

Regional Response Plan for TB/HIV collaboration, 2012–2015



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Regional Response Plan for TB/HIV collaboration, 2012–2015



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Abbreviations and acronyms

ACSM	advocacy, communication and social mobilization
AIDS	acquired immunodeficiency syndrome
ART	anti retroviral therapy
ARV	anti retroviral
CBO	community-based organization
CPT	co-trimoxazole preventive therapy
DOTS	directly observed treatment short-course
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
IC	infection control
ICF	intensified case finding
IPT	isoniazid preventive therapy
MDGs	Millennium Development Goals
MNCH	maternal, neonatal and child health
NGO	nongovernmental organization
PLHIV	people living with HIV
SEAR	South-East Asia Region
TB	tuberculosis
TB/HIV	the intersecting epidemics of TB and HIV
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Foreword

The WHO South-East Asia (SEA) Region continues to bear more than one third of the global burden of tuberculosis (TB), an estimated pool of nearly 5 million cases to which about 3.5 million are added each year. This is despite a decrease of over 40% in prevalence rates since 1990. This decrease has been achieved due to good case-notification and a treatment success rate of more than 85% for the Region as a whole.

TB is the most common presenting illness and the leading cause of death 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. 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 people living with HIV. In the South-East Asia Region, HIV prevalence among new TB patients is 5.7% and accounts for nearly 15% of the global burden of new HIV-positive tuberculosis cases.

The overall HIV prevalence among the adult population is very low (0.3%) in the South-East Asian Region, but 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 the HIV infection in the South-East Asia 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. These 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. In 2009, WHO published a policy on TB Infection Control in Health Care

Facilities, Congregate Settings and Households. Furthermore, WHO revised its guidelines on intensified case-finding and isoniazid preventive therapy 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 isoniazid preventive therapy. The TB/HIV indicators were harmonized and the interlinked patient monitoring system now includes TB/HIV.

In May 2012, WHO launched a policy on collaborative TB/HIV activities which included guidelines for national programmes and other stakeholders.

Although there is substantial progress in the implementation of TB/HIV collaborative activities in the South-East Asia Region, many challenges still remain in expanding the coverage.

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. The support of partners is important in resource mobilization and in the 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 is crucial in ensuring that the WHO guidance translates from policy to action.

Central to all these efforts is the recognition that weaknesses in health systems must be addressed if we are to deliver an essential package of primary healthcare services. Primary health care is the best way to achieve concerted action by multiple sectors for equitable access to services, including TB services, and to reach the most vulnerable and those who find it hardest to seek care.

Given the nature of the TB epidemic, increased and sustained commitment will be needed, from all stakeholders, including national governments and national and international partners. Our continued collaboration is critical to deliver much-needed services more effectively and efficiently, to reach all population groups and to overcome the physical, social and financial barriers that prevent people from accessing care.

The Regional Response Plan on TB/HIV Collaboration will provide a good opportunity to review the current status of implementation of the

TB/HIV collaborative activities and to share the best practices for scaling-up the TB/HIV efforts. It will facilitate further identification of critical needs of the countries and the increased role and possible engagement of various partners and community organizations in scaling up the required interventions.



Dr Samlee Plianbangchang
Regional Director

1. Introduction

1.1 Background

Globally, there were 8.8 million estimated cases of TB in 2010 (WHO Global TB Report, 2011), of which 3.5 million (~40%) were accounted for by the South-East Asia Region (SEAR). Five countries (Bangladesh, India, Indonesia, Myanmar and Thailand) in the SEA Region are among 22 high-TB-burden countries.

As per the Global AIDS Report 2010, there were 33.3 million people living with HIV in 2009, of which 3.5 million (~10%) were accounted for by SEAR. Five countries in SEAR, India, Indonesia, Myanmar, Nepal and Thailand together contribute almost 99% of the HIV infection burden in the Region. Among them, Thailand, Myanmar and India (nine states) have generalized HIV epidemics.

In the South-East Asia Region, an estimated 3.5 million people were living with HIV in 2010 (Ref: UNAIDS report on Global AIDS epidemic, 2010), with an overall HIV prevalence among the adult population of 0.3%. Sex workers and their clients, men who have sex with men, transgenders and people who inject drugs are disproportionately affected by HIV.

