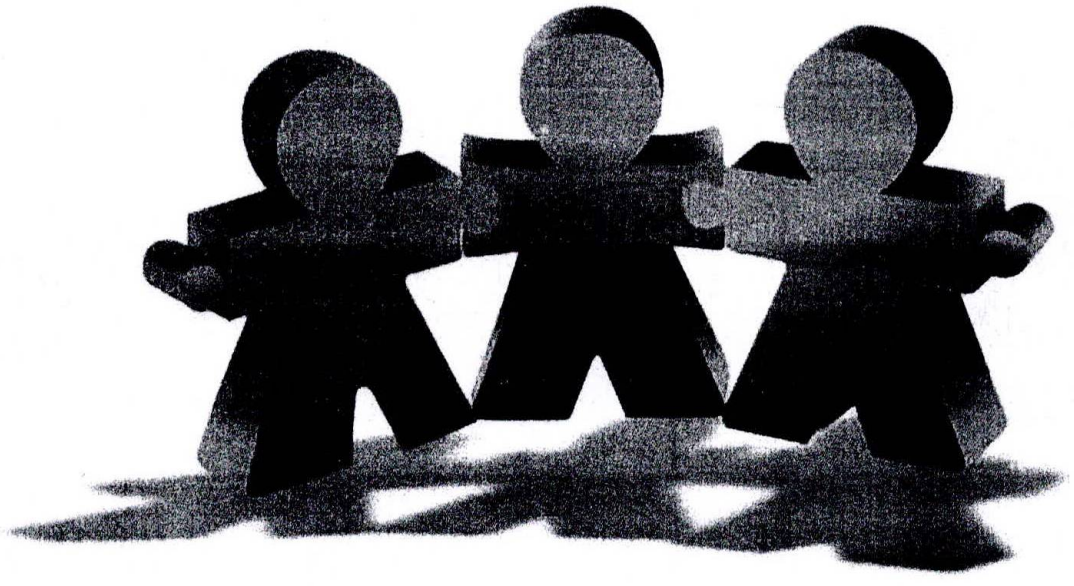
Training Manual on Intensified *TB/HIV Package*

for NACP & RNTCP Programme Managers

at State and District level



Central TB Division and National AIDS Control Organization

Ministry of Health and Family Welfare

Government of India

New Delhi

June 2008

DOTS-
sure cure for TB.

NACO

Intensified TB/HIV package

Training Manual for NACP & RNTCP Programme Managers

and Supervisors at State and District level

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Preface

It is estimated that 2.5 million people are infected with HIV in India and considering estimated 40% of the Indian population is infected with Mycobacterium tuberculosis, an estimated 1 million persons are co-infected with Mycobacterium tuberculosis & HIV. HIV is the most powerful risk factor for the progression of TB infection to TB disease. Active TB disease is the commonest opportunistic infection amongst HIV-infected individuals and is also the leading cause of death in PLHA (People living with HIV/AIDS). This is further substantiated by the fact that an HIV positive person has 50-60% lifetime risk of developing TB disease as compared to an HIV negative person who has a lifetime risk of 10% of developing the TB disease.

HIV survey amongst the TB patients jointly conducted by CTD & NACO has shown 1% to 13% HIV amongst TB patients. This diverse data shows us that different strategies need to be employed within the country to reach out to PLHAs and addresses their needs for early diagnosis, treatment and care & support. The need of the hour is to establish an intensified package of services for TB-HIV for high HIV prevalence areas and a basic package for the rest of the country.

TB can be easily cured through the DOTS strategy provided through RNTCP; there is still no cure for HIV. With ART being provided free through NACP, HIV is now a **chronic manageable illness**.

The basic purpose of HIV-TB collaborative activity is to ensure synergy between the two programmes for the prevention and control of both diseases. National Framework for joint TB/HIV collaborative activities has been laid down by both the programmes and the collaborative activities have yielded very promising results over the last few years. In order to further strengthen the collaborative activities training of staff is very crucial. To streamline training, both the programmes have come up with joint modules which address the training needs of various categories of staff. It is envisaged, that standardized modular training shall be imparted to all the Programme and general health staff in the country.

The modules cover the relevant aspects of both the diseases comprehensively, and will be a valuable guide for the different category of health service provider towards discharging their duties optimally. We hope this module would be useful for further strengthening the TB/HIV collaborative activities in the country.

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Acknowledgements

This training material has been prepared jointly by Central TB Division, DGHS & National AIDS Control Organization for the training of programme managers under the guidance of Dr Jotna Sokhey, Addl DG, NACO and Dr LS Chauhan, DDG (TB) CTD, DGHS by a writing group comprising of Dr. A. K. Khera, Dr. Devesh Gupta, Dr. Neeraj Raizada, Dr. Rahul Thakur and Dr. Puneet Dewan.

INTRODUCTION:

Active TB disease is the most common opportunistic infection amongst HIV infected individuals. From the public health point of view, the best way to prevent TB is to provide prompt effective diagnosis & treatment to people with infectious TB. This interrupts the chain of transmission. For HIV-infected patients who have TB, they will benefit from HIV-related care and treatment. Basic TB/HIV collaborative interventions are necessary across the country. These include the establishment of coordination mechanisms at all levels, service delivery coordination and cross referrals, involvement of NGOs in TB/HIV activities, and implementation of airborne infection control measures in HIV care settings.

Surveillance has shown that where HIV seroprevalence is high, HIV infection among TB patients is also common. Because of this association, in areas where HIV seroprevalence is high and HIV testing services are widely available, it is important that patients with tuberculosis have the opportunity to know their HIV status. An Intensified TB/HIV Package of Services has been established for high HIV prevalence areas. This package would facilitate early detection of HIV infection in TB patients and promote early access to HIV care and treatment, and is expected to reduce death and disease among HIV-infected TB patients.

HIV counselling and testing and care and treatment services including management of OIs, Cotrimoxazole Prophylaxis and access to ART is rapidly expanding and widely available under the National AIDS Control Programme. Management of TB is provided through widely acclaimed DOTS strategy under RNTCP which now provides emphasis amongst HIV/TB patients for management of TB and early linkage to care & support services.

The expanded scope of a new approach to TB control in populations with high HIV prevalence comprises of up scaled interventions against TB and HIV. Interventions include intensified case finding at high HIV settings like ART centers, Community Care Centers (CCCs), NGO led Targeted Intervention sites (TIs). This would help in early diagnosis of HIV/TB patients and provision of care & support including DOTS treatment for TB, CPT prophylaxis and ART. Counsellors and clinicians at HIV care settings regularly interact with persons living with HIV and thus are in the key position to refer to the nearest RNTCP services when indicated. Therefore, the crucial service delivery sites of NACP i.e. ICTCs, ART centres, Community Care Centres, and Targeted Intervention sites should be effectively involved for implementation of the up scaled activities.

ROUTINE OFFER OF HIV TESTING TO ALL TB PATIENTS

Rationale

HIV counselling and testing is now widely available under the National AIDS Control Programme. For persons who are HIV-infected, care and treatment services are also widely available, and access to treatment for HIV infection is rapidly expanding. Surveillance has shown that where HIV seroprevalence is high, HIV infection among TB patients is common. Because of this association, it is important that patients with tuberculosis have the opportunity to know their HIV status. This will allow appropriate prevention, care, and treatment for patients and their families.

HIV testing of TB patients

Central TB Division (CTD) & the National AIDS Control Organization (NACO) have adopted the policy of **routinely offering voluntary HIV counselling and testing to all TB patients** as part of an intensified TB/HIV package of services for states with the highest HIV burden. This policy will facilitate early detection of HIV infection in TB patients, and lead to early access to HIV care and treatment. These interventions are expected to reduce death and disease among HIV-infected TB patients.

In these states, providers will routinely offer of voluntary counselling and testing for all TB patients, except those with an already known HIV status. "Known" HIV status means those patients with a history of positive HIV test from an ICTC or those with a negative HIV test from ICTC within the past 6 months. HIV test results from ICTCs are preferred because there HIV testing uses reliable laboratory kits, is conducted using a multiple-test algorithm to reduce false results, and is properly accompanied by counselling.

TB patients with unknown HIV status are to be referred to the nearest and most-convenient ICTC. The referral may be made any time after TB diagnosis, during or after initiation on TB treatment (preferably at the earliest). Treating physicians and paramedical workers should explain the need and importance for patients to be confident about their HIV status, and also that HIV testing is **'voluntary'** and **'not mandatory'**. This offer should be made at least once during the course of TB treatment.

