



Government of India
Ministry of Health and Family Welfare
Department of AIDS Control
6thFloor, Chandralok Building,
36-Janpath, New Delhi-110001

National Framework for Joint HIV/TB Collaborative Activities



November 2013



Central TB Division
Directorate General of Health Services
Ministry of Health and Family Welfare
Government of India, New Delhi



Basic Services Division
Department of AIDS Control
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Government of India, New Delhi



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Foreword

Tuberculosis continues to be a public health challenge in India and it is the commonest opportunistic infection (OI) in People living with HIV (PLHIV). TB is the foremost cause of death among PLHIV. To mitigate the effect of dual burden of HIV and TB co-infection, the Ministry of Health and Family Welfare, Government of India through its Department of AIDS Control and Central TB Division (Department of Health and Family Welfare) has been undertaking joint collaborative efforts. For this purpose the National Framework was developed in 2008 and updated in 2009 with an "Intensified TB/HIV Package", for nationwide implementation in phased manner which has been achieved by June 2012.

The strong collaboration between NACP and RNTCP has helped in enhancing HIV testing coverage amongst notified TB cases and Intensified TB Case Finding activities are being implemented amongst PLHIV in the country, with efforts to ensure universal access to HIV-TB collaborative services, while minimising stigma and discrimination associated with HIV/TB.

The "WHO policy on collaborative TB/HIV activities-guidelines for national programmes and other stake holders 2012" recommends establishing and strengthening the mechanisms for delivering integrated TB and HIV services, reducing the burden of TB in PLHIV and initiating early ART and reducing the burden of HIV in patients with presumptive and diagnosed TB. The Government of India is already implementing these recommendations. Considering the technical advancements under RNTCP and NACP the existing National Framework (2009) has now been updated and revised during 2013. This National Framework on HIV/TB collaborative activities, duly endorsed by the National Technical Working Group on HIV/TB under Department of AIDS Control, in December 2012 aims to further strengthen the Government of India's response to TB/HIV in the country.

The dedicated efforts of Basic Services Division, Department of AIDS Control, Central TB Division and various experts are appreciated in meticulously developing this National Framework 2013, which will serve as a valuable resource for enhancing the Joint HIV/TB collaborative efforts at all levels of the health system in India.


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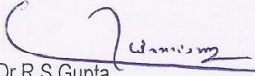
Preface

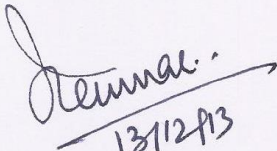
Over the past two decades, the HIV/AIDS is fuelling a global resurgence of tuberculosis. TB is now among the most common causes of death by infectious disease amongst People living with HIV (PLHIV). Role of HIV/TB collaboration in increasing the universal access to prevention, early diagnosis, and treatment services is vital in combating the threat of HIV/TB. Such well-planned collaborative interventions are being implemented in India since 2001. While joint HIV/TB activities started with differential strategies based on underlying HIV burden initially, the programme evolved over the years and currently implements uniform HIV/TB collaborative activities across the country. The decade old collaboration between National AIDS Control Programme (NACP) and Revised National Tuberculosis Control Programme (RNTCP) in India is considered a global success.

In 2008 and 2009, NACO (now Department of AIDS Control) and Central TB Division (Directorate General Health Services) jointly developed a National Framework for HIV/TB Collaborative Activities to address the intersecting epidemics. The framework called for "Intensified TB HIV Package" which emphasised on increased HIV testing of TB patients, TB screening for PLHIV and prompt treatment for persons affected with HIV/TB. India has achieved great progress in responding to its HIV epidemic and in reducing TB prevalence and mortality with the countrywide implementation of Intensified TB/HIV Package. There is an encouraging increase in provision of Cotrimoxazole Preventive Therapy (CPT) and Antiretroviral Therapy (ART) coverage among HIV-positive TB patients.

As per the recommendations of National Technical Working Group (NTWG) during its meeting in April 2011 and the technical advancements in RNTCP and NACP, "the National Framework for Joint HIV/TB Collaborative Activities, November 2013" was developed jointly by Basic Services Division/Department of AIDS Control and Central TB Division. The National Framework November 2013 duly endorsed by NTWG (December 2012), takes into consideration the recent developments in TB and HIV/AIDS with respect to TB diagnosis, HIV Testing in presumptive TB cases, Isoniazid Preventive Therapy, Notification of TB, Use of rapid diagnostics to diagnose TB and drug resistant TB early in PLHIV. Revised as well as Web based recording and reporting system etc. The National Framework November 2013 continues to lay emphasis on strong supportive supervision, monitoring and programme evaluation. Similarly operational research under both the national programs will continue to drive the evidence based modifications wherever required under the programs.

It is a pleasure to present this "National Framework for Joint HIV/TB Collaborative Activities, Nov 2013" which has been developed as guidance tool for policy makers, program managers, professionals at health facilities, health care workers and partners to strengthen the HIV/TB Collaborative activities in our country. The continued guidance of various organisations like National TB Institute Bangalore, National Institute of Tuberculosis and Respiratory Diseases New Delhi, National Institute of Research in Tuberculosis Chennai, National JALMA Institute of Leprosy and other Mycobacterial Diseases Agra (ICMR), National AIDS Research Institute Pune (ICMR) and various technical divisions of Department of AIDS Control and development partners was of immense help in developing this National Framework. It is our hope that all stakeholders in the fight against HIV/TB will find this National Framework document useful in the planning and implementation of their activities within the ambit of NACP and RNTCP


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1. NATIONAL FRAMEWORK FOR JOINT HIV/TB COLLABORATIVE ACTIVITIES

INTRODUCTION

The adult HIV prevalence in India is estimated to be 0.27 % translating into 2.1 million people living with HIV/AIDS (PLHIV) in 2011. This is third highest burden in the world. On the other hand, India is highest Tuberculosis (TB) burden country in the world with an estimated 2.2 million new TB cases occurring annually. While TB is commonest opportunistic infection (OI) in HIV-infected individuals, HIV infection is an important risk factor for acquiring TB infection and its progression to active TB. HIV/TB together is a fatal combination with extremely high death rates (15 to 18%) reported among HIV-infected TB cases notified under Revised National TB Control Programme (RNTCP). Overall, TB is estimated to cause about 25% of all deaths among PLHIV in India. Early detection of HIV/TB cases and prompt provision of Anti-Retroviral Treatment (ART) and Anti-TB Treatment (ATT) are key interventions to reduce mortality rates significantly.

India's National AIDS Control Programme (NACP) and RNTCP recognized importance of HIV/TB co-infection, in their control efforts, as early as 2001. The two programmes jointly developed interventions to ensure early detection and prompt linkage of TB and HIV cases to care, support and treatment. These interventions were governed by joint national policy called National Framework for joint HIV/TB Collaborative Activities. The national (policy) framework is a dynamic document that evolved as the programmes gained experience of field implementation, also assimilating the changes in global guidelines and evidence generated through operational research. The current revision of national Framework coincides with finalization of the vision documents of both national programmes for next 5 year i.e. the NACP-Phase IV and RNTCP National Strategic Plan, (NSP) 2012-2017, and update in WHO HIV/TB policy recommendations.

History of Joint HIV/TB activities in India

The joint HIV/TB activities in India started in 2001 with 6 states, Maharashtra, Manipur, Nagaland, Karnataka, Tamil Nadu and Andhra Pradesh. These early activities included joint training of staff and cross-referral meaning intensified (TB) case-finding at Integrated Counselling and Testing Centres (ICTC) with referral of presumptive TB cases to RNTCP Designated Microscopy Centres (DMCs), and referral of TB patients having HIV risk factors to ICTC for voluntary HIV counselling and testing. These Collaborative Activities were extended to 8 additional states in 2004 (Delhi, Gujarat, Himachal Pradesh, Kerala, Orissa, Punjab, Rajasthan and West Bengal) and to cover entire country by 2008.

The first national policy framework was developed based on experience gained during programme implementation in initial years, important operational research (OR) studies instituted by NACP and RNTCP and the WHO HIV/TB interim policy. The OR included, the first demonstrating feasibility of decentralized delivery of co-trimoxazole preventive therapy (CPT) for HIV infected TB patients through RNTCP and

second showing feasibility of provider-initiated HIV testing and counselling (PITC) for TB patients. The first National Framework was published in November 2007, which endorsed *differential strategy* for implementation of HIV/TB activities in the country, reflecting the heterogeneity of HIV/TB epidemic in India. This strategy included “**essential**” HIV/TB interventions to be implemented nationwide and an “Intensified TB/HIV package of services” for states having high burden of HIV/TB.

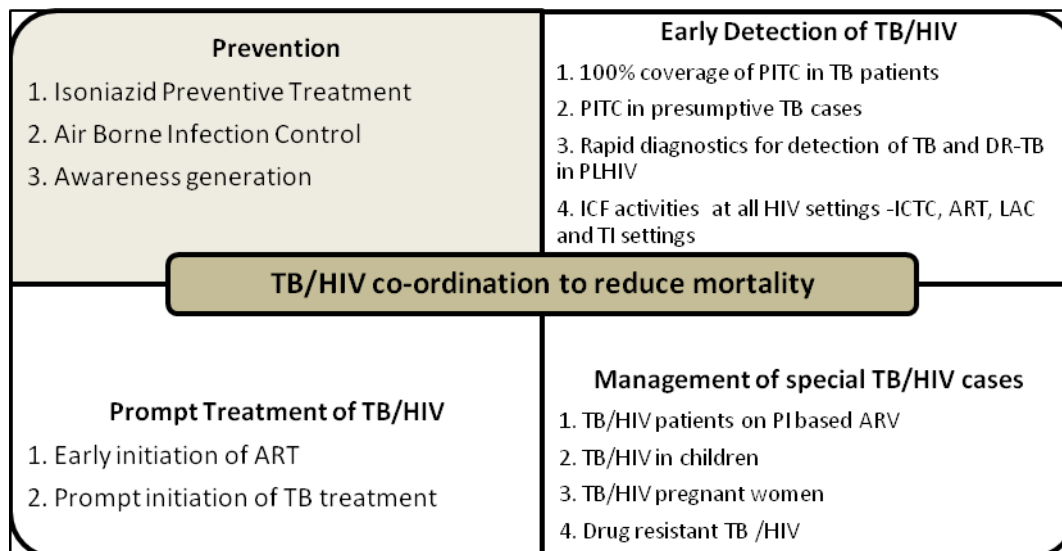
The selection of states for implementation of intensified package was based on HIV prevalence, absolute HIV burden, availability of decentralized HIV testing and treatment services and programme management capacity. In 2008 it was started in 9 states (Andhra Pradesh, Goa, Karnataka, Maharashtra, Manipur, Mizoram, Nagaland, Puducherry and Tamil Nadu). Review of this implementation demonstrated that it was a highly useful strategy for early detection of HIV in TB cases and prompt linkage to HIV care and support. The National Framework was therefore revised in 2009 with a decision to implement full spectrum of HIV/TB activities including scale-up of Intensified HIV/TB package uniformly across the country by 2012. This revision established uniform set of activities at all ART centres and ICTC including intensified TB case finding and reporting. It also strengthened joint monitoring and evaluation with specified national HIV/TB programme indicators and performance targets. Current revision of National Framework also aims to incorporate recent policy updates in NACP and RNTCP and align with respective national strategic plan for next 5 year along with recommendations in WHO HIV/TB policy guidelines 2011. The formerly-named ‘intensified package’ of HIV/TB services is now the national TB/HIV policy standard for all states. A single and uniform policy, national policy framework exists.