Globally, one third of the population including people living with HIV is infected with TB bacilli. People living with HIV are 20 to 37 times more likely to develop TB disease during their lifetime than people who are HIV-negative. Globally, of an estimated 8.8 million TB cases in 2010, 1.1 million (13%) were people living with HIV. In South-East Asia, HIV prevalence among people with TB is 5.7%, equivalent to about 0.2 million TB patients living with HIV, and this accounts for over 15% of the global burden of new HIV-positive TB cases.

Table 1: Epidemiology of TB and HIV

Region	Estimated incidence of TB in numbers (2010)	Estimated number of people living with HIV (2009)	Estimated TB cases living with HIV (2010)	
			%	Numbers
World	8.8 million	33.3 million	13	1.1 million
SEAR	3.5 million	3.5 million	5.7	0.2 million

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, there were an estimated 1.1 million deaths from TB among HIV-negative people and an additional 0.35 million deaths from TB among HIV-positive people (WHO Global TB report, 2011).

Table 2: Epidemiology of TB and HIV in SEAR countries–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 pop	Numbers	%	Numbers
India	0.3	2 300 000	256	3 000 000	9.2	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

(Ref: TB/HIV in South East Asia Region, status report, Dec 2011)

1.2 WHO response to TB/HIV epidemic (major milestones)

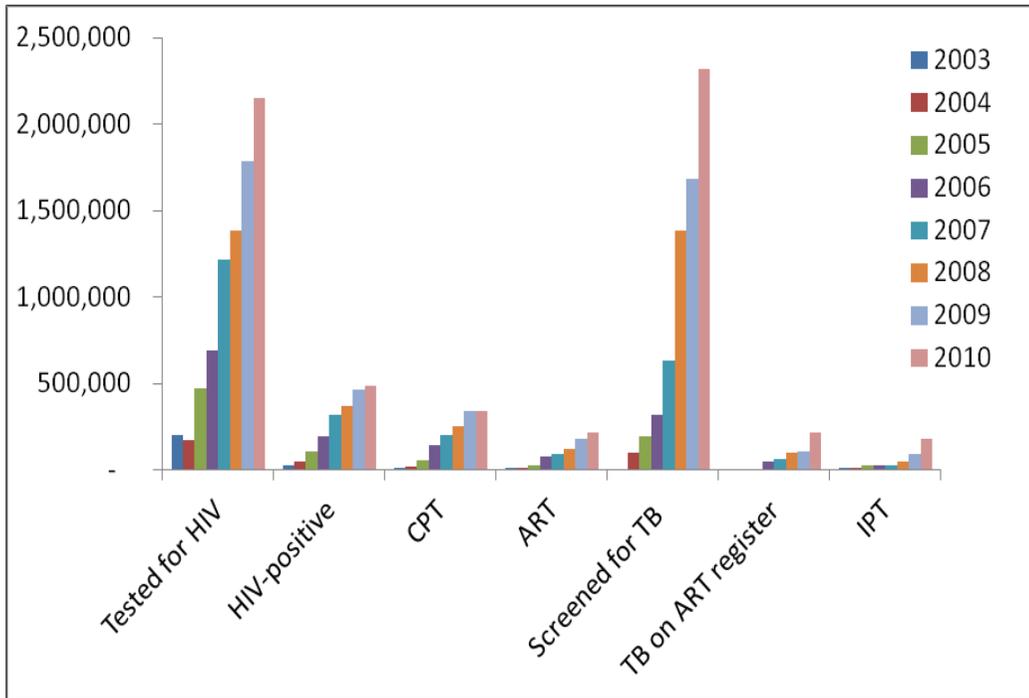
- In response to the dual (TB and HIV) epidemics in 2004, WHO published a core set of policy and programme guidance to reduce the impact of the TB and HIV epidemics. WHO recommended 12 collaborative TB/HIV activities which include activities:
 - to establish a mechanism for collaboration;
 - to decrease the burden of TB in people living with HIV/AIDS; and
 - to decrease the burden of HIV in TB patients.
- WHO began monitoring the implementation and expansion of collaborative TB/HIV activities in 2004 and included key TB/HIV elements in the WHO standard data collection form.
- WHO South-East Asia Region responded to the dual epidemic of TB and HIV by adapting global strategies and guidelines to the unique needs of the Region in 2004.
- Building on the successes of the DOTS strategy and to meet the targets of the Global Plan for TB Control, 2006-2015 and MDG targets, the Stop TB Strategy was published in 2006, which included TB/HIV as an important component.
- In 2007, WHO issued guidance on improving diagnosis of smear-negative and extra-pulmonary cases among adults and adolescents in high HIV-prevalent settings.
- In 2008, WHO, the UN Office on Drugs and Crimes (UNODC) and UNAIDS jointly developed the guidelines for collaborative TB/HIV services for injecting drug users.
- In 2009, WHO published a policy on TB Infection Control in Health Care Facilities, Congregate Settings and Households.
- In 2009, WHO developed a guide for monitoring and evaluation of TB/HIV collaboration for TB and HIV control programmes.
 - The TB/HIV indicators were harmonized and the interlinked patient monitoring system now includes TB/HIV.