If the patient accepts the advice for VCT, then the patient is referred to the nearest ICTC using the standard "**Integrated Counselling and Testing Centre referral form**" (**Annex 2**). The counsellor during the counselling session should spend adequate time with the TB patient to explain the importance of sharing their HIV test result with the treating physician, for better care. To facilitate the process of routine referral of TB patients a one-page tool (**Annex 1**) reminding providers about the need to determine the HIV status of TB patients should be widely disseminated to all PHIs, and used during medical officer, nursing, and paramedical staff trainings.

KEY POINTS
➢ All TB patients should have the chance to know their HIV status. ➢ Quality-assured HIV counselling and testing is available widely at ICTCs. ➢ All TB patients should be routinely offered voluntary HIV counselling and testing. ➢ All HIV-infected TB patients should be provided CPT and promptly referred for ART. **What should programme officers know?** ➢ Providers and paramedical staff will require training and monitoring to implement new policy and records. ➢ HIV status and CPT/ART will be recorded on TB treatment cards, TB registers, and for the cohort will be reported on quarterly reports. ➢ CPT will be provided locally to HIV-infected TB patients at PHI level, facilitated by RNTCP ➢ The recording of HIV status and updating of CPT and ART information on treatment cards must be included in routine monitoring and supervision activities. **What should providers and paramedical staff do?** ➢ Refer patients to nearest ICTC. ➢ Who need NOT be referred to an ICTC? o Patients who report being HIV-positive, with results from an ICTC. o Prior HIV test result negative from an ICTC in past 6 months. ➢ Use the referral form to facilitate feedback. ➢ Document HIV status on treatment card. ➢ Patient history alone is adequate to record HIV status. ➢ Prescribe CPT and ensure prompt referral to ART centre. ➢ Follow up with patient to ensure CPT and ART being taken. ➢ Document CPT and ART on original TB treatment cards only

Communication of HIV test result to treating physician: 'Shared CONFIDENTIALITY'

ICTC Counsellors will counsel patients to share their HIV result with the referring physician. In addition, unless patients object counsellors should directly and confidentially share HIV test results with the referring or treating physician, to ensure optimal care & case management. Knowledge of HIV status will enable providers to:

- Provide the correct anti-TB treatment and correctly manage other illnesses.
- Counselling to reduce risk to current and future partners
- Linkage to social support services
- Initiate Cotrimoxazole Preventive Therapy (CPT).
- Prompt referral for anti-retroviral treatment.

The **mechanisms** for sharing the HIV status of referred TB patient, by the counsellor with the treating physician are as under:

1. **Through the client:** The Counsellor counsels the client to share the HIV test result, completes the referral form, and sends the form via the client to the referring physician. Also while referring a known HIV-infected clients suspected of having TB to RNTCP, the counsellors asks client to share his/her HIV test report with the treating physician.

2. **By the counsellor:** When the physician referring the TB patient for HIV testing which is physically located in the same premises as the ICTC or in very close proximity, after advising

the patient the ICTC Counsellor can personally share the HIV result with the concerned Medical Officer.

3. **By the counsellor –telephonically**: The counsellor can, after advising the client, communicate the HIV test result to the treating physician telephonically, using the telephone of the facility where the ICTC is located.

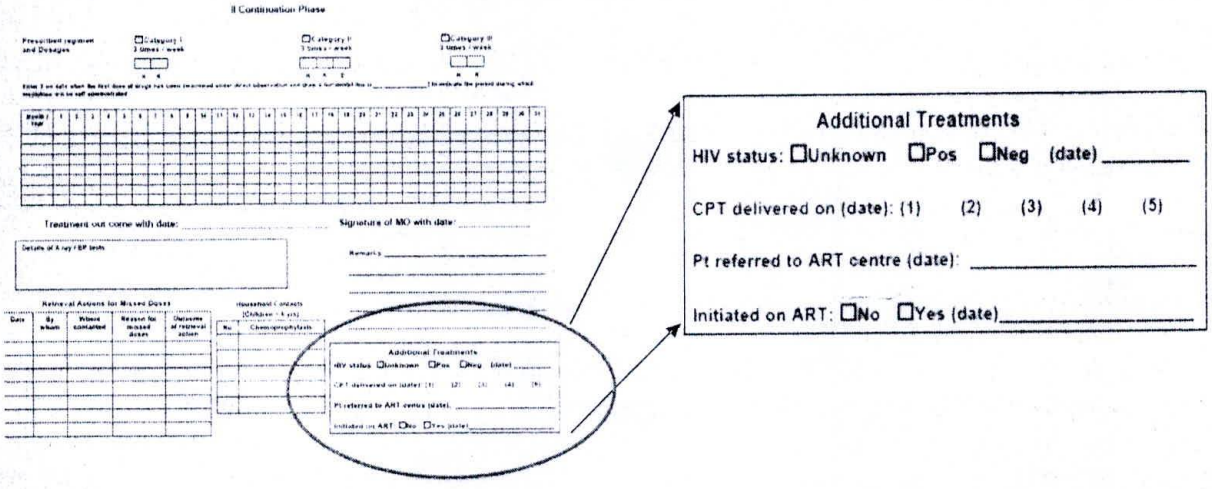
In case the TB patient raises his/her objection to the direct communication of the HIV test result from the ICTC to the medical officer, his objection should be honoured and the HIV test result should not be communicated directly by the counsellor to the referring physician. Treating physician shall record the HIV status of the TB patient on the original TB treatment card in the provided space, along with date of testing. The HIV status shall not be recorded on the duplicate treatment card, held by community DOT provider

It is the responsibility of the PHI staff to maintain the confidentiality of the HIV status of the TB patients with in the health system.

Recording of HIV status on PHI-held TB treatment Cards

Treating physician shall record the HIV status of the TB patient on the original TB treatment card in the provided space, along with date of testing (Figure). The HIV status should not be recorded on the duplicate treatment card, held by community DOT provider.

Figure: Back of TB treatment card, and space for recording HIV status and additional treatment



- If HIV status of the patient is known, tick the appropriate box ('Pos' or 'Neg') and record the date of test. For patients who decline HIV testing, tick 'Unknown'
- Patients should not be required to show proof of HIV test results for recording on treatment cards, but documentation of positive HIV test results from an ICTC is required by NACP ART centres.
- If the HIV status is ascertained during the course of TB treatment, the latest information should be updated on the card.
- If HIV status of the patient remains unknown at the end of the treatment, tick the appropriate box ('unknown'), at the time of declaring treatment outcome for the patient.

COTRIMOXAZOLE PROPHYLAXIS THERAPY (CPT)

Co-trimoxazole is a fixed dose combination of sulfamethoxazole and trimethoprim; it is a broad spectrum antibiotic that targets a range of gram-positive and gram-negative organisms, fungi, and protozoa. Co-trimoxazole can also be given routinely for the prevention of opportunistic infections in HIV-infected persons; this strategy is called **Cotrimoxazole prophylaxis therapy**.

Why provide CPT?

- Reduces morbidity and mortality of HIV-infected patients
- All HIV-infected TB patients registered under RNTCP are eligible for CPT, irrespective of their CD4 counts.

Eligibility

All adults (≥ 14 years old) who are HIV-infected with tuberculosis disease on RNTCP treatment are to be prescribed CPT. Patients who report being HIV-infected should have their HIV status confirmed at an ICTC if not yet done. CPT can be prescribed at any point during TB treatment, whenever HIV-infection is determined. Pregnant patients are also eligible, regardless of foetus gestational age. Patients with a history of a serious drug allergy to sulpha drugs or known glucose-6 phosphate dehydrogenase (G6PD) deficiency should be excluded.

Prescribing CPT

- No baseline laboratory investigations are required to initiate CPT
- Dose for prophylaxis for adults (≥ 14 years old) and ≥ 30 kg body weight): 960 mg (800 mg sulfamethoxazole + 160 mg trimethoprim) daily.
- Daily (self-administered), one tablet per day
- Taken alongside anti-tuberculosis treatment (ATT) and ART
- CPT is provided to patients in monthly packets.
- CPT is self-administered by the patient on a daily basis, and not under direct observation.

Duration of treatment

Co-trimoxazole is to be given for the entire duration of TB treatment. After TB treatment, CPT should be continued from the patients' ART centre.

Treatment interruptions

Patients who do not take CPT do not get the prophylactic benefits. If patients are noted to have interrupted CPT, counselling by the health staff (including medical officer) is recommended to promote adherence at the next available opportunity. There is no "Default" in CPT; the treatment is voluntary. Patients who have interrupted CPT may choose to re-start and continue later.

Children

HIV-infected children are recommended to be provided lifelong CPT. Paediatric formulations of cotrimoxazole are available at ART centres. Paediatric HIV patients are to be immediately referred to

the most convenient ART centre for CPT and ART evaluation and initiation.