Purpose of National Framework: The overall purpose is to articulate the national policy for TB/HIV Collaborative Activities between RNTCP and NACP so as to ensure reduction of TB and HIV burden in India.

Objectives:

1. To maintain close coordination between RNTCP and NACP at National, State and District levels.
2. To decrease morbidity and mortality due to TB among persons living with HIV/AIDS.
3. To decrease impact of HIV in TB patients and provide access to HIV related care and support to HIV-infected TB patients.
4. To significantly reduce morbidity and mortality due to HIV/TB through prevention, early detection and prompt management of HIV and TB together.

The four pronged strategy summarised below is based on the foundation of strong collaboration between NACP and RNTCP



Existing HIV/TB Collaborative Activities

1. Strong NACP-RNTCP coordination mechanisms at national, state and district level
2. Joint monitoring and evaluation with standardized reporting shared between NACP and RNTCP
3. Joint training of key programme and field staff in HIV/TB activities
4. Operational research to strengthen implementation of HIV/TB Collaborative Activities
5. Implementation of basic infection control measures at ART centres e.g. fast tracking
6. Specific service delivery coordination activities are as follows:

Activities to reduce burden of HIV among TB patients:

- a) Provider initiated HIV testing and counselling (PITC) among TB patients
- b) Provision of co-trimoxazole preventive therapy (CPT) for HIV infected TB patients
- c) Provision of Anti-Retroviral Therapy (ART) for HIV infected TB patients
- d) Provision of HIV prevention education for patients with presumptive or diagnosed TB cases

Activities to reduce burden of TB among HIV infected individuals:

- a) Intensified (TB) case finding (ICF) at ICTC
- b) Intensified (TB) case finding (ICF) at ART centres and Link ART centres
- c) Air borne infection control measures for prevention of TB transmission at HIV care settings
- d) Implementation of Isoniazid preventive treatment (IPT) for all PLHIV (On ART + Pre-ART)

What is new in National Framework 2013?

1. Emphasis on **Integrated TB and HIV services** e.g. HIV screening at RNTCP DMC
2. Focus on **early detection and early care**:
 - a. **Early detection of TB in PLHIV**:
 - i. Early suspicion of TB—symptoms of any duration among PLHIV
 - ii. Use of an **expanded clinical algorithm for TB screening** that relies on presence of **four clinical symptoms** (current cough, weight loss, fever or night sweats) instead of only cough, to identify patients with presumptive TB

- iii. Strengthen ICF at ART, Link ART centre (LAC) and Targeted intervention projects (TI) for High Risk Group (HRG) specially Injection Drug Users (IDU)
- b. Early detection HIV/TB:**
- i. Enhance HIV testing facilities in settings with lack of co-located HIV and TB testing facilities, by establishing HIV screening services using **whole blood finger prick test (WBT)**
 - ii. Strengthen HIV testing of TB patients in high HIV prevalent settings by promoting establishment of **Facility Integrated Counselling and Testing Centre(F-ICTC)** where DMC exists
 - iii. **PITC** among patients being evaluated by diagnostic smear microscopy presumptive TB cases in high HIV prevalent settings
- c. Early Care:**
- i. Strengthened linkage of HIV/TB patients to ART centres through travel support by RNTCP as per NSP (2012-2017) etc.
 - ii. ART for HIV infected TB cases irrespective of CD4 count
 - iii. Prompt ART initiation- within first 8 weeks of commencing Anti-TB treatment.
 - iv. Monitoring of timeliness of ART initiation through expanded ART reporting formats
- 3. Early detection and care of HIV infected Drug Resistant TB patients (DR-TB/HIV):**
- i. Strengthen HIV testing in presumptive DR-TB cases (Criteria C)
 - ii. Ensure access to culture and drug susceptibility testing for HIV infected TB patients
 - iii. Prompt linkage of HIV infected DR-TB cases to ART centres
 - iv. Prompt initiation of ART in HIV infected DR-TB cases
- 4. Prevention of TB among HIV infected adults and children:**
- i. Implementation of IPT for all PLHIV (On ART + Pre-ART)
 - ii. Strengthen implementation of air borne infection control strategies.
5. Strengthen HIV/TB activities among children and pregnant women
6. Promotion of participation of private, NGO, CBO health facilities and affected communities working with NACP and RNTCP to strengthen HIV/TB Collaborative Activities.

2. NACP-RNTCP COORDINATION MECHANISMS

I. National TB/HIV Coordination Committee(NTCC)

The Department of AIDS Control, Government of India Vide letter no. T-11025/15/2013-NACO/BSD has constituted 'National TB/HIV Co-ordination Committee' (NTCC) under the chairmanship of Secretary with the following terms of reference:

- 1.To strengthen co-ordination mechanisms between NACP and RNTCP at National, State and District level
- 2.To review and adopt policies for strengthening implementation of joint TB/HIV activities
- 3.To suggest strategies for roll out and scale up of activities aimed at minimizing mortality and morbidity associated with TB/HIV
- 4.To review implementation of joint TB/HIV activities and identify key areas for strengthening

The composition and terms of reference (TOR) of NTCC are annexed (**Annexure 1**)

II. National Technical Working Group (NTWG)

At The Department of AIDS Control, Government of India Vide letter no. T-11020/77/05-NACO/BSD has constituted national level technical working group comprising of key officials from NACO and CTD, experts from WHO, National institutes and civil society members. The NTWG should meet quarterly and performs following key functions:

- Review NACP-RNTCP coordination activities at state and district level
- Review, optimize and plan for future HIV/TB Collaborative Activities.
- Joint monitoring and review of HIV/TB activities
- Planning of supervision of HIV/TB activities, including joint field visits, joint national level review etc.
- Facilitate operational research to improve programme implementation and assess impact of joint HIV/TB activities
- Develop normative tools and training material for HIV/TB

The composition and key functions of NTWG are annexed (**Annexure 2**)

III. State level coordination mechanisms:

A. State Coordination Committee (SCC): To ensure smooth implementation and regular review of HIV/TB Collaborative Activities, State Coordination Committee chaired by principal secretary health are established in all states. The SCC meeting should be organized at least bi-annually by the State AIDS Control Society (SACS). The SCC provides administrative approval for TB-HIV activities recommended by State HIV/TB technical Working Group (SWG). The composition and terms of reference (TOR) of SCC are annexed (**Annexure 3**). Decisions of SCC meeting must be shared with BSD/DAC and CTD electronically at tbhiv@rntcp.org

B. State technical Working Group (SWG): The State technical Working Group (SWG) should meet once a quarter to review and streamline HIV/TB activities in the state. These meetings should be organized

after RNTCP quarterly reporting is completed. It may be organized on side-lines of RNTCP quarterly DTO review meeting to facilitate quick dissemination of decisions to districts. Composition of SWG and generic agenda for quarterly SWG meetings is annexed (**Annexure 4**). Based on deliberations and decisions of SWG nodal officers for TB and HIV in the state should send feedback to all districts. Actions taken by district should be monitored and presented to SWG in its next meeting. Approved minutes of SWG meetings must be shared with Basic services Division/DAC and CTD by member secretary of SWG electronically at tbhiv@rntcp.org

IV. District level coordination mechanisms

A. District Coordination Committees (DCC): To ensure smooth implementation and regular review of HIV/TB activities, District Coordination Committee (DCC) are established. DCC should meet on a quarterly basis preferably within 15 days of submission of RNTCP quarterly report. The composition and TOR of DCC is annexed (**Annexure 5A**). Minutes of DCC meetings should be sent to the State AIDS Control Society (SACS) and State TB Cell (STC). The member secretary of DCC should invite representative from SACS and STC to participate in DCC meeting every time. State HIV/TB coordinator or other officers from STC and SACS should attend these meetings in rotation. A generic agenda for DCC meetings is annexed (**Annexure 5B**)

B. Monthly HIV/TB coordination meeting: A monthly meeting of RNTCP and NACP staff should be held with participation of all key programme staff. Monthly meetings of RNTCP staff are routinely conducted at district level. During these meetings, one session should be dedicated to review of HIV/TB activities and all Key NACP staff including DAPCU officer or DNO, district ICTC supervisor, ICTC counsellors, ART centre SMO/MO and ART centre staff nurse should participate in this meeting. A generic agenda for these meetings is annexed (**Annexure 5B**). Based on discussions in this meeting feedback should be provided to all health centres. Minutes of these meetings should be sent to SACS and STC. On behalf of SACS the In charge of BSD will be responsible for collecting and analysing these for necessary action and the same to be submitted within fortnight after every quarterly meeting for BSD/DAC and CTD with copy to STWG. The issues identified in these meetings should also be discussed in monthly medical officer review meeting by CMHO at district level.

V. Annual review of HIV/TB Collaborative Activities at National and State level: RNTCP conducts regular review meetings at national and state level. In one of these meetings at national level, joint review of HIV/TB activities should be done with participation of state programme managers of both programmes. This meeting should be held jointly by NACO and CTD.

Similar joint review meeting should be held at state level by adding one additional day to one of the quarterly RNTCP review meetings, inviting all district nodal officers for HIV/AIDS or DAPCU officer and SACS officials. The joint review meetings should be organised in close coordination by SACS and STC. The schedule of joint meetings should be communicated to NACO and CTD and representatives from CTD or NACO should participate in the same. The expenditure incurred on TA/DA of officers for both these

meetings should be borne by respective national programme while organizational cost should be borne by RNTCP.

VI. **Human resources:** To facilitate co-ordination and successful implementation of HIV/TB activities, following positions should be in place:

- a) A full-time regular government officer should to be in charge of HIV/TB activities at national and state level in both NACP and RNTCP
- b) National consultants for HIV/TB in NACO and CTD
- c) NACO regional co-ordinators (RC) for care and support programme
- d) Joint Director/DD Basic services Division at SACS.
- e) State RNTCP TB/HIV co-ordinators (2 states HIV/TB co-ordinators in bigger states for NSP 2012-17) in all states.
- f) District level:
 - DAPCU officer or DNO(regular government officer) and DTO
 - District HIV/TB and DR-TB/HIV supervisor under RNTCP and district ICTC supervisor under NACP in A and B category districts

3. TB AND HIV SERVICE DELIVERY COORDINATION

3.1 HIV testing of TB patients

Provider Initiated HIV Testing and Counselling (PITC) of TB patients is now implemented across the country. It is critical that the offer of HIV testing should be done early after TB diagnosis and results are promptly communicated to referring provider so as to ensure early linkage to HIV care and support.

HIV testing of TB patients should be done at NACO ICTC (stand-alone or F-ICTC or PPP ICTC). Currently there is considerable gap in availability of co-located HIV testing facility *vis a vis* the RNTCP DMC. It is envisaged by NACP and RNTCP that all DMC will have a collocated HIV testing facility over the period of NACP IV (2012-17).

The measures to bridge the gap in these states include

1. Re-allocation of stand-alone ICTC from high prevalence states to low prevalence states so that a stand-alone ICTC are made available at CHC level across the country
2. Promote establishment of Facility Integrated ICTC at all the 24*7 facilities below CHC level
3. Promote establishment of HIV screening centres using whole blood figure prick test at RNTCP DMC at facilities not having co-located ICTC or F-ICTC
 - Patients screened for HIV using whole-blood finger prick test if found “non-reactive” do not require further testing, while if results is “reactive”, it should be confirmed at nearest ICTC.