- The guidelines on ICF/IPT were revised in 2010 and recommended the use of simplified symptom-based screening algorithm to identify those people living with HIV who are unlikely to have active TB and hence eligible for IPT.
- After collecting the evidence, in 2011, WHO made a strong recommendation to include Xpert MTB/RIF in the initial diagnostic workup in individuals suspected of HIV-associated TB.
- 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 recommendations follow the same framework as the 2004 interim policy document:
 - 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.
- The Global Plan for TB Control was updated for 2011- 2015 and new targets were set for TB/HIV collaborative activities

1.3 Progress made on implementation of TB/HIV collaborative activities

Since WHO began monitoring the implementation of TB/HIV activities in 2003, considerable progress has been made globally and in SEAR.

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



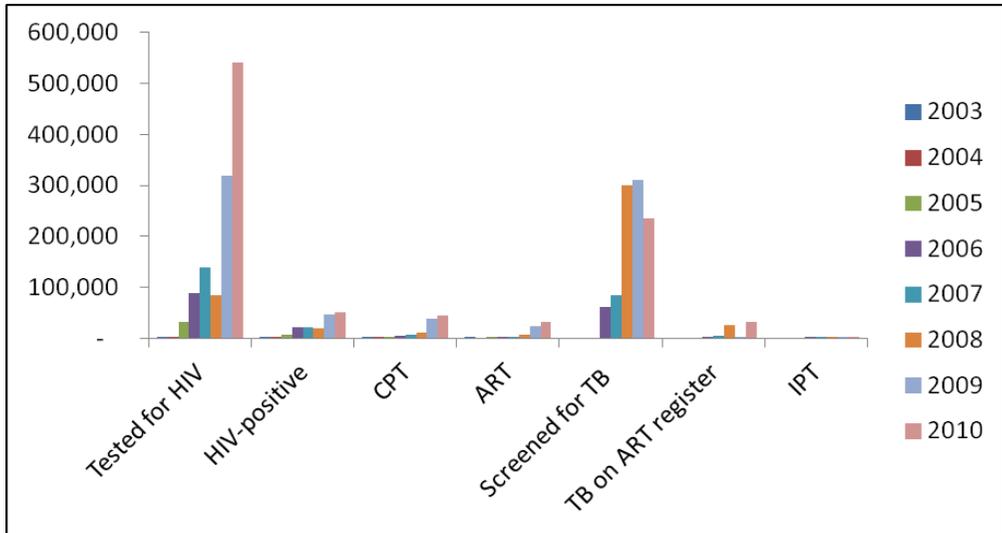
As shown in Figure 1, globally, the number of TB patients who knew their HIV status reached 2.1 million in 2010, equivalent to 35% of notified TB cases.

Globally, over 0.3 million TB patients living with HIV were enrolled on CPT, equivalent to 77% TB patients known to be HIV-positive in 2010.

Globally, the number of HIV-positive TB patients on ART steadily increased since 2003 and reached over 200 000 in 2010 equivalent to 46% of TB patients known to be living with HIV in this year.

TB screening among people living with HIV and provision of IPT have steadily increased. Globally, 2.3 million PLHIV were screened for TB, which is equivalent to 58% of the reported number of people who were enrolled in HIV care in 2010 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 in HIV care in 2010.

Figure 2: **SEAR implementation of TB/HIV collaborative activities (2003–2010)**



In SEAR, the number of TB patients tested for HIV reached over 0.5 million in 2010, which is equivalent to 23% of the total notified TB cases in a year.