Clinical and laboratory monitoring of patients on CPT

No baseline laboratory investigations are required to initiate CPT. Drug-related side effects to Cotrimoxazole are uncommon and usually occur within first 2 weeks of starting treatment. When initiating treatment, patients should be asked to report side effects as soon as they are recognized. Clinical monitoring should be carried out regularly, at least once every three months. During clinical monitoring visits, adherence should be encouraged. No specific laboratory monitoring is required among children or adults receiving CPT. Although Cotrimoxazole can induce haemolytic anaemia in patients with G6PD deficiency, routine testing for G6PD deficiency is not indicated.

Side effects

Major side effects are uncommon, but may occasionally occur. Anaemia, allergic reactions, skin rashes and yellowing of skin/eye are the major side effects for which the patients need to consult the treating physician. Loss of appetite, joint pains, nausea and vomiting are other minor side effects. Severe adverse reactions to Cotrimoxazole are rare, but include exfoliative dermatitis, erythema multiforme (Stevens Johnson Syndrome), severe anaemia, and pancytopenia. Because patients are usually taking other medications with similar side effects (e.g. isoniazid, pyrazinamide, efavirenz), care must be taken during clinical evaluation. Patients with serious side effects should be referred to a higher level centre, for evaluation and treatment by a physician comfortable with desensitization.

Discontinuing Cotrimoxazole prophylaxis

Serious side effects should lead to prompt discontinuation and referral for care. Otherwise, discontinuation of CPT would be decided upon by the ART centre, depending on the immune recovery due to ART.

Mechanisms for CPT delivery to HIV-infected TB patients

CPT delivery sites:

a. At all the ART Centres, and

b. At all PHIs in the districts having a Medical officer and an institutional DOT centre, supervised by RNTCP in coordination with NACP.

The treating physician should:

a. Initiate him/her on CPT from the institutional DOT centre, while also assessing the relevant history of adverse reaction to sulpha drugs.

b. The treating physician prescribes CPT by ticking the relevant cell on the TB patient identity card (**Page 23**).

c. Records the prescription of CPT on the TB treatment card (PHI-held, original treatment card) (**Page 7**).

d. Asks these clients to report to the PHI in case of any adverse drug reaction

e. Counsels the patient on the importance of regular follow-up examination and advice the client to come for monthly examination to monitor the progress of treatment.

f. For children and very low-weight adults (<30 kg), because alternate formulations of CPT are not provided under this decentralized mechanism, CPT for these patients is to be

managed by ART centres.

At the PHI, institutional DOT provider (pharmacist/ health worker) should:

a. Provide a monthly supply of CPT on seeing the TB identity card.

b. Record the date of delivery of CPT on the space provided on TB treatment card

c. Ask the client to come on a monthly basis to collect the monthly supply of CPT.

d. Encourage the patient to meet the MO for clinical evaluation, at time of these monthly visits to the PHI.

HIV-infected TB patients getting TB treatment from community DOT provider would get his monthly CPT supply from institutional DOT centre and continue getting TB treatment from community DOT provider. Records of HIV status, CPT delivery and ART are not be updated on the duplicate TB treatment card kept with the community DOT provider.

All HIV-infected TB patients initiated on CPT should be provided counselling on adherence to CPT by the ICTC counsellor at the time of each contact. The clients would also be encouraged to come for monthly/ regular clinical examination by the treating physician to evaluate progress of HIV disease & TB treatment.

STS during their each monthly visit to each PHI should:

1. Collect data on HIV test result of the TB patient, initiation on CPT, referral for ART, and initiation on ART from each TB treatment card and update the same in TB register (**Page 22-23**)

2. This information shall be reported in the district RNTCP quarterly case finding and results of treatment RNTCP reports (**Page 23-24**).

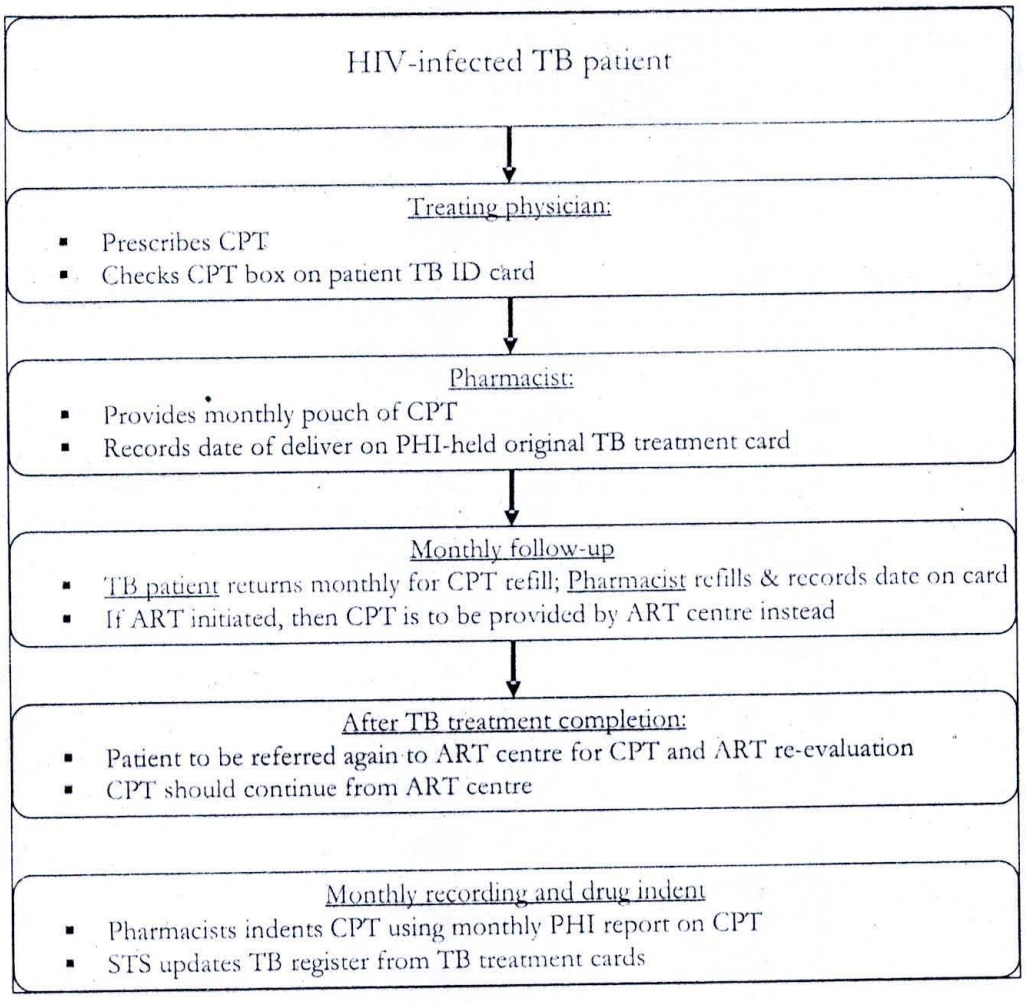
Transition of CPT for HIV-infected TB patients

During TB treatment – CPT should be made available to the patient at the PHI for the duration of TB treatment, or till the time the patient takes CPT from the ART centre. Feedback from the ART centre regarding initiation of CPT is essential to ensure a smooth transition.

In case the HIV-infected TB patient is already on CPT before the initiation of TB treatment, CPT can be continued from that source.

After TB treatment – After the completion of TB treatment the HIV-infected client is to continue CPT from ART Centre. Also if the HIV-infected TB patient is initiated on ART during TB treatment, he is to continue CPT along with ART from the ART Centre.

