with HIV/AIDS and decreasing burden of HIV in TB patients.
- (4) Share the best practices in TB/HIV collaborative activities in countries and discuss the role of partners and community organizations in scaling up.
- (5) Identify challenges and priority actions to strengthen TB/HIV collaboration through group work.
- (6) Draft a response plan to accelerate implementation of TB/HIV collaborative activities.
- (7) Conclusions and recommendations.

Annex 3

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Tuberculosis (TB) is the most common presenting illness among people living with HIV. At least one third of the 34 million people living with HIV worldwide are infected with TB. These coinfecting persons are 21-34 times more likely to develop active TB disease than persons without HIV. TB is the leading cause of death among people living with HIV. Almost one in four deaths among people with HIV is due to TB.

Globally, of the estimated 8.8 million incident TB cases in 2010, about 1.1 million (13%) were among people living with HIV. In the South-East Asia Region (SEAR), HIV prevalence among new TB patients is 5.7%, which is equivalent to 180 000 incident TB cases living with HIV. This constitutes nearly 15% of the global burden of new HIV-positive TB cases.

Considering the urgency of the need to scale up implementation of TB/HIV collaborative activities in the Region, and to provide strategic guidance for implementation, WHO-SEAR convened a workshop for TB and HIV programme managers, NGOs, community-based organizations and WCO staff.

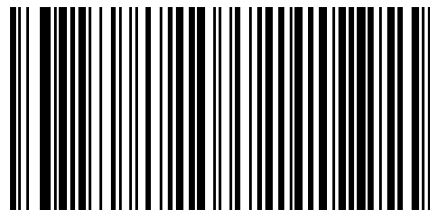
Recommendations for scaling up TB/HIV collaborative activities in countries emerged from the workshop.



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SEA-TB-342