3.2 HIV testing of presumptive TB cases:

An operational research study instituted by Central TB Division showed very high yield of HIV among TB suspects (7 to 10%) in high prevalence settings. This is as high as that observed in TB patients. In addition this intervention contributed significantly in detection of new HIV infection in the study area (by up to 35%). Also the updated WHO policy on TBHIV Collaborative Activities of 2012 recommended implementation of PITC among presumptive TB cases. Considering the country evidence and global recommendation, the National Technical Working Group on HIV/TB recommended that the programmes implement PITC among TB suspects in all "high" HIV prevalent settings in India (A and B category districts) in a phased manner. Operationalization of this strategy requires availability of co-located TB and HIV testing facilities. Therefore NACP and RNTCP nodal officers should develop joint micro-plan before implementation of the strategy. The plan should include following activities:

1. Enlisting facilities with co-located HIV and TB testing facilities
2. Availability of sufficient HIV test kits
3. Availability of ARV drugs to cope with anticipated increase in detection of new HIV cases
4. State level training of DTO, DAPCU officers, district HIV/TB and DOTS plus supervisors and district ICTC supervisors (**Annexure 13**).
5. Joint training of DMC laboratory technicians and institutional DOT providers
6. Joint training of other key staff under NACP and RNTCP
7. Modification of recording and reporting formats as per NACO and CTD directives

8. Funds required for training and sensitization activity should be booked under training component of basic services division.

3.3 Intensified TB case finding (ICF):

ICF at ICTCs

All ICTC clients should be screened by ICTC counsellors for presence of TB symptoms at every encounter (pre, post, or follow-up counselling). Clients who have symptoms or signs, irrespective of their HIV status, should be referred to RNTCP diagnostic and treatment facility located in same institution. Therefore NACP and RNTCP promote establishing co-located facilities, for better coordination between the two programmes. Hence as network of HIV testing facilities is being expanded, consideration should be given to establish them at sites which already have RNTCP designated microscopy centres (DMC).

The referrals of presumptive TB cases from ICTCs to TB diagnosis facility should be recorded on a line list (**Annexure 7**) to facilitate exchange of information with RNTCP and track the client through the process of TB diagnosis and initiation of DOTS. To streamline this process further RNTCP programme staff should stay in touch with ICTC counsellors to complete the exchange of information in time. In addition ICTC counsellors and RNTCP programme staff participate in monthly HIV/TB coordination meeting at district level to validate line-lists and monthly HIV/TB reports (**Annexure 6**) and resolve operational issues if any.

ICF at ART Centres

HIV-infected persons attending ART centres for pre-ART registration have a high prevalence of TB disease (6 to 8%). The incidence of TB among ART clients is also very high, even when on ART. Although ART reduces risk of incident TB, it remains many times higher compared to general population. Also HIV-infected clients having undiagnosed or untreated TB may seek care at ART centres and thus exposing other HIV-infected persons to the risk of acquiring TB. Therefore active efforts for intensified TB case finding (ICF) at ART centres is critical for early suspicion and detection of TB, linkage to treatment and thus for prevention of transmission of infection to other clients. The national ART guidelines clearly state that all patients coming to ART centres should be actively screened for opportunistic infections, particularly tuberculosis. The presumptive TB cases identified at ART centres or Link ART centres should be prioritized and “fast-tracked” for evaluation by SMO/MO to minimize opportunities for airborne transmission of infection to other PLHIV.

Also the referrals presumptive TB cases should be recorded on an ART centre TB-HIV line list (**Annexure 10**) to facilitate coordination with RNTCP programme staff and to track the patient closely through the process of TB diagnosis and DOTS initiation. It is also crucial that ART Centre staff members attend monthly HIV/TB coordination meeting. The HIV/TB monthly reporting format to be generated at ART centres is incorporated into the ART centre monthly report (CMIS) (**Annexure 10**).

Information of all HIV infected TB patients in HIV care should be recorded in the ART centre HIV/TB register (**Annexure 11**). These include TB patients detected by ART centre staff as well as those TB patients found HIV infected while on DOTS treatment and referred to ART centre by the RNTCP. TB-HIV register is an important monitoring tool to track timeliness of initiation of CPT and ART also the TB treatment outcome so as to modify ARV regimens as per guidelines. It is also important that ART centre staff carry this register when they attend monthly HIV/TB coordination meeting to update information on TB treatment outcome from RNTCP staff and share information pertaining to CPT and ART with them for recording into RNTCP TB registers.

ICF at Link ART Centres (LAC)

The ICF activity is also implemented at all Link ART plus and Link ART centres in the country. As in ART centres LAC-Plus and LAC should 1) implement ICF using symptom screening on every encounter 2) promptly refer presumptive TB case to RNTCP diagnostic facilities, and 3) refer the patient to ART centre promptly if TB is detected for initiation of ART or modify current ARV regimen. Similar to ART centre, the LAC staff nurse /counsellor should maintain line-list, exchange with local RNTCP staff to seek information on TB diagnosis and treatment and complete the line-list.

The LAC Plus use same line-list format as the ART centre (**Annexure-9**) while at LAC Plus centre the ICTC line-list format is used (since ICTC counsellor runs the LAC) (**Annexure 7**). The completed line-list from LAC-plus is merged with ART centre line-list whereas that from LAC is merged into ICTC line-list for the same period and monthly report is generated accordingly.

These mechanisms are designed considering operational feasibility but key point is if TB is detected among patients at LAC plus of LAC, they **must be promptly referred to ART centre** for further management.

ICF among HIV high risk groups (HRG)

Operational research conducted in high HIV prevalent states have shown that HRG's like female sex workers (FSW), men having sex with men (MSM), injection drug users (IDU) etc. are more likely to have tuberculosis compared to general population. Also it is known that HIV prevalence among the HRG is several times higher than general population. While NACP provides HIV prevention interventions for the HRG through its targeted interventions, the ICF provides an opportunity to provide additional services to this population. This intervention is likely to help in detection HIV/TB cases early and link to care support and treatment. Among the HRG's, IDU have highest HIV prevalence therefore the programmes aim to provide ICF services and prompt linkage to care support and treatment to IDU as a priority.

3.4 Linkage of HIV-infected TB patients to NACP, for care and support and treatment

The Anti-TB treatment of HIV infected TB patient should be done using RNTCP DOTS as per national policy. All HIV infected positive TB patients are considered seriously ill regardless of sputum smear results and are offered either RNTCP Category I or Category II treatment, depending on their previous history of TB treatment.

In addition to TB treatment all HIV-infected TB patients must be provided access to care and support for HIV/AIDS, including antiretroviral therapy. ART reduces TB case fatality rates and the risk of recurrent TB. ICTC counsellors and the treating physicians should counsel these patients on the importance of ART and its free availability.

HIV-infected TB patients should be promptly referred to nearest ART centre by the treating physicians and ICTC counsellors. The RNTCP staff should also closely monitor linkage of HIV infected TB patient to ART since it is critical for preventing mortality. At ART centre, these patients should be fast tracked through all the base line evaluation and initiated on ART at the earliest and not later than 2-8 weeks after TB diagnosis. NACO recommends that all HIV infected TB patients should be started on ART irrespective of CD4 count or clinical condition. For details on ART eligibility, reference ART guidelines are available at www.nacoonline.org. This visit to ART centre should preferably occur two weeks after initiation of ATT to ensure some reduction in TB transmission potential. They should also receive education on cough hygiene etc.

3.5 Provision of co-trimoxazole preventative treatment (CPT) for HIV-infected TB patients

CPT has been shown to reduce mortality among HIV-infected TB patients, and is recommended by NACP for all HIV-infected patients. All HIV-infected TB patients should be provided CPT. At a minimum, monthly provision of CPT should be available at all ART centres.

CPT should also be made available to RNTCP for initiation among TB patients on DOTS who are detected to have HIV. These patients should be promptly referred to ART centres. On enrolled into ART care the CPT provision should be shifted to ART centre. The supply of CPT should be procured and packaged into monthly pouches by SACS and local distribution should be managed by RNTCP. In this mechanism, CPT is delivered by peripheral health institute staff, and not the community DOT providers, to maintain confidentiality regarding HIV status within the health-care system.

3.6. Mechanisms for management of difficult to treat HIV/TB cases:

A. Treatment of HIV/TB patients on Protease Inhibitor (PI) based ARV regimen:

It is known that there are significant drug interactions between PI and Rifampicin. Rifampicin has hepatic enzyme inducing capacity, which risks rendering PI levels sub-therapeutic. Another Rifamycin called Rifabutin is a less potent inducer of CYP 3A4 liver enzyme compared to Rifampicin, while being equally safe and effective for treatment of TB. It can therefore be administered along with PI-containing ARV regimen without compromising efficacy of ART or Anti TB treatment. Rifabutin can be administered thrice-weekly like other ATT drugs.

Procurement of Rifabutin is to be done by RNTCP at national or state level based as per requirement at NACO centres of excellence (CoE) or ART-Plus centres. If TB is diagnosed among PLHIV on PI based regimen, TB treatment should be started using RNTCP prolongation pouches replacing Rifampicin with Rifabutin. At the same time communication should be sent to STC, SACS and concerned DTC electronically

to arrange for patient wise box to be used at patients DOT centre near his residence. At discharge patient should be referred to nearest PHC to complete the course of ATT. The operational guidelines regarding the procurement and use of Rifabutin is summarized in the flowchart at **Annexure 12**

B. HIV infected patients having drug resistant TB (DR-TB):

Early detection of HIV among DR-TB cases:

- All DR-TB cases must be offered HIV test.

Early detection of DR-TB among HIV infected individuals:

- The PMDT prioritizes offering culture and drug sensitivity testing to HIV/TB patients as per criteria-C districts.
- RNTCP also prioritize HIV/TB patients for diagnosis using rapid diagnostic technologies for early detection and prompt treatment

Early linkage of DR-TB/HIV patients to ART centres

- NACP and RNTCP to ensure early initiation of ART among HIV infected DR-TB cases

C. Management of HIV/TB among children: NACP and RNTCP is to ensure early detection of HIV/TB among children through

- Measures to strengthen PITC among children suffering from TB
- Measures to strengthen intensified TB case finding among HIV infected children

D. Management of HIV/TB among pregnant women:

NACP provides PITC to all pregnant women registered in ante-natal care (ANC), for early detection of HIV infected pregnant women, provision of ARV prophylaxis and thus prevent mother to child transmission of HIV. But since risk of acquiring TB in pregnant women is similar to the general population, intensified TB case finding is not implemented in this group.

Recent evidence suggests that TB in HIV infected pregnant women is an independent risk factor for increased mother to child HIV transmission. Thus although ICF will not be implemented among all pregnant women, it is a critical activity among HIV infected pregnant women. This activity is routinely implemented at ART centres, but to ensure closer monitoring, ICF is incorporated in the NACP tracking line-list for PPTCT clients. Hence ICF should be routinely done for HIV infected pregnant women both at ICTC and ART centres, and if TB is detected treatment should be promptly initiated.

4. PREVENTION OF TB IN PLHIV

4.1 Prevent spread of TB in facilities caring for HIV-infected persons

In health care settings frequented by high numbers of HIV-infected persons, measures to reduce airborne tuberculosis transmission should be undertaken. These include simple administrative and environmental measures aimed at generally reducing exposure of HIV-infected patients to *M. tuberculosis*.