Summary of mechanism for providing CPT for HIV-infected TB patients



CPT Drug supply management

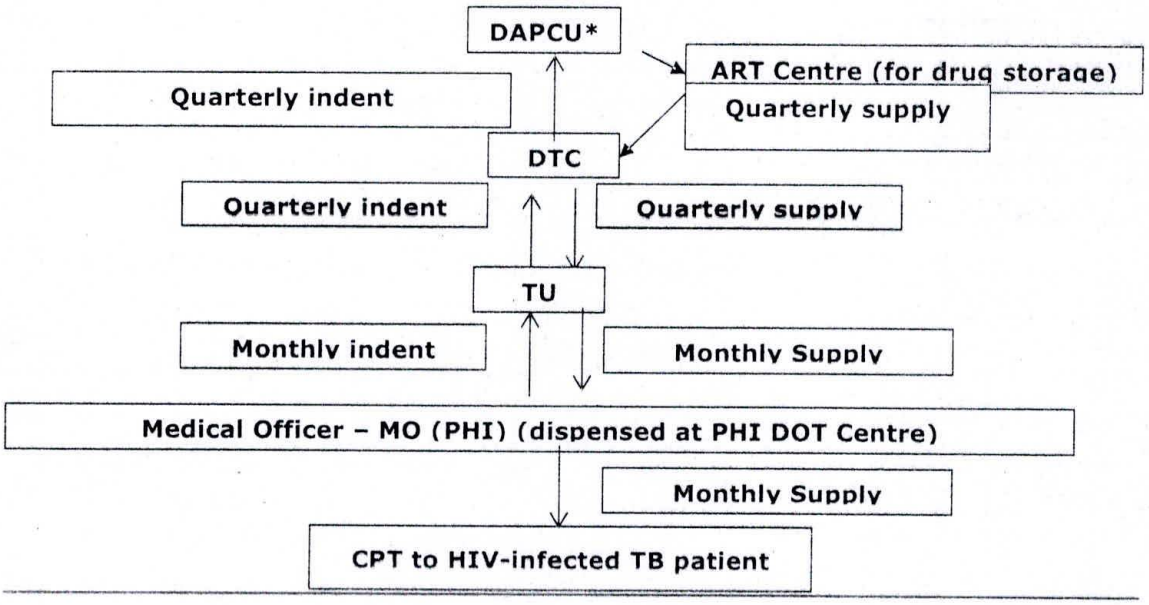
Management of drug supply of cotrimoxazole (CTX) is challenging due to the irregular duration of treatment. Patients may start CPT late, may transition to CPT from ART centre at any time during TB treatment, may die or default from TB treatment, may interrupt CPT, or may even require more than 6 months in the case of Cat II patient or extensions of TB treatment. Therefore the system for CTX supply management is similar to RNTCP prolongation pouches.

Cotrimoxazole (CTX) for provision of CPT to HIV-infected TB patients are to be procured by the State AIDS control societies and supplied in monthly packs containing contain 30 tablets of Cotrimoxazole 960 mg (800 mg sulfamethoxazole + 160 mg trimethoprim) to the ART Centre and District TB officer.

- At the time of initiation of CPT availability in a district:
  - All PHIs should be supplied with 10 CPT monthly pouches, to account for patients immediately eligible for CPT and to have a CPT buffer supply.
  - All TU's should maintain a stock of one quarter's requirement, which should be a number pouches of equal to

- [6*(5% of the number of TB patients registered the previous quarter)].
  - All Districts should maintain a stock of one quarter's requirement, which should be a number pouches of equal to [6*(5% of the number of TB patients registered the previous quarter)].
- The CPT should be stored in the Pharmacy of the PHI; the Pharmacist is to maintain a record of stock in the regular PHI Stock Register.
- On a regular monthly basis, PHIs should obtain CPT pouches from the concerned TU based on their actual requirements, considering the number of CPT pouches consumed, and the number HIV-infected TB patients detected. Regular re-supply of CPT pouches are requested from the TU headquarters using the monthly PHI CPT Indent (Annex 4).
- TU will supply CPT monthly pouches to the PHI on the basis of the number of pouches requested.
- The stock and requirement of the TU for CPT monthly pouches should be reported by the TU to the district level in **Quarterly TU CPT Report** (**Annex 5**).
- The District TB cell based on these requests, supplies CPT monthly pouches to TU.
- On a quarterly basis, the District TB Cell is to indent supply requirement of CPT monthly pouches from the District AIDS prevention and Control Unit (DAPCU) (or SACS if DAPCU not established) by the '**Quarterly District CPT Report**' (**Annex 6**).
- In addition, emergency indent can also be made in case of urgent requirements.

Summary of mechanism for providing CPT for HIV-infected TB patients



ANTI-RETROVIRAL THERAPY (ART) FOR HIV-INFECTED TB PATIENTS

Anti-retroviral drugs act by blocking the action of enzymes that are important for replication and functioning of HIV. The drugs must be used in standardized combinations (usually three drugs together). Anti-retroviral therapy (ART) results in reductions in morbidity and mortality in HIV-infected people. For ART to remain effective, extremely good adherence is required. Intensive counselling, support, and monitoring are required.

ART eligibility criteria for HIV-infected TB patients

All HIV-infected TB patients are in HIV clinical stage 3 or 4 (Pulmonary TB-Stage 3 & Extra-pulmonary TB-Stage 4). NACO recommends (March, 2007) that ART be given to:

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

Most HIV-infected TB patients will be eligible for ART. The decision of the ART Centre Medical Officer for ART initiation should be based on NACP ART guidelines. In general, ART should be initiated for eligible HIV-infected TB patients as soon as possible as per NACP ART guidelines.

Linking HIV-infected TB patient with ART Centres

Smear-positive TB patients should be asked to attend the ART centre only after completing at least 2 weeks of intensive phase anti-TB treatment (i.e. 6 doses), and to carefully 'cover your cough' with a cloth. This is to reduce the risk of TB transmission of TB to other persons seeking care in the same place.

HIV-infected TB patients not already on ART should be referred using the standard "ART Centre referral form" (**Annex 3**). The referral to ART centre should also be recorded on the TB treatment card. TB treatment is the priority, and should not be interrupted by ART referral. However, prompt referral and evaluation for ART are also very important. For those patients already on ART, prompt referral is also important so that their ART drugs can be adjusted to account for their TB treatment.

While referring the HIV-infected TB patient to ART centre, the client must be counselled by the treating/referring physician and the ICTC counsellor on:

- The importance and free availability of ART
- The locations of ART centres
- The need to take the ICTC HIV test report to the ART centre for confirmation of HIV status
- Procedure of pre-ART evaluation including CD4 testing
- The days on which the CD4 testing is available at the respective ART centre.

Process at ART Centre

1. In view of advanced clinical stage of HIV disease, HIV-infected TB patients are to be evaluated

for ART on priority. HIV-infected TB patients should be prioritized for CD4 testing.

2. The ART Centre staffs are to record patients' TB number and name of referring unit in the pre-ART register (along with 'entry point code') and ART- register.

3. If the HIV-infected TB patient is initiated on ART, they would also continue their CPT from the ART Centre.

4. The ART Centre staffs are expected to provide feedback to the referring physician.

Mechanism for feedback from ART centres to the referring physician:

1. Feedback is to be provided by the ART centre MO on the referral form sent from TB treating physician.

2. The patient is to be counselled by the ART centre staff to share the ART patient booklet and treatment history with the TB treating physician

3. An ART Centre staff should attend the district level monthly RNTCP meeting for better coordination.

4. The ART centre staffs are to on a monthly basis compile a list (**Annex 7)** of those ART clients who were on RNTCP TB treatment during that month, including TB number, and share the same with the DTO. For patients from other districts, that list should be forwarded to the respective DTO of the neighbouring district. This information can be directly updated onto TB registers.

The initiation on ART should be recorded on the original TB treatment card with the date of ART initiation and ART registration number. If the HIV-infected TB patient is not been initiated on ART after their initial referral, s/he should be again referred to the ART centre after completion of TB treatment for ART re-evaluation, and for continuation of CPT.

Reporting by the ART Centre

A section is to be added in the regular ART centre reporting formats on the number of TB patients received from RNTCP, of this number on pre- ART care, and number on ART & CPT.

INTENSIFIED TB CASE FINDING AT ART CENTRES

HIV-infected persons attending ART centres for pre-ART registration have a high prevalence of TB disease. The incidence of TB disease among ART clients is also very high. While ART reduces the risk of TB disease, this risk is still remains many times higher than the general population. Hence intensified TB case finding at ART centres is very important for early suspicion and diagnosis of TB. The ART guidelines describe that all patients coming to centre should be screened for opportunistic infections specially TB before start of ART. The ART centres MO should have a very high index of suspicion for TB and ensure that TB disease in clients attending ART centre is not missed. This provisional guidance is intended to define the minimum standard for TB disease screening among clients attending ART centres. This guidance is expected to evolve, as ongoing and planned operational research will clarify the optimum screening and diagnostic procedures for TB.

WHAT to do:
Counsellors & Other Para-medical staff of ART Centre: Screen all patients (even if no complaint), for the following signs and symptoms:

Symptoms
- Cough (of 2 week duration and/or of any duration with a history of contact with a sputum smear positive pulmonary TB patient)
- Cough with blood in sputum, any duration
- Fever
- Unexplained weight loss, excessive fatigue/night sweats/ loss of appetite
- Pleuritic chest pain (increasing on cough/deep breathing)
- Swelling in the neck, arm-pits, groin, abdomen, joints, etc.

