

Training Manual on Intensified TB/HIV package

For Medical Officers



National AIDS Control Organization
And
Central TB Division
Ministry of Health & Family Welfare
Government of India
New Delhi

December 2009

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Preface

It is estimated that 2.31 million people are infected with HIV in India and considering estimated 40% of the Indian population is infected with Mycobacterium tuberculosis, an estimated 0.9 million persons are co-infected with Mycobacterium tuberculosis & HIV. HIV is the strongest known risk factor for the progression of TB infection to TB disease. Active TB disease is the commonest opportunistic infection amongst HIV-infected individuals and is also the leading cause of death in PLHA (People living with HIV/AIDS).

TB can be easily cured through the DOTS strategy provided free through RNTCP and with ART being provided free through NACP, HIV is now a **chronic manageable illness**.

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

This module details the important components of the Intensified TB/HIV package – Routine offer of HIV Counselling and testing to all TB patients with unknown HIV status, provision of decentralized CPT to HIV-infected TB patients, Referral of HIV-infected TB patients to ART Centre for evaluation and initiation of ART & an expanded recording and reporting system to manage and monitor these interventions. We hope this module would be useful for further strengthening the TB/HIV collaborative activities in the country.

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Acknowledgements

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

Further revisions to the module as per the new national guidelines on HIV-TB have been made under the guidance of Dr D.Bachani, DDG NACO and Dr L.S. Chauhan, DDG (TB) CTD, DGHS by a writing group comprising of Dr. Devesh Gupta, Dr. Puneet Dewan, Dr. Rahul Thakur, Dr. MV Ajay Kumar, Dr. Malik Parmar and Dr Vartika Sharma.

INTRODUCTION

Active TB disease is the most common opportunistic infection amongst HIV-infected individuals. Overall, HIV-infected persons have approximately an 8-times greater risk of TB than persons without HIV infection. Throughout the course of HIV disease, there is an increasing risk of TB. This increased risk is detectable as early as HIV seroconversion, and the risk of TB almost doubles during the first year after HIV seroconversion. The risk of TB in HIV-infected persons continues to increase as HIV disease progresses and CD4 cell count decreases. While anti-retroviral treatment can substantially decrease the risk of TB, this risk always remains higher than that in HIV negative individuals. Furthermore, among cured TB survivors with HIV infection, the risk of recurrent TB is also quite high.

TB patients who are HIV positive have higher risk of dying during treatment than TB patients without HIV. HIV positive patients who have TB have higher mortality than HIV positive patients without TB. Even if TB is survived, TB may also accelerate HIV disease progression, increasing the risk of subsequent death or other opportunistic infections in TB survivors.

From the public health point of view, the best way to prevent TB is to identify all persons in the community with infectious TB as early as possible, provide prompt & effective treatment and cure them. This interrupts the chain of transmission and can thus prevent the disease burden of HIV-TB co-infected cases. Among HIV-infected persons, early detection of TB, proper TB treatment, and linkage to HIV care and treatment also can reduce the harmful impact of TB on the patient's health and well-being.

The Revised National Tuberculosis Control Programme (RNTCP) and National AIDS Control Programme (NACP) have developed a policy of TB/HIV collaborative interventions, for implementation across the country. These include the establishment of coordination mechanisms at all levels, HIV testing of TB patients, linkage of HIV-infected TB patients to HIV care and treatment, early detection of TB in HIV-infected patients through Intensified TB Case Finding, involvement of NGOs in TB/HIV activities, and implementation of airborne infection control measures in HIV care settings.

An Intensified TB/HIV Package of Services has been established to provide additional services. These services include: Routine offer of HIV test to all TB patients, decentralized cotrimoxazole prophylaxis for HIV-infected TB patients, Referral of HIV-infected TB patients to ART Centre for evaluation and initiation of ART, and expanded recording and reporting on TB-HIV. This Intensified TB/HIV Package of services is being expanded in a phased manner nationwide.