In 2010, over 45 000 HIV-positive TB patients, equivalent to 87% of TB patients known to have HIV were enrolled on CPT in SEAR, one of the highest levels of enrolment on CPT compared with other Regions.

The number of HIV-positive TB patients put on ART showed a gradual increase and reached over 32 000 in 2010, which is equivalent to 57% of TB patients known to be living with HIV.

However, slow progress was made on TB screening and IPT for PLHIV in the Region. Only about 0.2 million HIV-positive people were screened for TB in 2010, and a small number, 581, enrolled on IPT in the Region.

1.4 Major challenges identified in implementation of TB/HIV collaborative activities in SEAR

Despite substantial progress in implementation of TB/HIV collaborative activities in SEAR, the expected outcomes could not be fully met. The countries faced many challenges in scaling-up the implementation of various components of TB/HIV collaboration, as described below.

Challenges identified in establishing a mechanism for TB/HIV collaboration

- Sub-optimal functioning of TB/HIV collaborative bodies at the national and sub-national levels in some countries.
- Poor representation of partner organizations, NGOs/ CBOs and people affected by two diseases in TB/HIV collaborative bodies.
- Limited geographical coverage of TB/HIV collaboration in some high-and most low-burden countries.
- Inadequate HR and technical capacity mostly in low-burden countries.
- Limited involvement of NGOs/CBOs in implementation of TB/HIV collaborative activities in most countries.
- Wide service gap between TB and HIV programmes compounded by a weak referral linkage.
- Inadequate availability of funding for expansion, in almost one third of countries in the Region.
- Cross-border migration is a challenge for some landlocked countries.
- Little progress in addressing children, women, people who use drugs and in involving prisons.
- Challenges in revision of recording and reporting system, harmonization of indicators between TB and HIV programmes and maintaining high quality of data, in most countries.
- Limited collaboration between TB and HIV programmes in data management and M&E activities.
- Limited operational research activities in TB/HIV.

Challenges identified in implementation of 3I's and early initiation of ART

- No uniform adoption of WHO recommended standard symptom screening algorithm for PLHIV especially children living with HIV, for TB.
- Misinterpretation and hence wrong reporting on “number and proportion of PLHIV screened for TB” in some high-burden

countries; reporting only those PLHIV who are investigated for TB.

- No nationwide implementation of IPT in any country in the Region. IPT policy has not been adopted in a number of countries.
- Poor implementation of infection control activities in almost all countries.

Challenges identified in implementation of HCT and HIV prevention and uptake of CPT and ART

- More than one third countries in the Region do not have a policy to screen all TB patients for HIV and only test a small number of TB patients with high risk of HIV infection.
- Limited access to ARV in some countries, especially Myanmar.
- Low ART uptake among TB patients living with HIV in most countries, and limited integration of ART and TB treatment services are the reasons for low uptake.

2. Regional response plan for TB/HIV collaboration, 2012-2015

2.1 Need for a regional plan

SEAR accounts for 26% of the global population but bears almost 40% of the TB burden. Although the per capita rate of HIV is low in the Region, many countries are witnessing an increasing trend of TB patients living with HIV.

Countries in SEAR have made some progress in implementation of TB/HIV collaborative activities, especially after the adoption of WHO guidelines on TB/HIV, published in 2004. However, the existing progress is not adequate to dramatically reduce the burden of TB/HIV in the Region. Moreover, many countries in the Region lack adequate implementation of all recommended TB/HIV collaborative activities and face critical challenges as described above, in scaling-up of implementation.

Recently, WHO has published many policy guidelines, based on latest evidence to guide Member States to effectively reduce the burden of HIV-

related TB. The WHO Stop TB Partnership updated the Global Plan for TB for the period 2011-2015, by taking account of mid-way progress of implementation of the Global Plan 2006-2015, new evidence and current epidemiological context. More realistic and ambitious targets have been set for 2015 for TB control including for TB/HIV.

WHO-SEARO aims to reduce the burden of HIV-related TB in the Region by adopting and adapting recent WHO policy and guidelines for TB/HIV collaboration. Considering the regional differences in epidemiology and resources, the Region-specific plan and targets for TB/HIV are essential for suiting the regional need.