Administrative measures should first include early recognition, diagnosis and treatment of tuberculosis cases, particularly those with smear positive pulmonary tuberculosis. It should also include separation of presumptive pulmonary TB cases from other HIV-infected patients e.g. in patients waiting areas, until TB diagnosis is excluded or confirmed and effective TB treatment is initiated. Environmental protection should include maximizing natural ventilation. The general guidelines for infection control are summarized below:

1. ART centres should not be located in close proximity DMC/DOT centres i.e. they should not share waiting areas
2. ART centres should have a well-ventilated waiting & seating area. More than 12 air-changes per hour required for ART settings as per the National Airborne infection control guidelines.
3. Screening of all patients for respiratory or other TB symptoms should be done at every visit to the ART centre to ensure early identification, referral for diagnosis and initiation of treatment.
4. Fast-tracking of chest symptomatic cases should be done through all waiting areas in ART centres and RNTCP DMC to minimize time spent around other waiting patients or risk of acquiring infection (DMC).
5. Separate, well-ventilated waiting area for respiratory symptomatic should be made available wherever possible.
6. Health education on cough hygiene should be stressed by counsellors, medical officers, staff nurse etc. simple measures like covering mouth while coughing should be demonstrated
7. As far as possible, use of re-circulating air conditioners in the waiting area should be avoided as these have been found to leading to no air exchange.
8. Display of IEC material reminding the patients to follow cough hygiene practices, need for fast-tracking etc.

4.2 Isoniazid Preventive Therapy (IPT)

IPT is one of the 3 I's globally recommended for prevention of incident TB among HIV infected individuals. Provision of IPT primarily involves

1. Exclusion of active TB disease among PLHIV
2. Administration of Isoniazid daily for 6 to 9 months

Isoniazid is the most effective **bactericidal drug** currently available. It protects both against progression of latent TB infection to active disease (reactivation) as well as from reinfection when exposed to active TB case. Implementation of programme for IPT is planned as below:

1. IPT should be provided to all HIV infected patients NOT having active TB disease
2. IPT can be provided both during pre-ART care and while on ART
3. Initiation of IPT should be done only at ART centre
4. In patients on ART, monthly INH collection can be done from ART centre or LAC Plus centres. Patients on pre-ART care eligible for IPT can collect INH from nearest LAC or stand-alone ICTC.
5. Adults and adolescents living with HIV should be screened for TB using a clinical algorithm, and patients not reporting any one of the symptoms of current cough, fever, weight loss or night sweats, are unlikely to have active TB (excludes TB confidently). They should be offered IPT.
6. Isoniazid should be given once daily for 6 months along with pyridoxine
7. Children living with HIV who do not have either of poor weight gain, fever or current cough are unlikely to have active TB and should be offered IPT regardless of their age
8. Children living with HIV who are more than 12 months of age and who are unlikely to have active TB on symptom-based screening, and have no contact with an active TB case should receive IPT for six months (10 mg/kg/ day)
9. RNTCP should procure and supply Isoniazid to NACP at state level. The SACS should then manage further supply to ART centres, LAC and stand-alone ICTC
10. Training requirement for IPT implementation is mentioned in Annexure-11

4.3 Prevent spread of HIV through safe injection practices in state and district health facilities providing services

Measures to reduce parenteral HIV transmission include use of sterilized injection and surgical equipment in all medical settings. Steps should be undertaken by concerned authorities (State and District) to ensure availability of sterilized disposable needles and syringes for administration of injectable drugs and needle destroyers for safe disposal at all times and in all facilities.

5. HIV/TB REPORTING, MONITORING AND EVALUATION

HIV/TB activities are implemented with close coordination between two national programmes having different reporting systems. HIV/TB recording and reporting involves staff of both programmes, hence it is little complex. Following table clarifies the reporting responsibilities:

	Essential HIV/TB recording and reporting
HIV/TB coordination activities	<ul style="list-style-type: none"> • Quarterly report on HIV/TB Collaborative Activities by SACS sent to NACO at tbhiv@rntcp.org*(Annexure-4) • Minutes of State Coordination Committee meetings sent to centre (at tbhiv@rntcp.org) and reported in RNTCP state PMR • Minutes of state TB/HIV working group meeting sent to centre at tbhiv@rntcp.org. • Minutes of District Coordination Committee meeting sent to State TB Cell and SACS and reported on RNTCP District PMR • Minutes of Monthly HIV/TB meeting sent to State TB Cell and SACS by district
Intensified TB case finding at ICTCs /LAC	<ul style="list-style-type: none"> • Monthly line-list of ICTC referrals of presumptive TB cases and TB diagnostic outcomes jointly prepared by ICTC counsellor and STS (Annexure 7) • Monthly ICTC TB-HIV Report (Annexure 8) • Consolidated state ICF at ICTC monthly report sent at tbhiv@rntcp.org.
Intensified TB case finding at ART centres/LAC Plus centre	<ul style="list-style-type: none"> • Monthly line-list of ART referrals of presumptive TB cases and TB diagnostic outcomes jointly prepared by ART centre staff nurse and RNTCP STS (Annexure 9) • Monthly ART centre TB-HIV report as a part of 4-page monthly report of ART centres(Annexure 10) • TB/HIV register at ART centre jointly maintained by ART centre staff nurse and RNTCP STS (Annexure 11) • Consolidated state ICF at ART centre monthly report sent at tbhiv@rntcp.org
HIV-testing of TB /DR TB patients	RNTCP Quarterly Reports (Case Finding Report)(Annexure 16A), PMDT reports (Annexure 16B)
HIV-testing of presumptive TB cases	RNTCP laboratory register, RNTCP Quarterly Report (Programme management report PHI, TU, District and state) (Annexure 16A)
Provision of CPT to HIV-infected TB patients	RNTCP Quarterly Report (Results of Treatment Report) (Annexure 16 A)
Provision of ART to HIV-infected TB patients	RNTCP Quarterly Report (Results of Treatment Report) (Annexure 16A)

1. * tbhiv@rntcp.org. email ID will change to tbhiv@rntcp.nic.in - in future

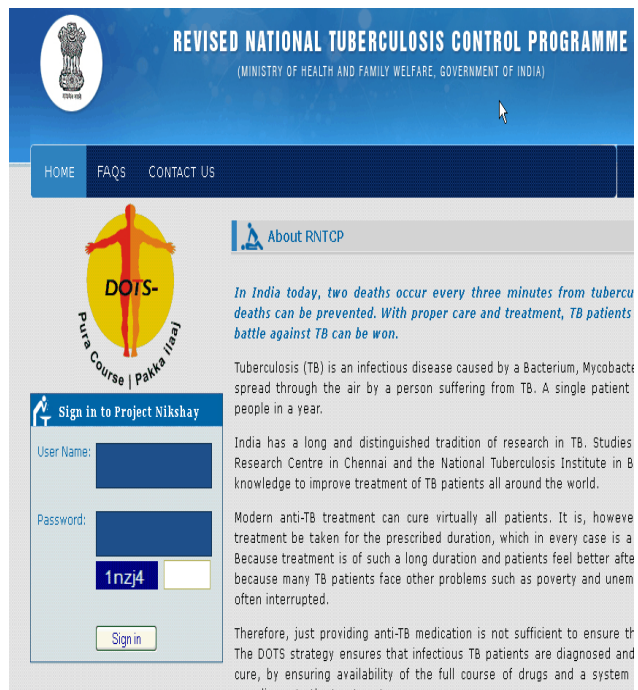
2. All ICF at ICTC reports from state to NACO should be done using standard reporting excel formats until NACO SIMS system is established for TB/HIV

Special note on reporting:

- ICF activity is also implemented specifically in HIV infected pregnant women since TB is independent risk factor for transmission of HIV infection from mother to the baby. This activity is therefore incorporated in NACO PPTCT line-list

- To allow complete diagnosis of TB in a presumptive TB case and initiation of TB treatment, TB-HIV monthly reporting is done for a month previous to the ICTC/ART centre monthly report. For e.g. in monthly ICTC report submitted to NACO for March 2012, the TB-HIV data belongs to February 2012
- All TB-HIV reporting from RNTCP is done through routine quarterly reports in Epi-Centre software (Case Finding (CF), Sputum Conversion (SC), Results of Treatment (RT), Programme Management Report (PMR) and PMDT quarterly report).

A web based case based electronic reporting system has been developed by RNTCP (NIKSHAY) with the support of National informatics centre, New Delhi and SIMS (Strategic Information Management system) by Department of AIDS Control.



Joint HIV/TB monitoring and evaluation

To strengthen implementation of Collaborative Activities at all levels joint field visits would be undertaken by a national team (NACO & CTD) to at least one state per quarter. Similarly state teams (SACS & STC) should visit at least one district every quarter. These states and districts are chosen based on key HIV/TB performance indicators. Observations made in joint visits should be discussed in state review meetings and the SWG. A copy of the same should also be submitted to NACO and CTD.

To aid in joint field visits and review meetings RNTCP and NACP jointly developed monitoring indicators and targets. Performance indicators and targets for HIV/TB Collaborative Activities target are shown in Annexure 15.

6. TRAINING OF PROGRAMME AND FIELD STAFF ON HIV/TB

HIV/TB training is an integral part of NACP and RNTCP activities. Budgets for training of respective programme staff should be borne by SACS and STC, while all field level trainings are supported by NACP under the global fund RCC round-2. Details of norms and trainings guidelines for HIV/TB Collaborative Activities are annexed (**Annexure 13**).

Standard training modules covering all aspects of HIV/TB activities including basics of HIV/TB activities, activities to reduce burden of TB among HIV infected individuals (ICF at ICTC and ART centre, implementation of Isoniazid Preventive Treatment etc.) and activities to reduce burden of HIV among TB patients are jointly prepared by NACO and CTD for training of programme and field staff.

To ensure quality of training of field staff state-level master trainers for HIV/TB should be trained at national level. The master trainer includes a group of experts/officials from SACS, STC, STDC and other academic or research institution jointly selected by SACS and STC. The training of master trainers should be jointly planned by CTD and NACO as per programme need. The master trainers should then facilitate training of DNOs/DAPCU officers and DTOs and the key programme staff at state level. The state level trainers then facilitate trainings at district level for programme staff and field staff with close coordination.

Given an exceptionally high burden of TB among Persons attending ART centres, ART medical officers should be routinely trained at State level in TB diagnosis, care, and RNTCP procedures, using standard RNTCP modules. Along with this ART MO should be trained in module for ART centre staff also. The person responsible for HIV/TB activities at the ART centre e.g. staff nurse should also be trained specifically to implement HIV/TB activities. The other ART centre staff (counsellor and data manager) should also be trained /sensitized in HIV/TB activities at ART centre.

7. ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION, AND INVOLVEMENT OF NGO / CBO WORKING IN NACP AND RNTCP IN HIV/TB COLLABORATIVE ACTIVITIES

Advocacy Communication Social Mobilisation is an important means to reach out to people, increase accessibility and utilisation of services. It is an important and crucial component of HIV/TB Collaborative Activities.

7.1 Involvement of affected communities

The empowerment of communities in the response to TB and HIV/TB is crucial; there is a great role for HIV activists to play in addressing the challenge of HIV/TB co-infection. PLHA networks should regularly distribute TB treatment literacy information, so that TB can be suspected early whenever a community member suffers from persistent cough or unexplained illness. Particularly in HIV care settings, community volunteers may make important contributions to TB screening and advocacy for improved TB infection control. The PLHA community needs to increase knowledge and literacy about TB in order to maximize their contribution. Where possible, RNTCP should include PLHA groups in social mobilization activities.