OFFER VCT TO ALL TUBERCULOSIS PATIENTS

Rationale

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

HIV testing of TB patients

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

In settings implementing the Intensified TB/HIV Package, providers will routinely offer HIV testing to all TB patients, except those with an already known HIV status. **“Known” HIV status** means those patients with a history of positive HIV test from an NACO HIV testing centre, or those with a negative HIV test from an NACO HIV testing centre¹ within the past 6 months. HIV test results from NACO are preferred because HIV testing in these centres use quality-assured diagnostic kits, is conducted using a multiple-test algorithm to reduce false results, and is properly accompanied by counselling.

TB patients with unknown HIV status are to be referred to the **nearest and most-convenient place where NACO HIV counselling and testing is offered**. This may be an ICTC or any PHI where whole blood testing is offered for HIV screening. The referral should be made at the earliest after TB diagnosis, but may be made at any time during TB treatment if HIV status remains unknown. Treating physicians and paramedical workers should explain the need and importance for patients to be certain about their HIV status, and also that HIV testing is **‘voluntary’** and **‘not mandatory’**. This offer should be made at least once during the course of TB treatment.

If the patient accepts the advice for HIV testing, then the patient should be referred using the standard **“Integrated Counselling and Testing Centre referral form”** (Annex 1). During the counselling session, the counselling provider should spend adequate time with the TB patient to

¹ In many settings, NACO has made available whole-blood HIV testing by the general health staff. Whole-blood HIV-testing involves limited pre-test counselling by general health staff, followed by the use of a single rapid test using a drop of whole blood to screen for HIV infection. Patients who are screened for HIV through NACO whole-blood testing and are found to be HIV-negative do not require further testing. If whole blood testing results are reactive/positive, then the patient should be referred on priority to an NACO ICTC for confirmatory testing and diagnosis.

explain the importance of sharing their HIV test result with the treating physician, regardless of whether the result is HIV-positive or HIV-negative. This will enable better care of the TB patient.

Communication of HIV test result to treating physician: ‘Shared Confidentiality’

HIV test counselling may be conducted by ICTC counsellors or ANM/Staff Nurse/MO in a NACO approved HIV counselling and testing centre. Health care providers who are conducting HIV test counselling should also motivate patients to share their HIV result with the referring physician. In addition, unless patients object, these providers should directly and confidentially share HIV test results with the referring or treating physician, to ensure optimal care & case management. This process of sharing confidential health information of a patient within the health care system for the benefit of the patient is termed as **‘shared confidentiality’**. Knowledge of HIV status will enable providers to:

- Provide appropriate diagnosis and treatment for other illnesses.
- Provide patient counselling to reduce risk of HIV spread to others
- Initiate Cotrimoxazole Preventive Therapy (CPT).
- Prompt referral for anti-retroviral treatment.
- Linkage to social support services

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

1. **Through the client:** The counselling provider motivates the client to share the HIV test result, completes the feedback in the referral form, and sends the form via the client to the referring physician. If no referral form is available, patients should be asked to inform their providers and show their laboratory results.
2. **By the counselling provider:** When the physician referring the TB patient for HIV testing is physically located in the same premises or in very close proximity, the counselling provider can personally share or telephonically communicate the HIV result with the concerned Medical Officer.

In case the TB patient raises his/her objection to the direct communication of the HIV test result to the medical officer, his objection should be honoured and the HIV test result should not be communicated directly to the referring physician.

Recording of HIV status on PHI-held TB treatment Cards

The treating physician shall record the HIV status of the TB patient on the **“original” TB treatment card** in the provided space, along with date of testing and PID (Person Identification Digit) Number if available (**Figure 1**). The “original” TB Treatment Card is the card held at the PHI, which is present regardless of whether the patient is getting DOT from the PHI or from a local community DOT provider. **The HIV status should not be recorded on the duplicate treatment card, held by community DOT provider.**

Figure 1: Back of TB treatment card, and space for recording HIV status and additional treatment

II Continuation Phase

Prescribed regimen and Dosages: Category I 3 times / week Category II 3 times / week Category III 3 times / week

Enter X on date when the first dose of drugs has been swallowed under direct observation and draw a horizontal line (x) to indicate the period during which medicines will be self administered.