In a new regional plan, WHO-SEARO takes into account lessons learnt by implementing TB/HIV collaborative activities since 2003 and aims to respond to challenges and tap the opportunities in order to strengthen and scale-up TB/HIV collaboration in the Region.

The Regional Strategic Plan for TB/HIV will complement the Global Plan for TB control with the ultimate goal of achieving MDGs and Stop TB targets.

The regional plan is intended to provide strategic direction to the countries in the Region to prioritize activities and set reasonable targets. It will guide how interventions are to be further expanded and improved by strengthening the health system and improving access and equity.

2.2 Regional plan development process

In July 2012, WHO-SEARO organized a workshop of the national TB and HIV programme staff and relevant partners to review the status of implementation of TB/HIV collaborative activities, share best practices, discuss the role of partners and community organizations in scale-up and to draft a country response plan for accelerating TB/HIV collaborative activities.

At the end of the workshop, participating countries identified priority actions as a result of discussion on the status and challenges of implementation of TB/HIV collaborative activities. The countries developed draft response plans for the acceleration of implementation of TB/HIV collaborative activities in consultation with the stakeholders.

Recent WHO guidelines, the global plan 2011-2015 and country situations were taken into consideration to draft a strategic plan for TB/HIV collaboration.

The strategic plan was finalized after a wide consultation with WHO experts, country TB and HIV programme managers and stakeholders.

2.3 Structure and content of the plan

The Regional Plan for TB/HIV collaboration 2012-2015, defines what needs to be done to achieve the 2015 targets set within the context of MDGs and Stop TB Partnership.

The plan is structured in a logical sequence of goal, objectives, recommended TB/HIV activities and major indicators and targets.

2.4 Expected achievements in SEAR if the plan is fully implemented

If the required funding is mobilized for the implementation of this plan in SEAR, there will be substantial achievements in implementation of TB/HIV collaborative activities as mentioned below.

By the end of 2015 (in a four year period)

More than 2.8 million PLHIV are screened for TB

Assumption

In SEAR, there are an estimated ~3.5 million people living with HIV, of them about 20% are enrolled (700 000) and are visiting HIV care facilities every year. Achieving the target of screening 100% of them for TB will result in 2.8 million PLHIV screened for TB in four years.

About 0.12 million new HIV-positive patients started on IPT

Assumption

In SEAR, about 200 000 people contract HIV infection every year and of them, it is assumed that, 20% (40 000) are enrolled and of the enrolled, 80% (32 000) are eligible for IPT. Achieving 100% IPT among eligible people will result in about 0.12 million new HIV-positive patients started on IPT in four years.

Over 9 million notified TB patients (~2.3 million per year) are tested for HIV and 0.5 million are diagnosed as TB patients living with HIV

Assumption

In SEAR, about 2.3 million TB cases (of all types) are notified every year and achieving the target of HIV testing of 100% of them will result in a total of 9 million TB cases tested for HIV in four years.

In SEAR, HIV prevalence in TB cases is about 5.7% and applying that to the number tested (9 million) results in detection of 0.5 million TB patients living with HIV.

About 0.5 million TB patients living with HIV (all 100%) are started on CPT and ART

Assumption

Achieving the target of putting all diagnosed HIV-infected TB cases on CPT and ART will result in about 0.5 million TB patients living with HIV started on CPT and ART in four years.

3. Framework for implementation of the Regional Response Plan for TB/HIV collaborative activities, 2012-2015

The regional framework is aligned to the WHO policy on collaborative TB/HIV activities and the global plan for TB control, 2011-2015.

3.1 Goal

To reduce the burden of HIV-associated TB in the Region.

3.2 Objectives, targets and priority actions

To achieve the above goal, the plan includes eight major objectives and associated targets and activities as described below:

Objective 1: Strengthen mechanism for delivering integrated TB and HIV services.

Objective 2: Establish harmonized indicators and standard recording and reporting of TB/HIV activities.

Objective 3: Scale up TB screening among people living with HIV.

Objective 4: Implement IPT among people living with HIV and who do not have active TB.

Objective 5: Implement measures for TB infection control in health care facilities especially those providing services to TB patients and people living with HIV and in congregate settings.

Objective 6: Scale up access to HIV testing among TB patients.

Objective 7: Scale up access to early ART for HIV-positive TB patients.