If symptoms are suspicious for TB disease are present:
- ART Centre health staff to refer patient to ART MO for clinical evaluation
- ART Centre medical officer to refer patient on the same day for:
    1. Sputum microscopy to the institutional Designated Microscopy Centre
    2. Chest X-Ray, if indicated as per NACO ART guidelines
    3. For additional investigations as clinically indicated in ART guidelines

WHEN to do it:
At all patient encounters at the ART centre
- Pre-ART registration & follow-up visits
- ART initiation
- Monthly visits to ART centre & ART medical follow up (6 monthly)
- Unscheduled follow-up visits

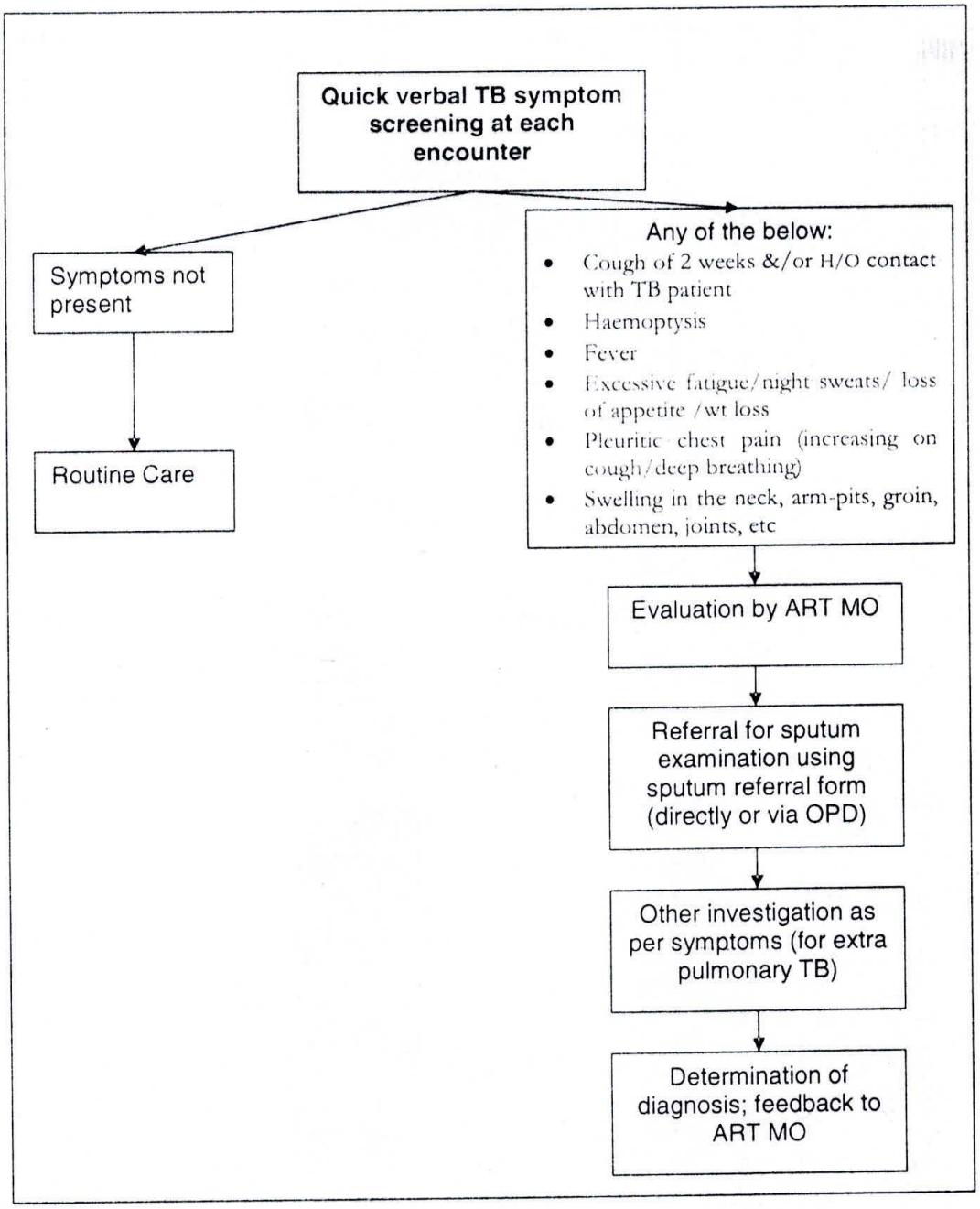
TB diagnosis and treatment:
- TB Diagnosis to be done based on RNTCP diagnostic algorithm
- In case the client has three negative sputum smear examination results, but has abnormal CXR, diagnosis of TB disease should be decided in clinical consultation between ART MO & RNTCP MO.

- All patients diagnosed with TB disease should be initiated on RNTCP DOTS as quickly as possible and be referred for treatment to a DOTS centre near their place of residence.
- Once client is initiated on TB treatment, feedback to be provided to ART Centre.
- For clients not initiated on ART so far, once the TB treatment is started, ART should be considered as per NACP guidelines.

Recording:

- Referral to RNTCP: Use standard RNTCP sputum referral slips, indicating patient is from ART centre .
- At RNTCP DMC: In the RNTCP Lab register, ART Centre is to be recorded as the referring centre
- Initiation on DOTS: As per RNTCP referral for treatment mechanism, by DMC staff
- At ART Centre: TB diagnosis & initiation on DOTS to be recorded on ART treatment cards & registers, per NACO guidelines

INTENSIFIED TB CASE FINDING AT ART CENTRES:



MONITORING AND SUPERVISION

Roles and Responsibilities

ROLE OF PHARMACIST/ INSTITUTIONAL DOT PROVIDER

1. Check the TB identity card for CPT prescription.
2. Provide monthly supply of CPT to the HIV-infected TB patients, who have been prescribed CPT by the attending MO and record the date of delivering on the TB treatment card.
3. Indent (from MO-TC) and maintain stock of Cotrimoxazole for the HIV-infected TB patients prescribed CPT for the entire duration of their TB treatment.
4. Encourage the HIV-infected TB patients, during their monthly visit to PHI for collecting CPT, to meet the Medical Officer for routine examination.
5. Ensure confidentiality of HIV status of the TB patients remains confidential with in the health system.
6. Encourage patients on CPT to continue their CPT from an ART centre after TB treatment is finished.

ROLE OF COUNSELLORS

1. Screen clients for TB symptoms, and refer TB suspects to the DMC, recording referrals on the TB suspect line list.
2. Record referral from RNTCP in the counselling register.
3. Record the HIV test result on the referral form and send it back to referring physician through the TB patient.
4. Communicate the HIV test result of TB patients referred for VCT, to the referring/ treating physician unless the patient has requested that the HIV test results not be shared.
5. Emphasis, while counselling clients, on the importance of sharing HIV test result with the referring/ treating physician
6. Counsel HIV-infected clients on the importance of CPT, including adherence.
7. Provide information to ICTC clients having TB disease or suspected of having TB on availability of decentralized CPT through the RNTCP.
8. HIV-infected clients on the importance of ART and CPT, including adherence and their free availability under the programme.
9. Counsel the clients being referred to ART centre, on the process of ART evaluation and the importance of completing the necessary steps to determine the need for ART.

ROLE OF STS

1. Update TB registers during monthly visits to PHIs with information on HIV status, and (for HIV-infected TB patients) provision on CPT and ART from the original TB treatment card.
2. Coordinate with MO-PHIs and pharmacist and facilitate the availability of CPT at the PHIs.
3. Ensure HIV status of the TB patients remains confidential with in the health system.
4. Supply cotrimoxazole to requesting PHI's on an as-needed basis.
5. Coordinate with ART centre staff during monthly meeting to ascertain ART provision to HIV-infected TB patients.

ROLE OF MEDICAL OFFICER

1. Assess HIV status of TB patients, and refer all with unknown HIV status to the nearest ICTC for voluntary HIV counselling and testing. Use the referral form.
2. Prescribe CPT to all known HIV-infected TB patients without contraindications. Counsel HIV-infected TB patients, prescribed CPT on possible side effects of Cotrimoxazole.
3. Refer HIV-infected TB patients to the nearest ART Centre, preferably after two weeks of TB treatment. Use the ART referral form.
4. Monitor the updation of information on CPT and ART delivery to HIV-infected TB patients on the TB treatment card.
5. At the end of TB treatment refer all HIV-infected TB patients not already taking ART again to the ART Centre for continuation of CPT and for re-evaluation of eligibility for ART. Use ART referral form.
6. Ensure HIV status of the TB patients remains confidential with in the health system.