Month / Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

Treatment outcome with date: _____ Signature of MO with date: _____

Details of X-ray / EP tests: _____ Remarks: _____

Retrieval Actions for Missed Doses					Household Contacts (Children < 6 yrs)	
Date	By whom	Whom contacted	Reason for missed doses	Outcome of retrieval action	No	Chemoprophylaxis

Additional Treatments

HIV status: Unknown Pos Neg (date) _____

CPT delivered on (date): (1) (2) (3) (4) (5)

Pt referred to ART centre (date): _____

Initiated on ART: No Yes (date) _____

- **If HIV status of the patient is known**, tick the appropriate box ('Pos' or 'Neg') and record the date of test & PID No. **(If PID is available)**. If the HIV status is not known, don't tick any box initially.
- **If the HIV status is ascertained during the course of TB treatment**, the latest information should be updated on the card.
- **If HIV status of the patient remains unknown at the end of the treatment**, tick the appropriate box ('unknown'), at the time of declaring treatment outcome for the patient.
- Patients should **not** be required to show proof of HIV test results for recording on treatment cards. However it should be noted that NACO ART centres will require documentation of positive HIV test results from a NACO HIV testing centre whenever any patient seeks HIV care and treatment.

PRESCRIBE CPT TO ALL HIV-INFECTED TB PATIENTS

Co-trimoxazole is a fixed dose combination of sulfamethoxazole and trimethoprim; it is a broad spectrum antibiotic that targets a range of gram-positive and gram-negative organisms, fungi, and protozoa. Co-trimoxazole is given routinely for the prevention of opportunistic infections in HIV-infected persons; this strategy is called **Cotrimoxazole prophylaxis therapy**. This section describes the mechanism of decentralized delivery of CPT for HIV-infected TB patients. 'Decentralized' in this context means from all PHIs (Peripheral Health Institutes) having a Medical officer and an institutional DOT centre.

Why provide CPT?

CPT reduces morbidity and mortality of HIV-infected patients in general and HIV-infected TB patients in particular. NACO makes CPT available from ART centres and Link-ART Centres, but in most settings CPT is not available through the general health system. To improve access to CPT, CPT is to be made available to HIV-infected TB patients through the general health system in settings implementing the intensified TB/HIV package.

Eligibility for CPT

All adult HIV-infected TB patients on RNTCP treatment, not already being provided CPT from any other source should be initiated on CPT. Additional points to remember include:

- Pregnant patients are also eligible, regardless of foetus gestational age.
- Patients should have no history of a serious drug allergy to sulpha drugs or glucose-6 phosphate dehydrogenase (G6PD) deficiency.
- Patients who are already on ART but not currently on CPT should have CPT initiated from the PHI as for any HIV-infected TB patient.
 - The ART centre can consider whether or not to continue CPT.
- **For children and very low-weight adults (<30 kg)**, because alternate formulations of CPT are not provided under this decentralized mechanism, CPT for these patients is to be managed by ART centres.

How is CPT to be prescribed?

- Dose for prophylaxis for adults (≥ 14 years old) and ≥ 30 kg body weight): 960 mg (800 mg sulfamethoxazole + 160 mg trimethoprim) daily.
- CPT is provided to patients in **monthly pouches**.
- CPT is **self-administered** by the patient on a **daily** basis, and not under direct observation.
- CPT can be taken **alongside anti-tuberculosis treatment (ATT) and ART**. Many patients who are eligible for ART would also have CPT continued at ART centre.

Duration of CPT provision from PHI

Co-trimoxazole is to be provided by the PHI up till the end of TB treatment, or till the ART centre assumes responsibility for CPT provision – whichever is earlier. If ART Medical Officer decides to discontinue CPT in an individual patient based on NACO guidelines, that clinical judgement should be honoured by all providers and CPT stopped at PHI.