TB prevention is another important area where the community can contribute. Importance of measures like airborne infection control should be frequently emphasized during interactions with community members. Also compliance with Isoniazid preventive treatment is another important prevention intervention that should be widely disseminated.

7.2 Involvement of NGOs and CBOs

There are a large number of NGOs and CBOs working with both NACP and RNTCP. These organizations play an important role in programme implementation by increasing out reach of the individual programmes and provision of package of services to difficult to reach populations like migrants, truckers, tribal populations, commercial sex workers, etc.

NACP should include TB-HIV activities in the minimum set of activities required for NACP-supported Targeted Intervention (TI) NGO and CBOs. Similarly RNTCP should promote its “TB-HIV Scheme” to ensure provision of essential TB screening and referral services by organizations dealing with high-HIV prevalence population. Also all NGO and private providers contributing in RNTCP work should be provided option to contribute in HIV detection and linkage to care and support. Eligibility for the scheme is outlined in RNTCP Guidelines “Revised Schemes for NGOs and Private Providers, 2008” (available at www.tbcindia.nic.in). Under the proposed scheme NGO would undertake delivery of ‘Comprehensive TB Care for HIV high risk populations’ which includes all of the following components:

Components of “Comprehensive TB Care for high-HIV risk populations”

1. Intensified TB Case Finding:
 - a. TB symptom screening through outreach workers and peer educators at the time of each interaction with members of target population & referral of presumptive cases for diagnosis & treatment
 - b. TB symptom screening for clients attending NGO clinics
2. Patient friendly approach for diagnosis and treatment:
 - a. Sputum collection & transportation or facilitated referral
 - b. NGO staff to co-ordinate with government health facilities for investigations like X-Ray or FNAC etc. for diagnosis of smear negative TB and Extra-Pulmonary TB
 - c. Training of NGO clinic doctor in TB treatment categorization
 - d. Address verification by NGO staff before initiation of TB treatment
3. Treatment provision:
 - a. Treatment delivery to be organized by NGO by identifying appropriate community DOT provider in consultation with the client or DOT provision by NGO staff if convenient to patient
4. Adherence:
 - a. NGO staff to ensure timely follow up of patient and undertake retrieval actions in case of treatment interruption;
 - b. Coordinate with local RNTCP staff to ensure smooth transfer in case of anticipated migration of patient
 - c. Monitoring recording on TB treatment cards by NGO staff/community volunteer
5. Monthly meeting: DTO/DNO and NGOs
6. Outreach activities by NGOs, out-reach workers to include ACSM
 - a. Increase awareness of facilities under RNTCP for the HRG community
 - b. Community capacity building/CBO/community involvement in TB services
 - c. Advocacy with PLHA networks for TB control

7.3 IEC & BCC activities

- RNTCP and NACP IEC material should be displayed at ICTCs, ART centres, CCCs, Link ART Centres, TI sites, DMCs and other facilities providing care and support to PLHA and TB patients. Specifically material depicting symptoms of TB, cough hygiene etc. should be prominently displayed in all registration and waiting areas. Health care providers including counsellors should educate all HIV-infected clients on risk of TB, signs and symptoms, and what to do when signs and symptoms occur.
- Counselling at ICTCs and ART centres should specifically include counselling on TB. A “Counselling tool on TB-HIV” is developed for use by counsellors in ICTCs and ART centres.
- Efforts must be made by key RNTCP field staff and all general health care providers to generate awareness amongst all patients about HIV infection and availability of services for HIV care and support.

8. OPERATIONAL RESEARCH TO IMPROVE IMPLEMENTATION OF HIV/TB COLLABORATIVE ACTIVITIES

The successful evolution of HIV/TB Collaborative Activities in India can be attributed to a large extent to operational research (OR) instituted by NACP and RNTCP from time to time. The OR helped national programmes to generate specific national evidences to feed into policy decisions. This helped timely decisions and quick scale-up of activities to national level.

Operational research will continue to be an important pillar of HIV/TB Collaborative Activities in India. The OR agenda for HIV/TB should continue to be directed towards improving efficiency of implementing policies and procedures, evaluating new approaches to decrease morbidity and mortality due of TB in people living with HIV/AIDS and improving access to HIV care and support. Following are specific priority areas for TB-HIV operational research for national programmes to make policy changes over next few years:

1. Study of prevalence of WHO recommended TB symptom complex among ART centers attendees in India
2. To design the optimum algorithms to rule out active TB disease among HIV infected individuals
3. Incremental yield of TB cases by screening all HIV infected patients having TB symptoms, using CBNAAT technology at ART centers
4. Evaluation of loss of referrals of presumptive TB cases from ICTCs to RNTCP
5. Study of reasons for delay in initiation of CPT and ART among HIV infected TB patients
6. Incidence and mortality associated with TB among patients awaiting ART and on ART.
7. Feasibility and effectiveness of daily versus intermittent chemotherapy for HIV infected TB patients under the RNTCP
8. To study TB treatment outcomes among HIV infected TB patients on PI based ARV regimens and Rifabutin
9. Evaluation of Airborne Infection Control practices at HIV care facilities like ART centers
10. Evaluation of the implementation and impact of infection control measures in ART centers.
11. Evaluation of the impact of infection control measures on the incidence of TB infection among health care workers
12. Evaluation of implementation of isoniazid preventive treatment for PLHIV on ART versus those on pre-ART care
13. Risk of TB among HCWs at HIV care, support and treatment centers
14. Spectrum of Immunological and Clinical staging of HIV disease in HIV-infected TB patients.

NATIONAL TB HIV COORDINATION COMMITTEE (NTCC)

Composition of committee:

1. Chairman: Secretary, Department of AIDS Control, Ministry of Health and Family Welfare, Government of India.
2. Vice chairperson of the NTCC is Additional Secretary, Department of AIDS Control, Ministry of Health and Family Welfare, Government of India
3. Nominee from Ministry of Health and Family Welfare, Government of India - concerned joint secretary
4. Deputy Director General (TB), Dte. GHS Ministry of Health and Family Welfare, Government of India
5. Deputy Director General, Care, Support and Treatment Division, Department of AIDS Control, Ministry of Health and Family Welfare, Government of India
6. Nodal person for HIV, WHO India
7. National Professional Officer (TB), WHO India
8. Director, National Institute of Research in TB (NIRT), Chennai
9. Director, National AIDS Research Institute (NARI), Pune
10. Project Director, Karnataka State AIDS Control Society, Bengaluru, Karnataka.
11. Project Director, Uttar Pradesh State AIDS Control Society, Lucknow, U.P.
12. Civil Society organisation Representative – TB, Global Health Advocates, New Delhi
13. Civil Society organisation Representative – HIV, President, Indian Network for Positive People (INP+)
14. National Program Officer (ART) DAC.MOHFW.GOI
15. Program Officer (HIV-TB) DAC/ MOHFW/GOI
16. Member secretary : Deputy Director General, Basic Service Division, DAC, Ministry of Health and Family Welfare, Government of India

The Terms of Reference for the committee are to:

1. Strengthen co-ordination mechanisms between NACP and RNTCP at National, State and District level
2. Review and adopt policies for strengthening implementation of joint TB/HIV activities
3. Suggest strategies for roll out and scale up of activities aimed at minimizing mortality and morbidity associated with TB/HIV
4. Review implementation of joint TB/HIV activities and identify key areas for strengthening.

The NTCC will meet at least once in every quarter or as per need with the permission of the chairperson.

**NATIONAL TECHNICAL WORKING GROUP ON TB-HIV COLLABORATIVE
ACTIVITIES (NTWG)**

Composition of NTWG:

Chairperson: Deputy Director General, Basic Service Division, DAC, Ministry of Health and Family Welfare, Government of India

Members:

1. Deputy Director General (TB), Dte. GHS Ministry of Health and Family Welfare, Government of India
2. CMO-TB(in charge for the TB-HIV activities) at Central TB Division, MoHFW
3. Medical officer- HIV, WHO India country Office, New Delhi
4. Medical officer/National Professional Officer (TB), WHO India, New Delhi
5. National consultant, TB/HIV, CTD, MoHFW, New Delhi
6. TB/HIV researcher, National Institute of Research in TB (NIRT), Chennai.
7. Joint Director/In charge TB/HIV activities at State AIDS Control Society nominated by DAC,(Annual rotation)
8. State TB officer Nominated by CTD(Annual rotation)
9. DDG(CST),Dept of AIDS Control, NACO, MoHFW
10. National Program Officer (ART). DAC, NACO, MoHFW
11. National Program Officer (ICTC). DAC, NACO, MoHFW.
12. Civil Society organisation Representative – TB, Global Health Advocates, New Delhi
13. Civil Society organisation Representative – HIV, President, Indian Network for Positive People (INP+)
14. Member secretary: Program Officer (HIV-TB), DAC, MOHFW.

The Terms of Reference for the committee are to:

1. To strengthen NACP-RNTCP co-ordination at National, State and District level.
2. To review, Optimize and plan for future TB/HIV Collaborative Activities as envisaged in NACP-IV and the National Strategic plan(2012-17)
3. To develop strategies for rollout and scale up TB/HIV interventions as recommended for implementation by NACP and RNTCP.
4. Strengthening mechanism for joint supervision and monitoring including standardized recording, reporting and data sharing between NACP and RNTCP as per the national framework for TB/HIV Collaborative Activities.
5. Identify key areas for research and facilitate conduct of Operational research to improve programme implementation or research for impact assessment of TB/HIV interventions. The NTWG will meet at least once in every quarter.

STATE TB-HIV CO-ORDINATION COMMITTEE (SCC)

Proposed composition:

1. Secretary, Health: **Chairman**
2. Director Health Services: Vice Chairman
3. Mission Director, National Rural Health Mission, Vice Chairman
4. Director Medical Education and Research: Member
5. Project Director, SACS: Member
6. Additional Project Director, SACS: **Member, Secretary**
7. State TB Officer: Member
8. Director, STDC: Member
9. DAPCU Nodal Officer at SACS : Member
10. Joint Director / Dy. Director, ICTC, SACS: Member
11. Dy. State TB Officer / Assistant Programme Officer (APO): Member
12. RNTCP and NACP consultants and Regional coordinators: Member
13. State HIV/TB coordinator
14. Representative of NGOs working with RNTCP: Member
15. Representative of NGOs working with NACP: Member

Note: The Chairman of the Committee if need arises can invite a person as special invitee whenever required for the betterment of the programme. In case the Chairman is not available for the meeting, a nominee of the chairperson may preside over the deliberations

Terms of Reference

1. To ensure implementation of collaborative TB-HIV activities as per national framework
2. To ensure that all District Nodal Officer for NACP and DTO for RNTCP **are in place**
3. To address issues related to sub-optimal detection of HIV/TB and linkage to DOTS and ART services
4. Policy decisions to implement all new initiatives recommended by the NTWG
5. To take measures to strengthen participation of general health system staff in HIV/TB activities
6. To take measures to strengthen TB infection control practices at all health facilities particularly those caring for TB and HIV/AIDS patients

Note: Expenditure for this meeting may be booked under the NACP budget for basic services division in SACS

STATE HIV/TB WORKING GROUP (SWG)

Proposed composition:

1. Project Director, SACS: Chairman
2. Additional Project Director, SACS: **Member, Secretary**
3. State TB Officer: Member
4. Director, STDC: Member
5. DAPCU Nodal Officer at SACS : Member
6. Joint Director / Dy. Director, ICTC, SACS: Member
7. Dy. State TB Officer / Assistant Programme Officer (APO): Member
8. RNTCP and NACP consultants and Regional coordinators: Member
9. State HIV/TB coordinator
10. Representative of NGOs working with RNTCP: Member
11. Representative of NGOs working with NACP: Member

Generic Agenda for quarterly SWG meetings

1. Review of actions taken by districts on recommendations of last SWG meeting
2. Review of progress in bridging service delivery gap like co-location of HIV and TB testing facilities, ART facilities, TB culture and DST facilities, etc.
3. Review of performance of Intensified TB case finding activities at ICTC, ART centers, Link-ART centers
4. Review performance of HIV testing of TB/DR-TB patients and presumptive TB cases (in HP states)
5. Review linkage of HIV infected TB/DR-TB patient to DOT, CPT and ART
6. Review of timeliness of ART initiation of HIV/TB cases enrolled at ART centers
7. Review implementation of Isoniazid Preventive Treatment (IPT)
8. Review of timeliness of reporting on HIV/TB from all facilities implementing ICF activities
9. Review implementation of co-ordination meetings at district level (DCC and monthly HIV/TB meeting) –specimen minutes of these meetings may be discussed
10. Discussion on observation of joint HIV/TB field visits made during the quarter and plan for the next quarter
11. Review of airborne infection control measures at all HIV and TB /DR-TB care settings
12. Review availability and supplies of logistics e.g. referral formats, CPT, HIV test kits, Rifabutin, Isoniazid etc.
13. Review issues in human resource management e.g. vacancies, appointment process, training, re-orientation etc.
14. Discussion and decisions on communications received from NACO and CTD during the quarter

Note: Expenditure for this meeting may be booked under the NACP budget for basic services division in SACS

DISTRICT COORDINATION COMMITTEE

Proposed composition:

1. Chairman: District Magistrate/Collector or CEO Zilla Panchayat
2. Vice Chairman: Chief Medical Officer / District Health Officer or equivalent
3. Member Secretary: DAPCU Nodal Officer/ District TB Officer (in non A and B districts)
4. Member: Medical Superintendent, District Hospital
5. Member: Medical Superintendent, Medical College Hospital
6. Member: City TB Officers (where applicable);
7. Member: MS of Hospital providing ART Services (where applicable)
8. Member: ART Centre Medical Officer (where applicable)
9. Member: Representative of NGO / CBO involved in NACP
10. Member: Representative of NGO / CBO involved in RNTCP

Note: Chairman of DCC, if need arises can invite a person as special invitee whenever required for betterment of programme. In case the Chairman is not available for the meeting, a nominee of the chairperson may preside over the deliberations.

Terms of Reference. To:

1. Strengthen coordination between RNTCP and NACP staff in the District.
2. Review performance of all HIV/TB activities implemented in the district as per National Framework, and provide guidance for improvement
3. Address issues related to human resources including filling of vacancies, training of key programme staff and general health staff in HIV/TB activities
4. Ensure participation of general health system staff in implementation of HIV/TB activities
5. Ensure that appropriate infection control measures are taken at all facilities providing HIV /TB /DR-TB care
6. Ensure safe injection practices in facilities providing health facilities to prevent HIV
7. Promote participation of NGO/CBO and Private Practitioners in implementation of TB-HIV activities

Generic agenda for DCC meeting:

1. Review of actions taken on recommendations of previous DCC meeting
2. Review of progress to bridge service delivery gaps e.g. HIV testing facilities, ART facilities, TB culture and DST facilities etc.
3. Review of Number (%) of TB patients or presumptive TB cases (in HP states) offered HIV testing –TB unit wise and PHI wise
4. Review of Number (%) of referrals of presumptive TB cases out of total attendees from HIV care settings (ICTC, ARTC, Link ART centers and TI NGO etc.) to RNTCP DMCs –Unit Wise
5. Review of linkage of HIV infected TB cases to DOTS, CPT and ART
6. Review of performance indicators of the district specially - HIV-TB death rates –TB unit Wise
7. Review of implementation of Isoniazid Preventive Treatment (IPT)
8. Review of Airborne infection control activities at HIV and other health care settings
9. Performance of NGO/PP involved in HIV/TB activities in the district
10. Review of Joint ACSM activities conducted during the quarter
11. Any other priority issues

Note: SACS to provide budget to DAPCU officer/DNO or DTO to make the expenditure for organization of this meeting from NACP budget for basic services division

GENERIC AGENDA ITEMS FOR MONTHLY HIV/TB COORDINATION MEETING

Two-three days Prior to monthly meeting RNTCP STS should handover completed line-list of presumptive TB cases for previous month to the ICTC and ART center counselor /staff nurse, and obtain Line-list for current month

1. The first agenda item should be validation of monthly report generated from completed line-list by ICTC counselor or ARTC staff nurse. These validated reports should then be sent to SACS and STC
2. Counsellors at stand-alone ICTC will be responsible for sharing data for F-ICTC in their jurisdiction
3. Review of Number (%) of referrals of presumptive TB cases from all HIV care settings like ICTC, ART and Link ART center and the TI NGO, to RNTCP–Unit Wise
4. ART center MO/staff nurse should provide feedback on enrollment of HIV/TB patients at ART center and status of ART initiation to concerned STS by referring to ART center HIV/TB register
5. RNTCP STS should provide feedback on status of TB treatment initiation of patient referred outside the district
6. The RNTCP STS should provide TB treatment outcome of all patients in the HIV/TB register to ART staff nurse
7. Review of Number (%) of TB patients /presumptive TB cases offered HIV testing –TB unit /DMC wise
8. Review of linkage of HIV infected TB cases to DOTS, CPT and ART
9. Review of availability of logistics like, HIV test kits, referral formats, CPT, Rifabutin, Isoniazid etc.
10. Discussion on field observations of DTO/DNO /district ICTCT supervisors, District HIV/TB supervisor etc.

Note: SACS to provide budget to DAPCU officer/DNO or DTO to make the expenditure for organization of this meeting from NACP budget for basic services division

Quarterly report on HIV/TB Collaborative Activities

Name of SACS: _____

Quarter/Year _____

A. HIV/TB Co-ordination activities

State level:

State Coordination committee meeting	
• Date of last meeting	
• Are proceedings shared with NACO and CTD? (Yes/No)	
State Working group meeting	
• Date of last meeting	
• Are proceedings shared with NACO and CTD? (Yes/No)	

District Level:

Sr. No.	Name of District	Date of last District Coordination Committee (DCC) meeting	Are proceedings of DCC meetings received at SACS (Yes/No)	Number of Monthly HIV/TB meetings conducted during the quarter	Number of monthly meetings of which, proceedings are received at SACS
1					
2					
3					

*use additional sheet to cover all districts in the state

Joint Supervision and monitoring:

1. **Joint supervision visits** conducted during the reporting quarter
 - a. Name of districts visited: _____
 - b. Date of visit: _____
 - c. Are visit reports shared with NACO _____
2. **Joint review** of District nodal officer/DTO
 - a. Is HIV/TB joint review done during the quarter (at least once a year): _____
 - b. Did SACS representative attend RNTCP quarterly DTO review meeting: _____
3. **HIV/TB reporting:**
 - a. ICF at ICTC: Number of months of compiled state report sent to NACO in the quarter: _____
 - b. ICF at ART Centre: Number of months of compiled report sent to NACO: _____
4. **Drugs and logistics:**
 - a. Number of districts with CPT stock sufficient to last 3 months (information from RNTCP PMR at state level): _____

ANNEXURE 7

LINE-LIST OF PERSONS REFERRED FROM ICTC TO RNTCP

REPORTING MONTH: YEAR NAME OF ICTC: NAME OF DISTRICT:

<i>TO BE COMPLETED BY ICTC COUNSELLOR</i>							<i>TO BE COMPLETED BY the STS</i>					
<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>	<i>10</i>	<i>11</i>	<i>12</i>	<i>13</i>
<i>Sr. No.</i>	<i>PID NO</i>	<i>Complete Name & Complete Address</i>	<i>Age</i>	<i>Sex</i>	<i>Date of referral to RNTCP</i>	<i>Name of facility referred to</i>	<i>Is patient diagnosed as TB – Yes or No</i>	<i>If diagnosed as TB, specify whether patient is sputum positive TB, sputum negative TB or Extra-pulmonary TB</i>	<i>Is patient initiated on DOTS</i>	<i>Date of Starting Treatment</i>	<i>TB No.</i>	<i>Remarks</i>
<i>Sign of Counsellor Sign of MO- ICTC</i> <i>Date of completion:</i>							<i>Name of the TU:</i> <i>Signature of STS Signature of DTO/CTO/MO-TU</i> <i>Date of Completion:</i>					

ICTC TB-HIV monthly report

REPORTING MONTH: _____ YEAR _____
NAME OF ICTC: _____ DISTRICT: _____

TOTAL NUMBER OF GENERAL CLIENTS ATTENDING ICTC:

a) Total no. of clients who attended ICTC in the month (excluding PPTCT clients)	
--	--

II. REFERRAL OF SUSPECTED TUBERCULOSIS CASES FROM ICTC TO RNTCP

	HIV positive	HIV Negative
a) No. of persons suspected to have TB referred to RNTCP diagnostic services		
b) Of the referred TB suspects, No. diagnosed as having:		
(i) Sputum Positive TB		
(ii) Sputum Negative TB		
(iii) Extra-Pulmonary TB		
c) Out of above (b), diagnosed TB patients, number receiving DOTS		

Signature of Medical Officer – In charge ICTC

Name of Medical Officer In-charge ICTC

ANNEXURE 9

LINE-LIST OF PERSONS REFERRED FROM ART CENTRE TO RNTCP

MONTH/YEAR NAME OF ART CENTRE: NAME OF DISTRICT:

To be completed by ART/CCC Nurse										To be completed by STS				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
<i>Sr. No.</i>	<i>Pre-ART/ART Number</i>	<i>Complete Name & Complete Address</i>	<i>Age</i>	<i>Sex</i>	<i>Date of referral to RNTCP for investigation</i>	<i>Name of facility referred to</i>	<i>Is patient diagnosed as TB –Yes or No</i>	<i>If diagnosed as TB, specify whether patient is sputum positive TB, sputum negative TB or Extra pulmonary TB</i>	<i>Date of referral to RNTCP for treatment</i>	<i>Date of Starting TB Treatment</i>	<i>TB Number with TU Name</i>	<i>Is the patient referred outside district (Yes/No)</i>	<i>Is the patient initiated on Non-RNTCP treatment (Yes/No)</i>	<i>Remarks</i>
Sign of ART Nurse							Sign of STS(TU where ART centre is situated)							
Sign of SMO/MO-ART							Sign of DTO							
Date of completion							Date of completion							