Objective 8: Scale up access to CPT among HIV-positive TB patients.

Objective 1: Strengthen mechanism for delivering integrated TB and HIV services

Joint strategic planning is essential to successfully and systematically scale up collaborative TB/HIV activities nationwide and deliver integrated TB and HIV services. TB/HIV collaborative bodies at different levels in the health system provide a platform for joint planning, coordination and synergy among stakeholders.

Target for WHO-SEARO by 2015

100% countries in the Region have developed a budgeted plan for scaling up of TB/HIV collaborative activities.

Recommended activities

- 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.
 - Formulate clear terms of reference and responsibilities of the collaborative body.
- Develop/revise TB/HIV guidelines by incorporating internationally recommended evidence-based policies.
- Formulate an operational plan for implementing TB/HIV collaborative activities that includes a plan to:

- Expand geographical coverage of integrated TB and HIV services to improve access.
- 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 and communities including those affected by the two diseases in planning, implementation and monitoring of TB/HIV collaborative activities.
- Mobilize resources for strengthening and expansion of TB/HIV collaboration.
- Strengthen linkage with MNCH, harm reduction services, high-risk groups including migrants etc.
- Implement joint ACSM activities.
- Conduct operational research for improving implementation.
- Advocate with policy makers for:
 - Accelerating and scaling-up uptake of HCT of TB patients, ART, IPT, and implementation of IC measures.
 - Placement of adequate and skilled human resources in TB and HIV control programmes.
 - Expanding infrastructure/ geographical coverage and minimizing service gap between TB and HIV programmes.
 - Allocating adequate resources.

Objective 2: Establish harmonized indicators and standard recording and reporting of TB/HIV activities

Monitoring and evaluation provides the means to assess the quality, effectiveness, coverage and delivery of collaborative TB/HIV activities. Establishing and identifying harmonized indicators that should be captured by each programme using standard recording and reporting formats are essential to avoid duplication of efforts.

Target for WHO-SEAR by 2015

100% countries in the Region are reporting on key harmonized TB/HIV indicators.

Recommended activities

- Standardize recording and reporting formats to collect harmonized data on key TB/HIV collaborative activities :
 - Train relevant staff in collection, quality assurance, analysis and interpretation of TB/HIV data.
- Establish strong referral/ feedback linkages and data harmonization between TB and HIV programmes.
- Establish harmonized indicators with minimum set of following key TB/HIV indicators: (1) Proportion of TB patients with known HIV status; (2) Proportion of HIV-positives among HIV-tested TB patients; (3) Proportion of HIV-positive TB patients who receive ART; (4) Proportion of HIV-positive TB patients who receive CPT; (5) Percentage of HIV-positive screened for TB; (6) Percentage of new HIV-positive patients starting IPT.
- Plan for regular joint supervision and review of TB/HIV component.

Objective 3: Scale up TB screening among people living with HIV

People living with HIV are 20-37 times more likely to develop TB disease in their lifetime than people who are HIV-negative. Early identification of signs and symptoms of TB in PLHIV followed by diagnosis and prompt initiation of TB treatment increases chances of survival, improve quality of life and reduces transmission of TB.

Target for WHO-SEAR by 2015

100% patients visiting HIV care facilities are screened for TB using a clinical symptom-based algorithm.

Recommended activities

- Screen all adults and adolescents living with HIV for TB by using a clinical symptom-based algorithm (current cough, fever, weight loss or night sweats) at every visit of the patient to HIV care facilities.
- Screen all children living with HIV for TB by using a clinical symptom-based algorithm (poor weight gain, fever, current cough or contact history with TB case) at every visit of the patient to HIV care facilities.

- Train health staff working in HIV care facilities on screening of PLHIV including children for TB and ensure application/implementation of symptom-based tools (both for adults/ adolescents and children) in all HIV care facilities.
- Modify HIV recording and reporting formats according to the international guidelines (three interlinked patient monitoring systems) to capture ICF/ IPT activities.
- Refer all TB suspects to appropriate health facilities for detailed investigations as per the national guidelines.
- TB programme to initiate TB treatment for all diagnosed TB cases as per the national guidelines.