Treatment interruptions

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

Clinical and laboratory monitoring of patients on CPT

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

Side effects

- Severe side effects are **rare**, but include: exfoliative dermatitis, erythema multiforme (Stevens Johnson Syndrome), severe anaemia, and pancytopenia.
- Minor side effects are **uncommon**, but include: Loss of appetite, joint pains, nausea and vomiting. Because patients are usually taking other medications with similar side effects (e.g. isoniazid, pyrazinamide, efavirenz), care must be taken during clinical evaluation.
- Patients with serious side effects should discontinue CPT immediately and be promptly referred to a higher level centre, for evaluation and treatment. Desensitization is possible by experienced physicians.

Mechanisms for CPT delivery to HIV-infected TB patients

CPT delivery sites:

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

The treating physician should:

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

Figure 2: TB Patient Identity Card, with CPT box

Tuberculosis Identity Card

Front

Revised National Tuberculosis Control Programme
IDENTITY CARD

Name of Patient: _____
Complete address: _____
TU / district name _____ Ph _____
Sex: M F Age: _____ TB No. _____
PHI: _____

Disease Classification
 Pulmonary
 Extra-pulmonary
Site: _____

Treatment Started on
Date Month Year

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

Category of Treatment
 Category I
 Category II
 Category III
 CPT

Back

Follow up sputum examination

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

Appointment dates

IP	CP
_____	_____
_____	_____
_____	_____
_____	_____

Treatment outcome with date:
Signature and stamp of MO with date: _____

REMEMBER

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

- b. The treating physician prescribes CPT by ticking the relevant cell on the TB patient identity card (**Figure 2**).
- c. Records the prescription of CPT on the PHI-held, original TB treatment card (**Figure 1**).
- d. Asks these clients to report to the PHI in case of any adverse drug reaction
- e. Counsels the patient on the importance of regular follow-up examination and advice the client to come for monthly examination to monitor the progress of treatment.

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

- a. Provide a monthly supply of CPT on seeing the TB identity card.
- b. Record the date of delivery of CPT on the space provided on TB treatment card
- c. Ask the client to come on a monthly basis to collect the monthly supply of CPT.
- d. Encourage the patient to meet the MO for clinical evaluation, at time of these monthly visits to the PHI.

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

Discontinuing Cotrimoxazole prophylaxis

Serious side effects should lead to prompt discontinuation and referral for care. Otherwise, discontinuation of CPT would be decided upon by the ART centre, as per NACO guidelines.