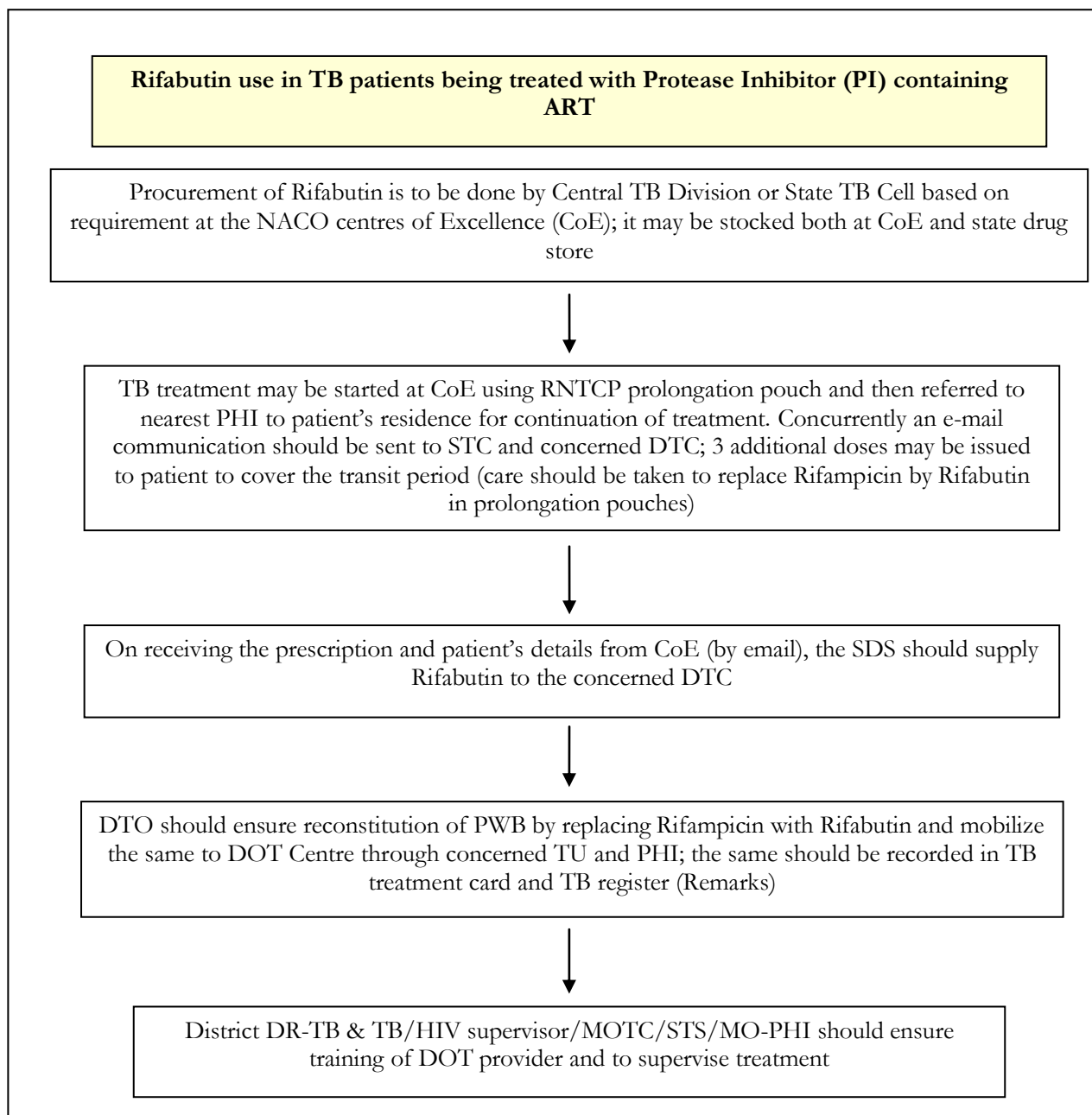
ART CENTRE MONTHLY TB-HIV REPORT (part of the 4 page ART center monthly report)

3 b. HIV/TB -Intensified TB Case Finding	
TB Diagnosis & Treatment (Source: completed HIV/TB Line-List <u>1 month</u> prior to reporting month)	
3b.1) Number of HIV positive patients attending ART centre during the month(Pre-ART and ART)	
3b.2) No. of TB Suspects referred from ART centre for TB diagnosis	
3b.3) Out of the above persons, number diagnosed as having TB :	
(i) Sputum Positive TB	
(ii) Sputum Negative Pulmonary TB	
(iii) Extra-Pulmonary TB	
3b.4) Total Diagnosed TB Patients	
3b.5) Out of (3b.4), number of TB patients receiving RNTCP treatment within the district	
3b.6) Out of (3b.4), number of TB patients referred outside district for RNTCP treatment	
3b.7) Out of (3b.6), number started on RNTCP treatment	
3b.8) Out of (3b.4), number of TB patients receiving Non-RNTCP treatment	
3 c. Treatment of HIV- (Source HIV/TB register, Data <u>2 months</u> prior to reporting month)	
3c.1) Total number of cases enrolled in HIV/TB register 2 months prior to the reporting month	
3c.2) Out of (3c.1) number of cases initiated on CPT	
3c.3) Out of (3c.1) number of cases initiated on ART	

ART CENTRE TB-HIV REGISTER

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>	<i>10</i>	<i>11</i>	<i>12</i>	<i>13</i>	<i>14</i>	<i>15</i>
<i>Sr. No.</i>	<i>Date</i>	<i>Complete Name & Address</i>	<i>Age</i>	<i>Sex</i>	<i>Type of TB - specify whether patient is Pulmonary TB or Extra pulmonary TB</i>	<i>Is patient initiated on RNTCH treatment (Yes/No)</i>	<i>Date of Starting Treatment</i>	<i>TB Number with TU and District Name</i>	<i>Pre-ART Number</i>	<i>Latest CD4 Count</i>	<i>Is the patient on ART (Yes/No)</i>	<i>ART Registration Number</i>	<i>Is the patient on CPT (Yes/No)</i>	<i>TB treatment Outcome</i>

Management of supplies of Rifabutin



HIV/TB Training guideline

	Training Type	Trainees	Trainers	Level	Duration	Responsibility	Training materials
A Basic HIV/TB Training for ICTC and RNTCP staff							
1	Training of trainers	SACS, STC officials, HIV/TB coordinator	CTD, NACO, WHO, NTI and NIRT	National	2 days	CTD +NACO	Combined TB-HIV module + HIV/TB module for ART centre staff
2	District programme managers	DTO / DNO (HIV-AIDS)/ DAPCU officer	State Master Trainers	State	2 days *	State TB cell +SACS	
3		MO-ICTC/MO-TC				DAPCU/SACS +DTO	Combined TB-HIV module
4	Key staff	District HIV/TB Supervisors / STS				State TB cell	Combined TB-HIV module + HIV/TB module for ART centre staff
5		District ICTC supervisors/ ICTC Counsellors				SACS	
6	Field staff	Medical Officers	DTO / DAPCU / DNO	District	1 day	DAPCU officer / DNO (DTO in their absence)	Combined TB-HIV module
7		Institutional DOT Provider	DNO		1 day		
B Basic HIV/TB activities for ART centre staff							
1	Key staff	ART Centre MO	SACS CST officers /RC/NACO trainers	State	2 days	State TB cell +SACS	RNTCP module for PP + HIV-TB module for ART staff
2	Field staff	ART centre staff nurse	State Master trainers		2 days*		HIV-TB module for ART centre staff
3		ART centre counsellors, data managers	ARTC SMO/RC	District	1 Day		
C Data management training							
		DEO at SACS and State TB Cell	Experts from NACO, CTD	State	1 day	State TB cell +SACS	Presentations + module reading
D HIV screening using Whole Blood Finger-prick test							
1	Training of trainers	SACS, STC officials, HIV/TB coordinator	Experts from NACO, CTD	National	2 days **	NACO	WBT technical module for LT + operational guidance
2	Training of Key staff	District HIV/TB supervisor, District ICTC supervisor, STLS, ICTC counsellors	State Master trainers	State	2 days **	SACS	WBT technical module for LT + operational guidance
3	Field training	Medical Officer DMC	State Master trainers	District	1 days	SACS/DAPCU	WBT technical module +operational guidance
4		DMC LT					
5		Institutional DOT provider					
E PITC in presumptive TB cases							
1	Training of trainers	SACS, STC officials, HIV/TB coordinator, /DTO/DAPCU	Experts from NACO, CTD	National	2 days **	NACO	RNTCP guideline for PITC in presumptive TB cases
2	Training of Key Staff	District HIV/TB Supervisors / ICTC supervisors/ STS /STLS	State Master trainers	State	1 days	SACS	
3	Field training	DMC LT	State Master trainers	District	1 days	SACS /DAPCU	
4		ICTC Counsellors	State Master trainers				
F IPT Operationalization							
1	Training of trainers	SACS, STC officials, HIV/TB coordinator, Regional Coordinators CST	Experts from NACO, CTD	National	2 days **	NACO	NACO guideline on IPT operationalization
2	Training of Key Staff	DTO/ DAPCU officer/ District HIV/TB Supervisors / ICTC supervisors/ STS	State Master Trainers	State	1 Day	SACS	
3	Field training	ART centre SMO/MO/counsellors	State Master Trainers	State	2 days ***	SACS	
4		ART centre staff nurse /data managers	ARTC SMO/RC	District	1 day	DAPCU /SACS	
* Includes visit to DMC, ICTC, ART centre and DOT Centre**Includes development of micro-plan*** Includes PowerPoint presentation of supportive evidence and also development of micro-plan for implementation							

Review checklist for TB-HIV activities at state level

	State and district-level coordination	
a	Whether TB-HIV State Coordination Committee (SCC) functional at state level?	
b	No. of SCC meetings held in last 4 quarters	
c	Number of TB-HIV State Working Group meetings held in last 4 quarters	
d	Proportion of districts with at least two DCC meeting in past 4 quarters	
e	Do all ICTC counsellors attend HIV/TB monthly coordination meeting	
f	Do ART centre staff attend HIV/TB monthly coordination meeting	
g	No. of field visits made to the districts jointly by officers from SACS and STC	
	Infrastructure	
a	Total no. of stand-alone ICTCs in the state as per last month CMIS report	
b	Distribution of ICTCs as per the district category (A,B,C,D)	
c	No. of Facility integrated ICTCs in the state as per last month CMIS report	
d	No. of PPP ICTCs functional in the state as per last month CMIS report	
e	No. of ART centres in the state as per last month CMIS report	
f	No. of LAC (Link ART Centres) functional in the state as per last month CMIS report	
g	No. of Designated Microscopy Centres (DMC) in the state (latest RNTCP PMR)	
h	No. of co-located ICTC and DMC as per latest RNTCP PMR	
	Intensified TB Case Finding at ICTCs and ART Centres	
a	Proportion of ICTC reporting on ICF as per last month CMIS report	
b	Total no. of clients who attended ICTCs during the month	
c	No.(%) of ICTC clients referred to RNTCP as presumptive TB case	
d	No. (%) of the referred TB suspects from ICTCs who are diagnosed with TB	
e	No.(%) of diagnosed TB patients from ICTCs who are initiated on DOTS treatment	
	Intensified TB Case Finding at ART Centres	
a	Proportion of ART centres reporting on ICF as per last month CMIS report	
b	No. (%) of ART centre attendees referred to RNTCP as presumptive TB cases	
c	No. (%) of the referred cases from ART centres diagnosed with TB	
d	No.(%) of diagnosed TB patients out of above initiated on DOTS treatment	
		<i>Contd/36</i>

e	Number percentage of ART centre NOT having TB symptoms (Monthly ART centre IPT report)	
f	Number percentage of above patients assessed for eligibility for Isoniazid Preventive Treatment (IPT)	
g	Number percentage of above patients initiated on IPT	
	HIV testing of presumptive TB cases (High HIV prevalence settings)	
a	Number of presumptive TB cases tested at DMC (latest quarterly PMR)	
b	Number (%) out of above with known HIV status	
c	Number (%) out of above found HIV infected	
	HIV testing of TB patients (all states)	
a	Total Number of TB patients registered during the quarter ((latest RNTCP case finding report))	
b	Number of TB patients with known HIV status (RNTCP case finding report)	
c	Number of TB patients with known HIV status from previous quarter (RNTCP sputum conversion report)	
d	No. (%) of registered TB patients found to HIV infected (RNTCP case finding report)	
e	No. (%) of HIV infected TB patients receiving CPT in corresponding quarter last year (RNTCP results of treatment report)	
f	No. (%) of HIV infected TB patients receiving ART during TB treatment in corresponding quarter last year (RNTCP results of treatment report)	
g	No. (%) of HIV infected TB patients initiated on ART as per latest month ART CMIS report	
	Human Resources	
a	No. (%) of ICTCs with vacancy of ICTC counsellor (ICTC CMIS report)	
b	No. (%) of ICTCs counsellors trained in TB-HIV	
c	No. (%) of ICTCs with vacancy of Laboratory Technicians	
d	Is the 10 point counselling tool for TB available at all the ICTCs and ART centres ?	Yes/No