Objective 4: Implement IPT among people living with HIV and who do not have active TB

Current evidence shows that, INH preventive therapy is effective in reducing the incidence of TB and death from TB in HIV-infected patients. Exclusion of active TB by symptom-based screening is critically important before IPT is started. The greater benefit is seen in those with positive tuberculin test. However, operational challenges for tuberculin test represent significant challenges in accessing IPT in resource-limited settings. It is therefore recommended that, tuberculin test should not be a requirement for initiating IPT in PLHIV.

Target for WHO -SEAR by 2015

100% of eligible newly enrolled PLHIV including children are initiated on IPT.

Recommended activities

- Build consensus on policy and implementation of IPT among PLHIV including children.
- Develop guidelines for implementation of IPT among adults, adolescents and children living with HIV.
- Consider IPT for all adults, adolescents and children of >12 months having no TB symptoms on screening, as per the guidelines.
- Train health staff in HIV care facilities in IPT implementation.
- Procure and supply INH to all HIV care facilities.

Objective 5: Implement measures for TB infection control in health care facilities especially those providing services to TB patients and people living with HIV and in congregate settings

In health-care facilities and congregate settings where people with TB and HIV are frequently crowded together, infection with TB increases. HIV promotes progression to active TB disease in infected individuals. Evidence has shown an increased risk of TB exacerbated by the HIV epidemic, among healthcare workers and people in congregate settings. Improving access to HIV and TB prevention, treatment, care and support services for healthcare workers, as well as of workers in congregate settings, is therefore crucial.

Target for WHO-SEAR by 2015

100% countries have developed national TB infection control plans.

100% countries are reporting on the number and proportion of health care staff in TB and HIV health care facilities developing TB every year.

Recommended activities

- Develop national TB infection control guidelines and a national TB infection control plan.
- Designate a focal person for infection control in each health facility.
- Implement administrative, environmental and personal protective measures as per the guidelines.
- Establish a system of regular surveillance of TB disease in health care staff including staff working in congregate settings like prisons, police and military barracks etc.
- Establish a system for monitoring implementation of measures for TB infection control.

Objective 6: Scale up access to HIV testing among TB patients

Evidence has shown that, prevalence of HIV is higher among TB patients, their contacts and TB suspects. HIV testing and counselling of TB patients offers an entry point for continuum of prevention, care, support and treatment for HIV and for TB.

Target for WHO-SEAR by 2015

100% of notified TB patients in the Region know their HIV status.

Recommended activities

- Develop a policy to test all notified TB patients irrespective of the status of risk, for HIV.
- Scale-up implementation of the policy to test all notified TB patients for HIV.
- Ensure availability of HIV test kits.
- Establish a system so that, 100% of HIV results are recorded and reported by the TB Programme.
- Conduct operational research on feasibility and yield of HIV screening among TB suspects.

Objective 7: Scale up access to early ART for HIV-positive TB patients

Antiretroviral therapy greatly improves the survival and quality of life of TB patients living with HIV and prevents HIV transmission. Evidence shows that early initiation of ART during anti-TB treatment is associated with a significant reduction in mortality rates.

Target for WHO-SEAR by 2015

100% of HIV-infected patients with active TB disease are receiving ART within the first two months after start of TB treatment.

Recommended activities

- Initiate ART to all TB patients living with HIV irrespective of CD4 counts (children & adults).
 - Initiate ART as soon as possible after the start of anti-TB treatment.
- Establish strong referral/ feedback linkage between TB sites and ART centres.
- Ensure uninterrupted availability of ARV drugs.
- Establish a system so that, all active TB patients on ART are recorded and reported in TB Programme's R&R system.

- Expand and decentralize ART services to improve universal access to HIV treatment.
- Conduct operational research on feasibility and outcomes of integration models for ART and TB treatment services, e.g. provision of ART at TB facilities.

Objective 8: Scale up access to CPT among HIV-positive TB patients

Co-trimoxazole preventive therapy (CPT) is a broad spectrum antimicrobial agent that prevents a range of secondary bacterial and parasitic infections in eligible adults and children living with HIV. CPT is a simple, safe and cost-effective intervention for people living with HIV and reduces the mortality rate in TB patients.

Target for WHO-SEAR by 2015

100% of HIV-infected patients with active TB disease are receiving CPT.

Recommended activities

- Provide CPT to all HIV-infected patients (children and adults) with active TB disease regardless of CD4 counts.
- Ensure uninterrupted availability of CPT at appropriate sites decided by the programmes.
- Establish a system so that, all TB patients on CPT are recorded and reported in by the TB Programme.