ROLE OF MO-TCS

1. Provide support to DTOs and DNOs in training of MOs, STS, Counsellors and Pharmacists on intensified TB/HIV package.
2. Sensitize medical officers in the implementation of routine referral of TB patients for HIV testing, CPT provision, and ART referral, and the correct updation of TB records.
3. Coordinate with all the PHIs and ensure the availability of CPT at PHI having HIV-infected TB patients.
4. Indent Cotrimoxazole in a timely manner from the DTO and maintain adequate supply at TU level.
5. Facilitate the training of field staff in coordination with DTO.
6. Supervise field staff and sensitize them regarding responsibilities.
7. Ensure HIV status of the TB patients remains confidential with in the health system.

ROLE OF DAPCU OFFICER

1. In coordination with DTOs, organize training for MOs-TCs, MOs, STS, Counsellors, ART centre staff and Pharmacist on intensified TB/HIV package.
2. Overall supervision and ensuring smooth implementation of intensified TB/HIV package, as per National framework of joint TB/HIV collaborative activities.
3. Ensure adequate ICTC human resource management and supply of test kits and consumables.
4. Supervise ICTC counsellor's provision of confidential feedback of HIV test results for TB patients to referring providers.
5. Ensure seamless supply of Cotrimoxazole to the DTO.
6. Ensure the availability of referrals forms for referral of all TB patients for VCT and referral of co infected patients to ART centre.
7. Ensure that ART centre staffs join the RNTCP monthly meeting.
8. Ensure that ART centre staffs have prepared the ART-TB notification list of ART clients on treatment with RNTCP and the same is sent to concerned RNTCP officials.
9. Monitor the effectiveness of intensified TB case finding at ART and Care and Support and Link centres.
10. Coordinate with ICTC counsellors and SACS, and ensure the compliance of counsellors.
11. Coordinate with DTO and facilitate in resolving the issues emerging in the field.

ROLE OF DTOS

1. In coordination with DTOs, organize training for MOs-TCs, MOs, STS, Counsellors, ART Centre staff and Pharmacist on intensified TB/HIV package.
2. Overall supervision and ensuring smooth implementation of intensified TB/HIV package as per National framework of joint TB/HIV collaborative activities.
3. Review the ascertainment of HIV status by medical officers, and the recording of HIV status on TB treatment cards.
4. Ensure that HIV status is recorded only on PHI-held original treatment cards, and not on duplicate treatment cards held by community DOT providers, and that HIV status remains confidential within the health system.
5. Monitor STS recording of HIV status, CPT, and ART from TB treatment cards onto TB registers.
6. Supervise the recording of ART provision to HIV-infected TB patients from ART-TB notification list.
7. Transmit information to neighbouring districts in the state for ART-TB notifications for TB patients from other districts.
8. Indenting Cotrimoxazole from DNOs and supply the same to the TUs
9. Collect information on the delivery of CPT from all the STSs on a monthly basis & compile a consolidated quarterly report on the same in a prescribed format.
10. Report promptly any shortcoming/ issues emerging in the field to STC & CTD.
11. Ensuring in coordination with DNOs, the availability of referrals forms for referral of all TB patients for VCT and referral of co infected patients to ART centre.

ROLE OF ART CENTRE

1. Evaluate HIV-infected TB patients for ART on priority, including prioritization for CD4 testing.
2. Record patients' TB number and name of referring unit in the pre-ART register (in the column 'entry point code', along with the appropriate code for RNTCP) and the ART- register.
3. Ensure CPT is provided to all HIV-infected TB patients for the duration of TB treatment from either the PHI or from ART centre.
4. Continue CPT after the end of TB treatment from ART centre as per NACP OI guidelines.
5. Provide feedback on CPT continuation and ART initiation to the referring physician, using the same ART centre referral form if received and available.

ROLE OF STATE TB CELL AND STDC

1. Organize training of trainers for DTOs and DNOs in coordination with SACS on intensified TB/HIV package.
2. In coordination with DTOs, organize training for MOs-TCs, MOs, STS, Counsellors, ART centre staff and Pharmacist on intensified TB/HIV package.
3. Overall supervision and ensuring smooth implementation of intensified TB/HIV package, as per National framework of joint TB/HIV collaborative activities.

ROLE OF SACS

1. Organize training of trainers for DTOs and DNOs in coordination with State TB Cell on intensified TB/HIV package.
2. In coordination with DNOs, organize training for MOs-TCs, MOs, STS, Counsellors, ART centre staff and Pharmacist on intensified TB/HIV package
3. Overall supervision and ensuring smooth implementation of intensified TB/HIV

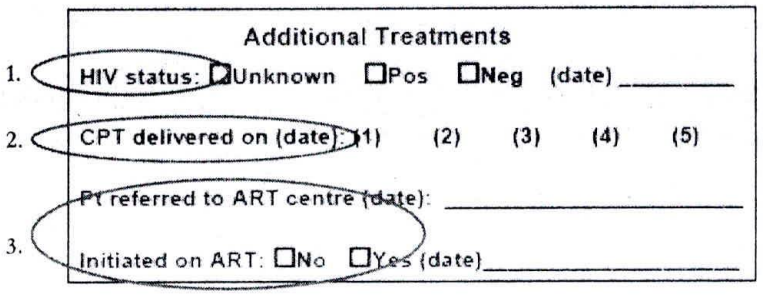
package, as per National framework of joint TB/HIV collaborative activities

4. Ensure optimal availability of HIV test kits, Cotrimoxazole (in monthly packs), and referrals forms (for referral of all TB patients for VCT and referral of co infected patients to ART centre).

Recording: Key points to remember

Original TB treatment card

Information on the TB treatment card, on HIV status, CPT delivery and ART referral and treatment of the TB patient is to be kept confidential within health system on the original TB treatment card. This should not be disclosed to the community DOT provider.



1. HIV Status:

i. HIV testing is a voluntary procedure and not mandatory. Patients not willing for HIV testing or sharing their HIV test result should not be forced to take the test or disclose this information.

ii. If HIV status of the patient is known, tick the appropriate box ('Pos' or 'Neg') and record the date of test.

iii. Patients already on HIV care should not be required to show proof of HIV test result

iv. If the HIV status is ascertained during the course of TB treatment, the latest information should be updated on the card.

v. If HIV status of the patient remains unknown at the end of the treatment, tick the appropriate box ('unknown'), at the time of declaring treatment outcome for the patient.

2. CPT (Cotrimoxazole preventive therapy) delivery

i. All known HIV-infected TB patients are to be provided access to CPT.

ii. If CPT provided from the PHI, record dates of each monthly delivery in the space provided.

iii. In case the TB patient is already on CPT before the initiation of TB treatment, record most recent date of CPT pickup.

3. Referral and initiation on ART

1. All known HIV-infected TB patients are to be referred for ART to the nearest ART Centre. For referred clients record the date of referral.
2. If patient initiated on ART, tick the "yes" box, and the date of initiation of ART should be entered on the treatment card.
3. In case the TB patient is already on ART before the initiation of TB treatment, tick yes, and record approximate date of initiation.

TB Identity card

Tuberculosis Identity Card

Front

Revised National
Tuberculosis Control Programme
IDENTITY CARD

Name of Patient: _____

Complete address: _____

_____

TU / district name _____

_____ Ph _____

Sex: M ☐ F ☐ Age: _____ TB No. _____

PHI: _____

Disease Classification
☐ Pulmonary
☐ Extra-pulmonary
Site: _____

Treatment Started on
Date Month Year

Type of Patient
- New
- Relapse
- Treatment after default
- Failure
- Transfer In
- Other-Specify _____

Category of Treatment
☐ Category I
☐ Category II
☐ Category III

☐ CPT

Back

Follow up sputum examination

Time point	Date	Lab No.	Result
Pretreatment			
End of IP/extended IP			
2 months in CP			
End of treatment			

Appointment dates

IP	CP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Treatment outcome with date:

Signature and stamp of MO with date:

_____

REMEMBER

1. Keep your card safely
2. You can be cured if you take treatment as advised.
3. You may infect your near and dear if you do not take your medicines as advised

A. CPT:

- If the patient is HIV-infected, and not already being provided CPT from any other source, MO (PHI) is to prescribe CPT by ticking in the section on CPT
- Institutional DOT provider on seeing the ticked box provides monthly supply of CPT and records the same on Original treatment card.