Transition of CPT for HIV-infected TB patients

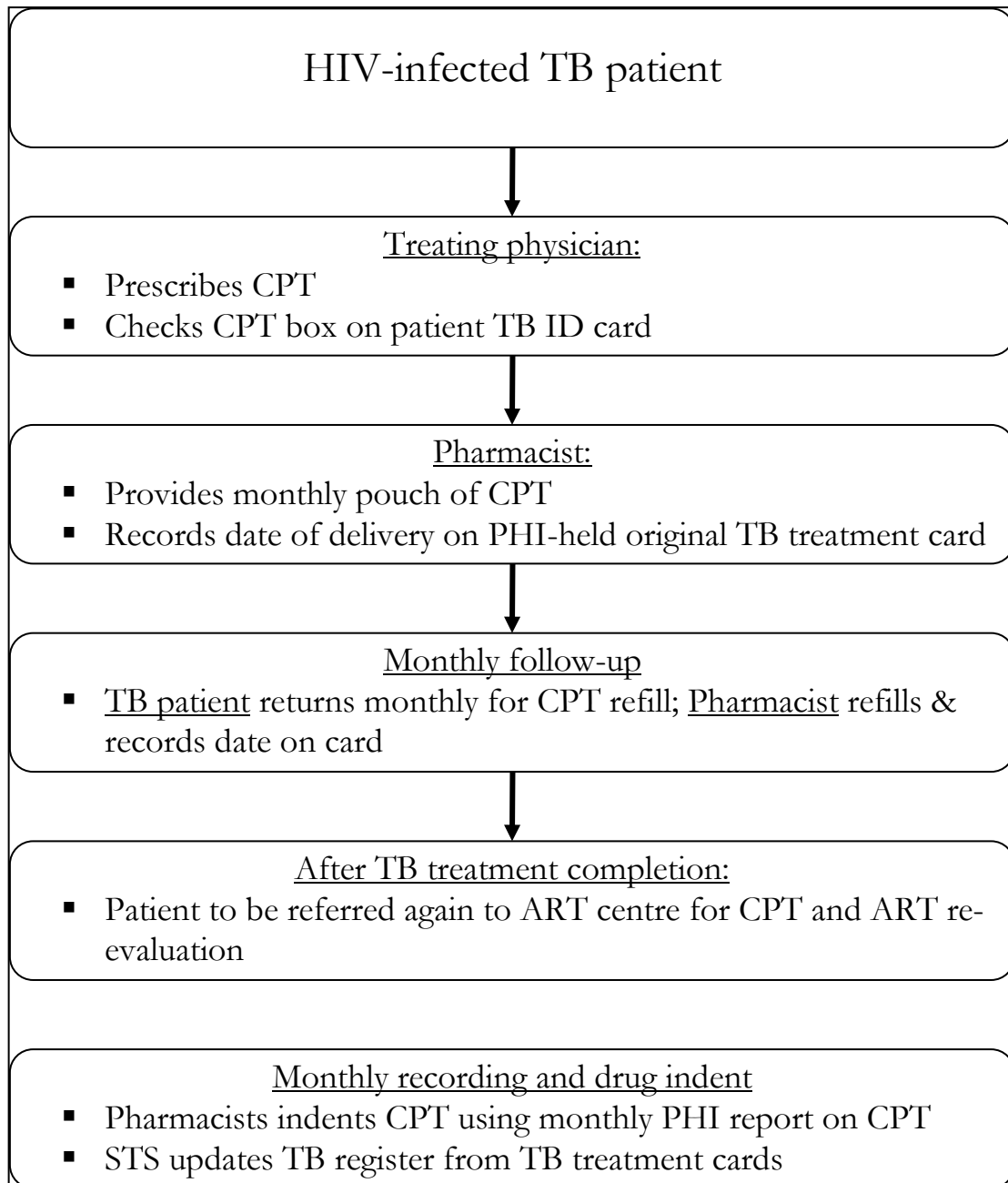
- In case the HIV-infected TB patient is already on CPT before the initiation of TB treatment, CPT can be continued from that source.
- If not already on CPT, it should be initiated for the HIV-infected TB patient at the PHI.
- If the HIV-infected TB patient is initiated on ART during TB treatment, he is to continue CPT along with ART from the ART Centre. **Feedback from the ART centre regarding initiation of CPT is essential to ensure a smooth transition.** If HIV-infected TB patient is not initiated on ART during TB treatment, CPT will be continued at PHI. After the completion of TB treatment the HIV-infected client should again be referred to the ART centre for ART re-evaluation and CPT continuation.
- Care should be taken that the patient is not receiving CPT from multiple sources.

Drug supply management

- The CPT is stored in the Pharmacy of the PHI and the Pharmacist is asked to maintain a record of stock in the PHI Stock Register.
- Consumption of CPT pouches during the month is to be reported by the PHI in the monthly PHI CPT report to the TU head quarters (**Annex 3**).

- TU will supply CPT pouches basis on the reported consumption and request in the PHI report.(monthly CPT PHI report).
- In addition, emergency indent can also be made in case of urgent requirements.

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



REFER ALL HIV-INFECTED TB PATIENTS TO ART CENTRE

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

ART eligibility criteria for HIV-infected TB patients

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

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

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

Linking HIV-infected TB patient with ART Centres

HIV-infected TB patients not already on ART should be referred as soon as possible to an ART centre for pre-ART registration and free CD4 testing, using the standard **“ART Centre referral form” (Annex 2)**. The referral to ART centre should also be recorded on the TB treatment card. TB treatment is the priority, and should not be interrupted by ART referral. However, prompt referral and evaluation for ART are also very important.

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

- The importance and free availability of ART
- The locations of ART centres
- The need to take the NACO HIV test report for confirmation of HIV status
- Procedure of pre-ART evaluation including CD4 testing
- The days on which the CD4 testing is available at the respective ART centre.
- The importance of cough hygiene, and patients should be asked to wear a mask or carry a cloth to cover their cough, especially important when visiting ART centre.