Source of information: NACO CMIS/SIMS for ICTC and ART centres and RNTCP quarterly reports

Performance Indicators and Targets for HIV/TB Collaborative Activities

Performance Indicator	Data Source	2012	2013	2014	2015	2016	2017
State and district-level coordination							
a. Proportion of TBHIV SCC/SWG meetings held at state level over past 4 quarters	RNTCP State PMR Qtrly Report	100%	100%	100%	100%	100%	100%
b. Proportion of Districts with at least 2 DCC Meetings over past 4 quarters	RNTCP District PMR Qtrly Report	>80%	>90%	>90%	>90%	>90%	>90%
Intensified Case Finding							
a. Proportion of ICTC/ART centre reporting on HIV/TB ICF activities *	NACO SIMS	80%	>90%	>90%	>90%	>90%	>90%
b. Number of ICTC clients referred to DMC as presumptive TB cases		3,76,390	Increasing trend in numbers				
c. Number of (b) who are diagnosed with TB		32,898					
d. Among (c), number/percentage of diagnosed TB patients put on DOTS		78%	>85%	>85%	>85%	>85%	>85%
e. Number of ART clients referred to TB diagnostic facilities as presumptive TB cases		91,242	Increasing trend in numbers				
f. Number of (e) who are diagnosed with TB		19,622					
g. Among (f), number/percentage of diagnosed TB patients put on DOTS		84%	>85%	>85%	>85%	>85%	>85%
Isoniazid Preventive Treatment (IPT)							
a. Number of ART clients NOT having symptoms suggestive of TB during last visit	NACO IPT monthly report	NA	Increasing trend in numbers				
b. Number out of (a) assed for eligibility for IPT		NA					
c. Number out of (b) initiated on IPT		NA					
HIV testing of TB patients and HIV care, support and treatment							
a. Number /percentage of presumptive TB cases with known HIV status**	RNTCP PM report		Increasing trend in numbers				
b. Number /percentage of presumptive TB cases found to be HIV positive**	RNTCP PM report						
c. Number/ percentage of registered TB patients with known HIV status	RNTCP CF and SC QtrlyRprts						
d. Number of registered TB patients found to be HIV-positive	RNTCP CF QtrlyRprts						
e. Number/ percentage of HIV-positive TB patients receiving CPT during TB treatment ‡	RNTCP RT QtrlyRprts						
f. Number/ percentage of HIV-positive TB patients receiving ART during TB treatment ‡	RNTCP RT QtrlyRprts						

* “yes” if reports received for past 6 months..** only in high prevalent settings ‡ For previous year’s TB patient cohort.

HIV/TB variables reported in RNTCP Quarterly reports (First line and second line TB treatment)

A. HIV testing of TB patients: case finding report: 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)

B. Linkage of HIV infected TB patients to HIV care and support and TB treatment outcome:

1) RNTCP Sputum conversion report:

Total Number of HIV-infected TB patients registered in the quarter (a)	Of (a), Number receiving CPT during TB treatment	Of (a), Number receiving ART during TB treatment

2) RNTCP Treatment Outcome report: BLOCK – B: TB treatment outcomes of HIV Positive TB Patients

Type of TB cases	Total No. known to be HIV infected	Treatment outcomes						
		Cured	Treatment completed	Died	Treatment Failure	Defaulted	Transfer out	Switched over to MDR-TB treatment
New								
Previously treated								
Total TB cases								

3. Block C: CPT and ART

Of all Registered TB cases, Number known to be tested for HIV before or during the TB treatment (a)	Of (a), Total Number of HIV-infected TB patients identified (b)	Of (b), Number receiving CPT during TB treatment	Of (b), Number receiving ART during TB treatment

C. Programme coordination and drug logistics reporting in RNTCP Programme Management Report:

1. Is there a District Coordination committee? (Yes/ No/ Not applicable)
2. If yes, did the DCC meeting take place in this quarter? (Yes/No)
3. Of the DMCs in the TU/district/state, number with co-located HIV testing services
4. Information on CPT pouches

HIV/TB reporting in programme for management of drug resistant TB (PMDT)

1) Case finding report:

Of all Registered MDR-TB cases, number known to be tested for HIV before or during the TB treatment (a)	Of (a), Total Number of HIV-infected TB patients identified (b)	Of (b), Number receiving CPT during TB treatment	Of (b), Number receiving ART during TB treatment

2) 12 month conversion report:

Number of HIV-infected MDR-TB cases registered on CAT IV regimen in the quarter	Culture results after 12 months of treatment								
	Culture Negative	Culture positive	Culture Unknown	Died	Default	Transferred Out	Treatment stopped due to adverse reactions	Treatment stopped due to other reasons	Switched to Cat-V

3) PMDT treatment outcome report:

Number of HIV-infected MDR-TB cases registered on CAT IV regimen	Cured	Treatment completed	Died	Failure	Default	Transfer out	Treatment stopped due to adverse drug reactions	Treatment stopped due to other reasons	Switched to Category V	Still on treatment	Total

A: Notification of TB Cases

Z-28015/2/2012-TB
Government of India
Ministry of Health and Family Welfare

Nirman Bhavan, New Delhi
Dated: 7th May 2012

Notification of TB cases

TB continues to be a major public health problem accounting for substantial morbidity and mortality in the country. Early diagnosis and complete treatment of TB is the corner-stone of TB prevention and control strategy. Inappropriate diagnosis and irregular/incomplete treatment with anti-TB drugs may contribute to complications, disease spread and emergence of Drug Resistant TB.

In order to ensure proper TB diagnosis and case management, reduce TB transmission and address the problems of emergence and spread of Drug Resistant-TB, it is essential to have complete information of all TB cases. Therefore, the healthcare providers shall notify every TB case to local authorities i.e. District Health Officer / Chief Medical Officer of a district and Municipal health Officer of a Municipal Corporation / Municipality every month in a given format (attached).

For the purpose of case notification, a TB case is defined as follows:

- A patient diagnosed with at least one sputum specimen positive for acid fast bacilli, or Culture-positive for Mycobacterium tuberculosis, or RNTCP endorsed Rapid Diagnostic molecular test positive for tuberculosis


OR

- A patient diagnosed clinically as a case of tuberculosis, without microbiologic confirmation, and initiated on anti-TB drugs.

For the purpose of this notification, healthcare providers will include clinical establishments run or managed by the Government (including local authorities), private or NGO sectors and/or individual practitioners.

For more detailed information, the concerned State TB Officers / District TB Officers, whose details are available on www.tbcindia.nic.in, may be contacted.

Encl: As mentioned


(Manoj Sinha)

Under Secretary to the Government of India

Copy for immediate further necessary action, to:

- 1) All Principal Secretaries / Secretaries of Health of States / UTs
- 2) All Directors of Health Services of States / UTs
- 3) All State TB Officers of States / UTs

With the request to kindly immediately bring this order to the notice of all concerned for compliance, in their respective State / UT

Ban on Serological test kits for TB in India. The Gazette of India - 7th June 2012

रजिस्ट्री. सं० डी० एल०-33004/99

REGD. NO. D. L.-33004/99


भारत का राजपत्र
The Gazette of India

असाधारण
 EXTRAORDINARY
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स्वास्थ्य और परिवार कल्याण मंत्रालय
 (स्वास्थ्य और परिवार कल्याण विभाग)
 अधिसूचना

नई दिल्ली, 7 जून, 2012

सा.का.नि. 433(अ).—जबकि केन्द्र सरकार इस बात से संतुष्ट है कि क्षयरोग के निदान के लिए सीरियोडायग्नोस्टिक परीक्षण किटों के प्रयोग से असंगत और संदिग्ध परिणाम मिल रहे हैं जिससे गलत निदान हो रहा है और उनके प्रयोग से लोगों को खतरा होने की संभावना है और जबकि इनके सुरक्षित विकल्प उपलब्ध हैं;

और जबकि केन्द्र सरकार इस बात से संतुष्ट है कि लोक हित में उक्त परीक्षण किटों के आयात को वर्जित करना आवश्यक और समीचीन है;

अतः, अब, औषध एवं प्रसाधन सामग्री अधिनियम, 1940 (1940 का 23) की धारा 10क के द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए केन्द्र सरकार एतद्वारा स्वास्थ्य एवं परिवार कल्याण मंत्रालय के दिनांक 23 जुलाई, 1983 की सं. सा.का.नि. 577 (अ) में भारत सरकार की अधिसूचना में निम्नलिखित संशोधन करती है, अर्थात्:—

उक्त अधिसूचना में संलग्न सारणी, क्रमांक 10 के पश्चात् और इससे संबंधित प्रविष्टि में निम्नलिखित क्रमांक और प्रविष्टि निवेशित की जाएगी, अर्थात्:—

“11. क्षयरोग के निदान के लिए सीरियोडायग्नोस्टिक परीक्षण किटें”

[फा. सं. एक्स-11014/13/2011-डीएफक्यूसी (2)]

अरुण के. पण्डा, संयुक्त सचिव

पाद टिप्पणी : प्रधान अधिसूचना को दिनांक 11-12-2009 की सं. सा.का.नि. 884(अ) के तहत भारत के राजपत्र में प्रकाशित किया गया।

2053 GI/2012

MINISTRY OF HEALTH AND FAMILY WELFARE
 (Department of Health and Family Welfare)
 NOTIFICATION

New Delhi, the 7th June, 2012

G.S.R. 433(E).—Whereas the Central Government is satisfied that the use of the serodiagnostic test kits of diagnosis of tuberculosis are giving inconsistent and imprecise results leading to wrong diagnosis and their use is likely to involve risk to human beings and whereas safer alternatives are available;

And whereas the Central Government is satisfied that it is necessary and expedient to prohibit the import of the said test kits in public interest;

Now, therefore, in exercise of the powers conferred by Section 10A of the Drugs and Cosmetic Act, 1940 (23 of 1940), the Central Government hereby makes the following amendment in the notification of the Government of India in the Ministry of Health and Family Welfare number G. S. R. 577 (E), dated the 23rd July, 1983, namely:—

In the Table appended to the said notification, after serial number 10 and the entry relating thereto, the following serial number and entry shall be inserted, namely:—

“11. Serodiagnostic test kits for diagnosis of tuberculosis.”

[F.No. X-11014/13/2011-DFQC (2)]

ARUN K. PANDA, Jt. Secy.

Foot Note : The principal notification was published in the Gazette of India vide No. G. S. R. 884(E), dated 11-12-2009.