TB Register

Left side of the TB register

Revised National Tuberculosis Control Programme – TB Register Quarter_____ Year_____

A

TB No.	Date of Registration	Name (in full)	Sex (M/F)	Age	Complete Address & Telephone Number	Name of PHI	Date of Starting Treatment	Category (I/II/III ND1/ND2)	Class (P/EP)	Type*	Pre-treatment sputum exam				HIV Status† (P/N/U)
											Date	DMC Name	Lab No	Smear	

Summary for Case Finding (DOTS Cases Only)								
	NSP	NSN	NEP	New Others	Relapse	Failure	TAD	Cat II Others
0–14 yrs								
≥15 yrs								
Male								
Female								

* Type of Patient (use complete words)
New, Relapse, Transferred in, Failure, TAD, Others

† HIV status
HIV status as reported before or during TB treatment.
P=Positive, N=Negative, U=Unknown

Right side of the TB register

Revised National Tuberculosis Control Programme – TB Register Quarter_____ Year_____

B

End of I.P. / Extended I.P.				2 Months in C.P. Exam				End of Treatment Exam				Treatment Outcome#	[If HIV-pos]‡		Remarks
Date	DMC Name	Lab No	Smear	Date	DMC Name	Lab No	Smear	Date	DMC Name	Lab No	Smear	Outcome	Date	CPT (y/n)date	ART (y/n)date	

DOTS SUMMARY	Cured		Comp. Tx.		Died		Default		Failed		Transfer Out	
NSP	M	F	M	F	M	F	M	F	M	F	M	F
NSP (M.T.)												
NSN												
NEP												
New Others												
Relapse												
TAD												
Failure												
Cat II Others												

Treatment Outcome – use complete words
Cured, Completed treatment, Died, Defaulted, Failure, or Transferred out

‡ Additional treatments if patient HIV-positive
Required only for patients known to be HIV-positive.
If provided on any source during TB treatment, enter "Y" and approximate date. If not provided / unknown, enter "N"

A: HIV status:

- HIV Status (as provided in the original TB treatment card) should be recorded in the space provided at the time of registration. Record 'P' for HIV-positive; 'N' for HIV-negative; 'U' for unknown.
- At the time of the case finding report preparation, all 'blank' entries in the HIV Status column in the TB register should be counted as 'Unknown' for the purposes of reporting.
- If the HIV status is later ascertained and updated on the treatment card during the course of TB treatment, the same should be updated in the TB register.
- By the time of Results of Treatment quarterly report preparation, ALL TB treatment cards should have an entry for HIV status (P, N, or U). Similarly, the TB register should reflect the entry on the TB treatment cards. If the HIV status information on the TB treatment card for whatever reason remains blank, that is to be recorded as 'Unknown' in the TB register.

B: CPT and ART delivery:

- The section is to be filled up for all TB patients known to be HIV-infected and should be left blank for others.
- CPT and ART information should be recorded on the register at the same time of treatment outcome recording i.e. within a month of TB treatment completion.
- Record CPT started as 'yes', with the date, if at least one month of CPT delivery is recorded in the original treatment card.
- Record ART started as 'yes' if recorded as 'yes' in the original TB treatment card. Record the documented approximate date of ART initiation from the original TB treatment card.
- For patients who were already taking CPT or ART at the time of TB diagnosis, the dates for CPT and/or ART initiation would be expected to be earlier than the date of initiation of TB treatment.

Reporting in RNTCP case finding report: Key points to remember

Block 3: TB/HIV Collaboration

Of all Registered TB cases no. known to be tested for HIV before or during the TB treatment (a)	Of (a), No. known to be HIV infected (b)

The purpose of this block 3 is to provide information on the process of ascertainment of HIV status of TB patients:

- In cell **'a'**, enter the sum of all TB patients registered in this quarter, with their HIV status recorded as either positive (P) or negative (N) in the TB register. Do not include those patients with HIV status recorded as (U) unknown, or those patients with no information available regarding HIV status.
- In cell **'b'**, enter the sum of all TB patients registered in this quarter, with their HIV status recorded as positive (P) in the TB register.

It is to be noted that the number of patients known to be HIV-infected may be less than the number that will ultimately be reported in the Results of Treatment quarterly report, as it is expected that some patients will undergo HIV testing during the course of treatment after the case finding report is prepared.

Reporting in RNTCP treatment outcome report: Key points to remember

1. **Treatment outcomes of HIV positive TB patients:**

Type of TB case	Total No. known to be HIV infected	Treatment outcomes					
		Cure	Treatment completed	Died	Treatment failure	Default	Transfer out
NSP							
All TB cases							

a. In this section TB treatment outcomes of HIV-infected TB patients are to be reported
b. In the first column 'Total No known to be HIV-infected', enter the sum of all TB patients registered in the relevant quarter, whose HIV status was recorded as positive (P) in the TB register, for 'NSP' only in the first row, and for 'All TB cases' (including NSP) in the second row.
c. Record the treatment outcomes of the known HIV-infected TB patients as indicated.

Note:

d. This number of known HIV-infected TB cases may be greater than reported in block 3 of case finding reported for this quarter, as more TB patients will have been identified as HIV positive during the course of treatment subsequent to the time of submission of the quarterly CF report.
e. **However, all efforts should be made to gradually decrease this difference and ensure that an increasing proportion of TB patients get their HIV status ascertained as early as possible after TB diagnosis**

2. **Provision of CPT & ART to HIV-infected TB patients**

Total no of TB patients known to be HIV infected	No. given CPT#	No. given ART#

During TB treatment

a) Enter the sum of HIV-infected TB patients that had 'yes' recorded in the CPT started column of the TB register and record in the space provided.

b) Enter the sum of HIV-infected TB patients that had 'yes' recorded in the ART started column of the TB register and record in the space provided.

1. Case finding report

Indicator 1: Proportion of TB patients with known HIV status (before or after TB treatment) (%)

In the states implementing intensified TB/HIV package, voluntary HIV testing should be offered to all TB patients and all TB patients should be counselled to get their HIV status ascertained

Optimal: Majority of TB patients with known HIV status

i. **Low proportion/ declining trend in proportion of TB patients with known HIV status**

Possible actions:

- ✓ Check whether VCT is being offered at all PHIs to TB patients using standard referral form.
- ✓ Check whether the information related to TB/HIV is being updated on the original TB treatment cards
- ✓ Check if all ICTC counsellors are providing feedback on HIV test to the referring physician.
- ✓ Re-sensitize all MOs on the policy of offering of VCT to all TB patients and timely recording of HIV status on the TB treatment card in the routine district level meetings of MOs conducted by CDHO/ DHS.
- ✓ Address the issue of ICTC feedback to referring physician by discussing the same with District nodal officer for AIDS and ICTC counsellors
  - Sensitize State TB Cell on the issue.
- ✓ Nurses and pharmacists should be sensitized on routine referral and the recording process.

ii. **Very high proportion or dramatic unexplainable rise in proportion of TB patients with known HIV status**

Possible actions:

- ✓ Ensure that while all TB patients are offered HIV testing, the process remains voluntary and no TB patient is forced to undergo HIV testing
  - Conduct random TB patient interviews;
  - Ask all field staff elicit information on the issue from TB patients and check if there was any coercion for getting HIV tested.
- ✓ In case of any instances of coercion:
  - Reassure the TB patient;
  - urgently discuss and clarify the policy with the concerned officials

2. Results of treatment report

Indicator 2: Difference between number of TB patients known to be HIV infected reported in Results of Treatment report and Case Finding report (for the same cohort)

Optimal: Declining trend over successive quarters

Explanation:

- The basic purpose of the intensified TB/HIV package is to 'promptly' identify all HIV infected TB patients and provide them access to HIV care.
- The difference between the number of patients knowing their HIV status at the end of TB treatment and at the time of compilation of case finding report indicates delay in ascertainment of HIV status of TB patients leading to delayed opportunity to access HIV

care. This may result in increased morbidity and mortality.

- As HIV testing is a voluntary procedure, some TB patients might not to get them selves tested for HIV. Some TB patients may choose to get them selves HIV tested beyond the first quarter of TB treatment.
- Also, there may be some delay on account of delay in communication of HIV test result from ICTC and also delay in its recording on the original TB treatment card.

- **Efforts should be made to decrease the difference between the two figures over the successive quarters.**

Possible actions:

- ✓ Check whether VCT is being offered at all PHIs to TB patients using standard referral form as soon as possible after TB diagnosis, preferable during the first few weeks of TB treatment
- ✓ Check if the TB patients being offered HIV testing are explained the importance early determination of HIV status and sharing the same with medical officer
- ✓ Check whether the information related to TB/HIV is being updated on the original TB treatment cards.
- ✓ Check if all ICTC counsellors are providing feedback to the referring physician.
- ✓ Re-sensitize all MOs on the policy of offering of VCT to all TB patients and timely recording of HIV status on the TB treatment card in the routine district level meetings of MOs conducted by CDHO/ DHS.
- ✓ Address the issue of ICTC feedback to referring physician by discussing the same with District nodal officer for AIDS and ICTC counsellors- sensitize State TB Cell on the issue.
- ✓ Nurses and pharmacists should be sensitized on routine referral and the recording process.