Timing of referral to ART Centre

- Patients who are not yet on ART should be provided with a referral to the ART centre immediately on identification as an HIV-infected TB patient. However, these patients (especially smear positive pulmonary TB) should be counselled to attend the ART centre after at-least 2 weeks of anti-TB treatment have been completed, so that the risk of TB transmission to others is lessened.

- Patients who are already on ART should be referred to the ART centre as soon as possible, as it is critical for the patient to have their ART regimen adjusted appropriately, to prevent adverse drug interactions and the consequent lowering of the efficacy of ART. Specifically, rifampicin can lower blood levels of Nevirapine, and hence NACO guidelines recommend immediate alteration of ART regimen. TB treatment should never be delayed, but it should be stressed to the patient to attend the ART centre as soon as possible, without delay. Patients who are on ART from a source other than NACP should be referred to an NACO ART Centre if they are willing or to their existing ART providers with information on TB treatment initiation otherwise.

Process at ART Centre

1. In view of advanced clinical stage of HIV disease, HIV-infected TB patients are to be evaluated for ART on priority. HIV-infected TB patients should be prioritized for CD4 testing.
2. The ART Centre staffs are to record patients' TB number and name of referring unit in the pre-ART register (along with 'entry point code') and ART- register.
3. The ART Centre staffs are to record the patient in the **“ART Centre TB-HIV Register” (Annex 4)**, and include information on whether or not ART was initiated.
4. If the HIV-infected TB patient is initiated on ART, they would also continue their CPT from the ART Centre.
5. The ART Centre staffs are expected to provide feedback to the referring physician. In particular, the ART Centre staff should communicate when they have assumed responsibility for CPT provision, so that the PHI Medical Officer can know if CPT is to be discontinued from that source.

Mechanism for feedback from ART centres to the referring physician:

1. Feedback is to be provided by the ART centre MO on the referral form sent from the physician treating TB.
2. The patient is to be counselled by the ART centre staff to share the ART patient booklet and treatment history with the TB treating physician
3. The ART centre staff Nurse is to update the TB/HIV register placed at ART Centre on a regular basis and share the same with the DTC staff during the monthly coordination meetings. This information can be directly updated onto TB registers.

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

SUMMARY

KEY POINTS

- All TB patients should have the chance to know their HIV status.
- Quality-assured HIV counselling and testing is available widely at NACO testing centres.
- All TB patients should be routinely offered voluntary HIV counselling and testing.
- All HIV-infected TB patients should be provided CPT and promptly referred for ART.
- PHI medical officer should ensure that patients complete their ART evaluation, and that HIV status, CPT, and ART initiation are properly documented on the TB treatment card.

What should providers and paramedical staff do?

- Refer all TB patients to nearest NACO HIV counselling and testing centre.
- Who need NOT be referred for HIV-testing?
 - Patients who report being HIV-positive, with results from an NACO counselling and testing centre.
 - Patients with prior HIV test result negative within the last 6 months from an NACO HIV counselling and testing centre.
- Use the referral form to facilitate feedback.
- Promptly record HIV status on original (PHI-held) TB treatment card.
- A verbal patient history regarding HIV testing and HIV test results is adequate to record HIV status for the purpose of recording.
- Prescribe CPT and ensure prompt referral to ART centre.
- Follow up with patient to ensure CPT and ART being taken.
- Document CPT and ART on original TB treatment cards only

What should programme officers know?

- Ensure that all the staff are trained in Intensified TB/HIV package
- Ensure uninterrupted supply of referral forms and CPT pouches.
- Ensure that the ICTCs are functional and conveniently located (Counselors and LTs in place and trained; uninterrupted supply of testing kits and consumables)
- CPT should be stocked at PHIs, and indented from the TU/DTC as per consumption, in a similar manner as with RNTCP Prolongation Pouch.
- HIV status and CPT/ART information will be recorded on TB treatment cards, TB registers, and for the cohort will be reported on quarterly reports.
- Supervision of the recording of HIV status and updating of CPT and ART information on TB treatment cards must be included in routine monitoring and supervision activities.