3.3 Summary of goal, objectives, indicators and targets

Table 3: goal, objectives, indicators and targets

Goal and Objectives	Indicators	Baseline (2011)	Targets (2015)
Goal: To reduce the burden of HIV-associated TB in the Region	Percentage reduction in TB deaths among HIV-positive people by 2015 compared with baseline of 2004	NA	50%
Objective 1: Strengthen mechanism for delivering integrated TB and HIV services	No. of countries developed budgeted plan for scaling up of TB/HIV collaborative activities	7	11

Goal and Objectives	Indicators	Baseline (2011)	Targets (2015)
Objective 2: Establish harmonized indicators and standard recording and reporting of TB/HIV activities	No. of countries reporting on key harmonized TB/HIV indicators	7	11
Objective 3: Scale up TB screening among people living with HIV	Percentage of all people living with HIV enrolled in HIV care screened for TB, during their previous visit to HIV care services	NA	100%
Objective 4: Implement IPT among people living with HIV and who do not have active TB	Percentage of people living with HIV newly enrolled in care started on IPT	<1%	80% (100% of eligible)
Objective 5: Implement measures for TB infection control in health care facilities especially those providing services to TB patients and people living with HIV and in congregate settings	Number of countries developed national TB infection control plan	8	11
	Number of countries reporting on no. and proportion of health care staff developing TB every year	0	11
Objective 6: Scale up access to HIV testing among TB patients	Percentage of TB patients who know their HIV status	23%	100%
Objective 7: Scale up access to early ART for HIV-positive TB patients	Percentage of TB patients diagnosed as HIV-positive started on (or continuing) ART	57%	100%
Objective 8: Scale up access to CPT among HIV-positive TB patients	Percentage of TB patients diagnosed as HIV-positive started on (or continuing) CPT during TB treatment	87%	100%

3.4 Role of WHO-SEARO in implementation of TB/HIV collaborative activities in the Region

WHO-SEARO will coordinate the regional-level efforts to reduce the burden of HIV-related TB in the Region.

Priority actions

- Organize meetings of all TB and HIV programme managers with the involvement of country level partners, NGOs, CBOs and people affected by the two diseases every two years to:
 - Review progress in implementation.
 - Discuss challenges and priority actions for improving implementation.
- Disseminate global policy guidance to all countries.
- Coordinate technical assistance to countries in planning, implementation and review of TB/HIV collaborative activities by:
 - Harmonizing technical assistance through TBTEAM and other partners.
- Advocate with the Member States to promote TB/HIV activities.
- Mobilize resources to support countries for strengthening activities.

4. 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) WHO guidelines for intensified TB case finding and INH preventive therapy for PLHIV in resource- constraint settings, WHO 2011
- (5) TB/HIV in South-East Asia Region, status report, Dec 2011

WHO aims to reduce the burden of HIV-related tuberculosis (TB) in the South-East Asia Region by adopting and adapting recent WHO policy and guidelines for TB/HIV collaboration. Considering the regional differences in epidemiology and resources, the Region specific plan and targets for TB/HIV are essential for meeting Regional needs.

In a new Regional plan, WHO takes into account lessons learnt by implementing TB/HIV collaborative activities since 2003 and aims to respond to challenges and tap into opportunities in order to strengthen and scale up TB/HIV collaboration in the Region.

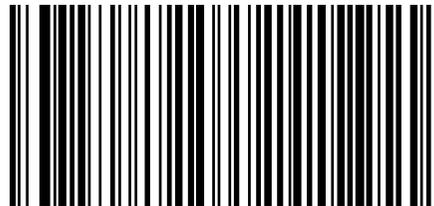
The Regional Strategic Plan for TB/HIV will complement to the Global Plan for TB control with the ultimate goal of achieving targets of the Millennium Development Goals and Stop TB. The Regional Plan is intended to provide strategic direction to the countries in the Region to prioritize activities and set reasonable targets. It will guide how interventions can be further expanded and improved by strengthening health systems and improving access and equity.



**World Health
Organization**

Regional Office for South-East Asia

World Health House
Indraprastha Estate,
Mahatma Gandhi Marg,
New Delhi-110002, India



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