3. TB Register & TB treatment cards

I. Indicator 3: Proportion of HIV infected TB patients given CPT

II. Indicator 4: Proportion of HIV infected TB patients given ART

Optimal: All HIV infected TB patients given CPT, and majority given ART

Explanation:

- The basic purpose of the intensified TB/HIV package is to promptly identify all HIV infected TB patients and provide them access to HIV care.
- All known HIV infected TB patients should be initiated on CPT and referred for ART as soon as possible preferably within the first month of TB or ascertainment of HIV status- which ever is earlier. Delay in initiating them on HIV care is known to lead poor TB treatment outcomes.
- All HIV infected TB patient are likely to have low CD4 count (<350) and be eligible for ART. However, a sub-group of these patients (~20%) might have higher CD4 count and might not be eligible for ART.
- Data on HIV infected TB patients being initiated on CPT and ART is reported in the RNTCP results of treatment report. However, this should be monitored at the district and sub-district levels on a monthly basis from the TB registers and TB treatment cards and all known HIV infected TB patients not initiated on CPT and not referred for ART should be promptly initiated on CPT and referred for ART.

Possible actions to ensure all known HIV infected TB patients are initiated on CPT:

- ✓ Check whether adequate supply of Cotrimoxazole is available at all TUs and PHIs
- ✓ Identify the PHIs not providing CPT and:
- ✓ Check if CPT delivery is being recorded on the treatment cards
- ✓ Check if patients are collecting the monthly supply of Cotrimoxazole from the PHI
- ✓ Check if concerned MOs and Pharmacist have been trained; identify and address issues at the PHI; Re-sensitize PHI staff
- ✓ During interaction with TB patients not collecting monthly supply of CPT, counsel the clients on the utility of CPT

- ✓ Re-sensitize all MOs during the routine district level meetings of MOs conducted by CDHO/ DHS

Possible actions to ensure all known HIV infected TB patients referred for ART and all eligible are initiated on ART:

- ✓ Check if adequate supply of ART referral forms is available at all PHIs; Also check if these forms are being utilized during referrals
- ✓ Check if ART Centre MOs are providing feedback to the referring physician on the outcome of the referral
- ✓ Identify the PHIs having HIV infected TB patient not referred/ initiated on ART; identify and address the issues related to referrals with PHI staff
- ✓ In case of clients being referred to ART Centre, but not started on ART; collect patient details and discuss with ART Centre staff to check if patient reached ART Centre and was evaluated for ART; conduct random patient interviews to identify issues, if any.
- ✓ Re-sensitize PHI staff and ART Centre staff.
- ✓ Re-sensitize all MOs during the routine district level meetings of MOs conducted by CDHO/ DHS
- ✓ Ensure ART centre staff participating in monthly meetings. STS to check HIV/TB register at ART centres during RNTCP monthly meetings, or at the ART centre if necessary.

Annex 1

GUIDANCE TOOL ON ROUTINE REFERRAL OF TB PATIENTS FOR VOLUNTARY HIV COUNSELING AND TESTING

The periodic HIV survey in TB patients for the year 2006-07 has demonstrated high HIV prevalence in TB patients within settings having high HIV seroprevalence. Given the increasing availability of decentralized services for VCT & HIV care in high HIV prevalence areas, Central TB Division (CTD) & the National AIDS Control Organization (NACO) have adopted the policy of routinely offering voluntary HIV counselling and testing to all TB patients in select States with high prevalence of HIV (listed below). The policy is expected to facilitate early detection of HIV infection in TB patients and pave way for their early access to HIV care and treatment. These interventions may reduce morbidity & mortality among HIV-infected TB patients.

WHOM TO ADVISE TO ATTEND ICTC

- **All TB patients, 'except'** those with a history of positive HIV test from an ICTC, or those with a negative HIV test from ICTC within the past 6 months.

WHEN TO ADVISE VOLUNTARY COUNSELLING AND TESTING FOR HIV

- Any time during, or after initiation on TB treatment (preferably at the earliest).
- The client should be explained the need and importance of counselling and testing for HIV, and also that HIV testing is **'voluntarily'** and **'not mandatory'**.
- The offer should be made at least once during the course of TB treatment.

HOW TO REFER TO ICTC

- **Referral can be done by medical officers with necessary support from paramedical staff of the health facility.**
- Ask TB patients if they have ever had an HIV test, if yes, when and where, and what was the result.
- If HIV status is unknown, advise the TB patient to get an HIV test done at an ICTC and also explain that HIV testing is 'voluntarily' and 'not mandatory'
- If the patient accepts the advice, & fulfils the above criteria, refer the patient to nearest ICTC.

ROLE OF ICTC COUNSELLOR

TB patients referred for HIV testing, on reaching ICTC are to be offered voluntary counselling and testing for HIV. The ICTC counsellor is to counsel these clients on HIV & TB (using 10 point counselling tool), and explain the clients the importance of sharing their HIV test result with the treating physician, for better care. All TB patients diagnosed with HIV infection are to be referred by the ICTC counsellor to the nearest ART Centre for ART evaluation and treatment of other opportunistic infections.

ROLE OF ART CENTRE STAFF

All HIV-infected TB patients referred to ART Centre are to be:

1. Promptly evaluated for ART, on priority
2. If found eligible for ART initiated as early as possible
3. Promptly initiated on monthly CPT course and provide treatment for other Opportunistic Infections
4. Counselled to share the information of ART evaluation & initiation on ART with the TB treating physician

Annex 2.

Integrated Counselling and Testing Centre referral form

Referral to Integrated Counselling and Testing Centre

Dear Counsellor,

The patient with the following details is being referred for VCT to your centre:

Name _____ *age/ sex*

TB Number (if available) _____

Kindly do the needful and provide me feedback on the same, in a confidential manner.

Referring Provider

Name: Contact Phone #:

Date of referral:

Name of the PHI:

Feedback by the Counsellor to referring provider

(To be filled in duplicate by the counsellor. One copy for patient, the other for referring MO)

TEST RESULT FROM ICTC

HIV positive	☐	HIV negative	☐
Indeterminate	☐	Opted out	☐

PID Number

Date of conducting test

Additional communication to the referring physician

Signature of MO ICTC/counsellor

ANNEX 3.

ART CENTER REFERRAL FORM

REFERRAL TO ART CENTER

(To be filled in duplicate by PHI MO. One copy for patient, one for record)

ART Centre (location, address):

Dear Doctor,

I am referring _____ Age, _____ Sex,_____who is a diagnosed HIV-infected patient to your ART centre for further evaluation.

(If applicable: Type of TB Case & TB number.....)

Referring Doctor: ***Contact Phone #:***

Name & signature: ***Date:*** _____

Name & address of the PHI: ***District:***

TU Name:

Details regarding ART

(to be filled by the ART medical officer and sent to the referring PHI through the patient)

Pre-ART Registration Number:_____

Patient Started On Art - Yes / No ART Reg No:_____

If No, reason:

Patient started on CPT - Yes / No

If No, reason:

Additional information:

Name & signature of the ART MO ***Date***

Annex 4

Monthly PHI report on CPT for HIV-infected TB patients (To be added to the monthly PHI report)

ITEM	Unit of Measurement	Stock on first day of month (a)	Stock received during the month (b)	Consumption during the month (c)	Closing stock on last day of the month (d) d=(a+b-c)	Quantity Requested (e)
Cotrimoxazole monthly pouch (960 mg Double Strength tablets)	Monthly pouch (30 tablets)					

Annex 5

Quarterly TU report on CPT for HIV-infected TB patients (To be sent to district as a separate sheet)

ITEM	Unit of Measurement	Stock on first day of quarter (a)	Stock received during the quarter (b)	Consumption during the quarter (c)	Closing stock on last day of the quarter (d) d=(a+b-c)	Quantity Requested (e)
Cotrimoxazole monthly pouch (960 mg Double Strength tablets)	Monthly pouch (30 tablets)					

Annex 6

Quarterly DTC report on CPT for HIV-infected TB patients (To be sent to DAPCU/SACS as a separate sheet)

ITEM	Unit of Measurement	Stock on first day of quarter (a)	Stock received during the quarter (b)	Consumption during the quarter (c)	Closing stock on last day of the quarter (d) d=(a+b-c)	Quantity Requested (e)
Cotrimoxazole monthly pouch (960 mg Double Strength tablets)	Monthly pouch (30 tablets)					

Annex 7

HIV / TB Referral Register at ART Center

Date of referral	Name	Address	Name of the District referred from	TB Unit (TU) name & TB No.	Pre ART No.	Baseline CD4	Date of starting of ART	ART No.