MONITORING AND SUPERVISION

Roles and Responsibilities

ROLE OF MEDICAL OFFICER

1. **Offer of VCT to all TB patients (with unknown HIV status)**
 - Use referral form; ICTC gives feedback on test result
 - Record HIV status on 'original' treatment card
2. **Prescribe CPT to all HIV infected TB patients**
 - If no contraindication for CPT, Prescribe CPT by ticking on TB ID card; send patient to Pharmacist
 - Provide monthly course of CPT; record delivery on 'original' treatment card
3. **Refer to ART Centre for ART evaluation**
 - Record referral on TB treatment card
 - Use referral form; Feedback from ART centre provided on same form
4. **Follow up with patient to ensure optimal care and support for HIV and TB**
 - **If patient initiated on ART**
 - Record ART initiation on TB Feedback recorded on TB treatment card
 - Continues CPT at ART Centre
 - Support patient for both ART and anti-TB treatment.
 - **If patient not initiated on ART**
 - Continue CPT from DOT centre
 - After TB treatment completion, refer patient again to ART Centre for ART re-evaluation & continuation of CPT

ROLE OF PHARMACIST/ INSTITUTIONAL DOT PROVIDER

1. Assess HIV status of TB patients, and refer all with unknown HIV status to the nearest NACO testing centre for voluntary HIV counselling and testing. Use the referral form. Document the results on the PHI-held original TB treatment card.
2. Check the TB identity card for CPT prescription.
3. Provide monthly supply of CPT to the HIV-infected TB patients, who have been prescribed CPT by the attending MO and record the date of delivery on the TB treatment card.
4. Indent from MO-TC and maintain stock of Cotrimoxazole to ensure uninterrupted supply of CPT for the HIV-infected TB patients.
5. Encourage the HIV-infected TB patients, during their monthly visit to PHI for collecting CPT, to meet the Medical Officer for routine examination

6. Refer HIV-infected TB patients to the nearest ART Centre, preferably after two weeks of TB treatment. Use the ART referral form. Record the referral and the result of ART evaluation in the original treatment card.
7. At the end of TB treatment refer all HIV-infected TB patients not already taking ART again to the ART Centre for continuation of CPT and for re-evaluation of eligibility for ART. Use ART referral form.
8. Ensure confidentiality of HIV status of the TB patients with in the health system.

ROLE OF COUNSELLOR

1. Record referral from RNTCP in the counselling register.
2. Emphasise, while counselling clients, on the importance of sharing HIV test result with the referring/ treating physician.
3. Record the HIV test result on the referral form and send it back to referring physician through the TB patient.
4. Communicate the HIV test result of TB patients to the referring/ treating physician either personally or telephonically unless the patient has requested that the HIV test results not be shared.
5. Counsel HIV-infected TB patients on the importance of CPT, the availability of decentralized CPT through the RNTCP including adherence.
6. Provide information to HIV-infected clients on the importance of ART, on the process of ART evaluation and the importance of completing the necessary steps to determine the need for ART including adherence and their free availability under the programme.
7. The above roles are in addition to the existing ones – to provide information on TB to all the clients, screen all the clients for TB symptoms, refer TB suspects to RNTCP, prepare a line-list of such referrals, attend the monthly co-ordination meeting with RNTCP staff, co-ordinate with STS to get the line-list completed and prepare & submit the monthly TB/HIV report.

ROLE OF STS

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

ROLE OF MO-TC

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

ROLE OF DAPCU OFFICER

1. In coordination with DTOs, organize training for MO-TCs, MOs, STS, Counsellors, ART centre staff and Paramedical staff on intensified TB/HIV package.
2. Overall supervision and ensuring smooth implementation of intensified TB/HIV package, as per National framework of joint TB/HIV collaborative activities.
3. Ensure adequate ICTC human resource management and supply of test kits and consumables.
4. Supervise ICTC counsellor's provision of confidential feedback of HIV test results for TB patients to referring providers.
5. Ensure seamless supply of Cotrimoxazole to the DTO in co-ordination with SACS.
6. Ensure the availability of 'referral forms' for referral of all TB patients for VCT and referral of HIV-positive TB patients to ART centre.
7. Ensure that ART centre staffs attend the RNTCP monthly meeting.
8. Ensure that ART centre staff maintain the TB/HIV register and share the information with RNTCP staff during the monthly meetings.
9. Coordinate with ICTC counsellors and SACS, and ensure the compliance of counsellors.
10. Coordinate with DTO and facilitate in resolving the issues emerging in the field.

ROLE OF DTO

1. In coordination with DNOs, organize training for MOs-TCs, MOs, STS, Counsellors, ART Centre staff and Pharmacist on intensified TB/HIV package.
2. Overall supervision and ensuring smooth implementation of intensified TB/HIV package as per National framework of joint TB/HIV collaborative activities.
3. Review the ascertainment of HIV status by medical officers, and the recording of HIV status on TB treatment cards.
4. Ensure that HIV status is recorded only on PHI-held original treatment cards, and not on duplicate treatment cards held by community DOT providers, and that HIV status remains confidential within the health system.
5. Monitor STS recording of HIV status, CPT, and ART from TB treatment cards onto TB registers.
6. Supervise the recording of ART provision to HIV-infected TB patients from TB/HIV register maintained at ART centre.

7. If TB patients from other districts are initiated on ART in this district, the DTO should provide feedback on the same to the concerned DTC.
8. Indenting Cotrimoxazole from SACS/SDS and supply the same to the TUs
9. Collect information on the delivery of CPT from all the STSs on a quarterly basis & compile a consolidated quarterly report on the same in the prescribed format.
10. Report promptly any shortcoming/ issues emerging in the field to STC & SACS.
11. Ensuring in coordination with DNOs, the availability of referral forms for referral of all TB patients for VCT and referral of HIV-positive TB patients to ART centre.

ROLE OF ART CENTRE

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

Annex 1.

Integrated Counselling and Testing Centre referral form

Referral to Integrated Counselling and Testing Centre

Dear Counsellor,

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

Name _____ age/sex

TB Number (if available) _____

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

Referring Provider

Name:

Contact Phone #:

Date of referral:

Name and address of the PHI:

Feedback by the Counsellor to referring provider

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

TEST RESULT FROM ICTC

HIV positive

HIV negative

Indeterminate

Opted out

PID Number

Date of conducting test

Additional communication to the referring physician

Signature of MO ICTC/counsellor

ANNEX 2.

ART CENTER REFERRAL FORM	
<i>(To be filled in duplicate by PHI MO. One copy for patient, one for record)</i>	
ART Centre (location, address): 	
Dear Doctor, I am referring _____ Age, _____ Sex, _____ who is a diagnosed HIV-infected TB patient to your ART centre for further evaluation. (If applicable: Type of TB Case _____ & TB number.....)	
<i>Referring Doctor:</i>	<i>Contact Phone #:</i>
<i>Name & signature:</i>	<i>Date:</i> _____
<i>Name & address of the PHI:</i>	<i>District:</i>
	<i>TU Name:</i>
Details regarding ART <i>(to be filled by the ART medical officer and sent to the referring PHI through the patient)</i>	
Pre-ART Registration Number: _____	
CD4 Count: _____	
Patient Started On ART -If Yes ART Reg. Number _____	
If No, reason:	
Patient started on CPT - Yes / No	
If No, reason:	
Additional information:	
<i>Name & signature of the ART MO</i>	<i>Date</i>

**Annex 3 Monthly PHI report on CPT for HIV-infected TB patients
(To be added as a line to the monthly PHI report)**

ITEM	Unit of Measurement	Stock on first day of month (a)	Stock received during the month (b)	Consumption during the month (c)	Closing stock on last day of the month (d) d=(a+b-c)	Quantity Requested (e)=c*2 -d
Cotrimoxazole	Monthly pouch (30 tablets)					

Annex 4

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>St. 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 Extrapulmonary TB</i>	<i>Is patient initiated on RNTCP 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>