Training Manual on Intensified TB/HIV package

For NACP & RNTCP Programme Managers

& Supervisors at State and District level

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

ROUTINE OFFER OF HIV TESTING TO ALL TB PATIENTS

Rationale

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

HIV testing of TB patients

Central TB Division (CTD) & the National AIDS Control Organization (NACO) have adopted the policy of **routinely offering voluntary HIV counselling and testing to all TB patients** as part of an intensified TB/HIV package of services. 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 centre[1] 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.

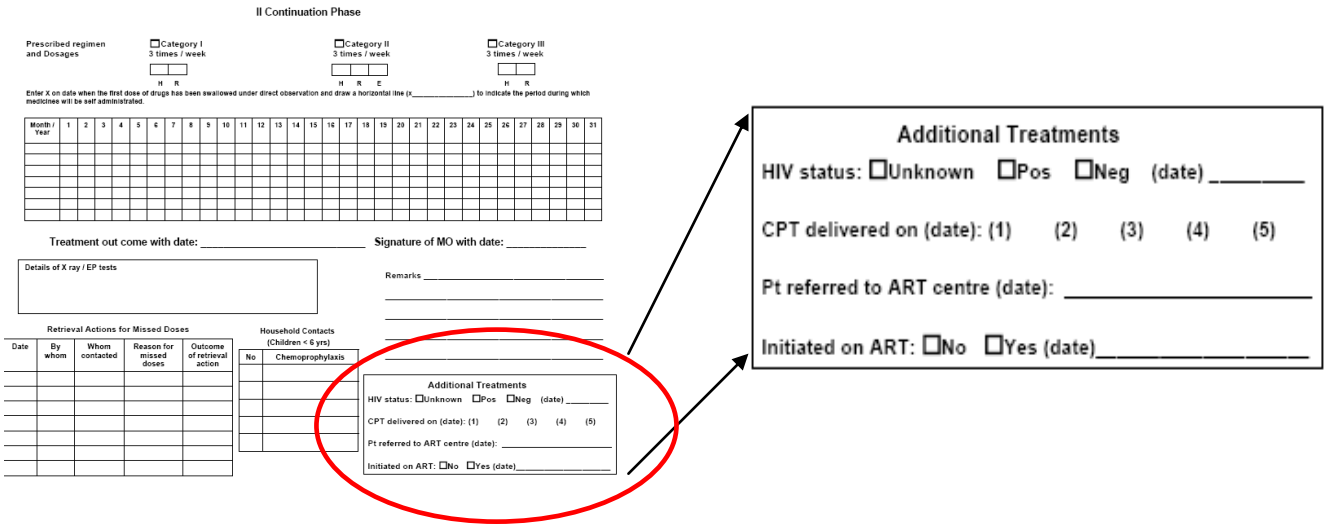
2. **By the counselling provider**: When the physician referring the TB patient for HIV testing is physically located in the same premises or in very close proximity, the counselling provider can personally share or telephonically communicate the HIV result with the concerned Medical Officer.

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



- **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.

PROVISION OF COTRIMOXAZOLE PROPHYLAXIS THERAPY (CPT) TO HIV-INFCTED 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 ($\geq$ 14 years old) and $\geq$ 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 cenrer.

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:

a. At all the ART Centres and Link-ART Centres, and

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

The treating physician should:

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

b. The treating physician prescribes CPT by ticking the relevant cell on the TB patient identity card (**Figure 2; Page 21**).

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.

STS during their each monthly visit to each PHI should:

1. Collect data on HIV test result of the TB patient, initiation on CPT, referral for ART, and initiation on ART from each TB treatment card and update the same in TB register (**Figure 3; page 22**)

2. This information shall be reported in the quarterly Case Finding and Results of Treatment reports of RNTCP (**Page 23-24**).

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

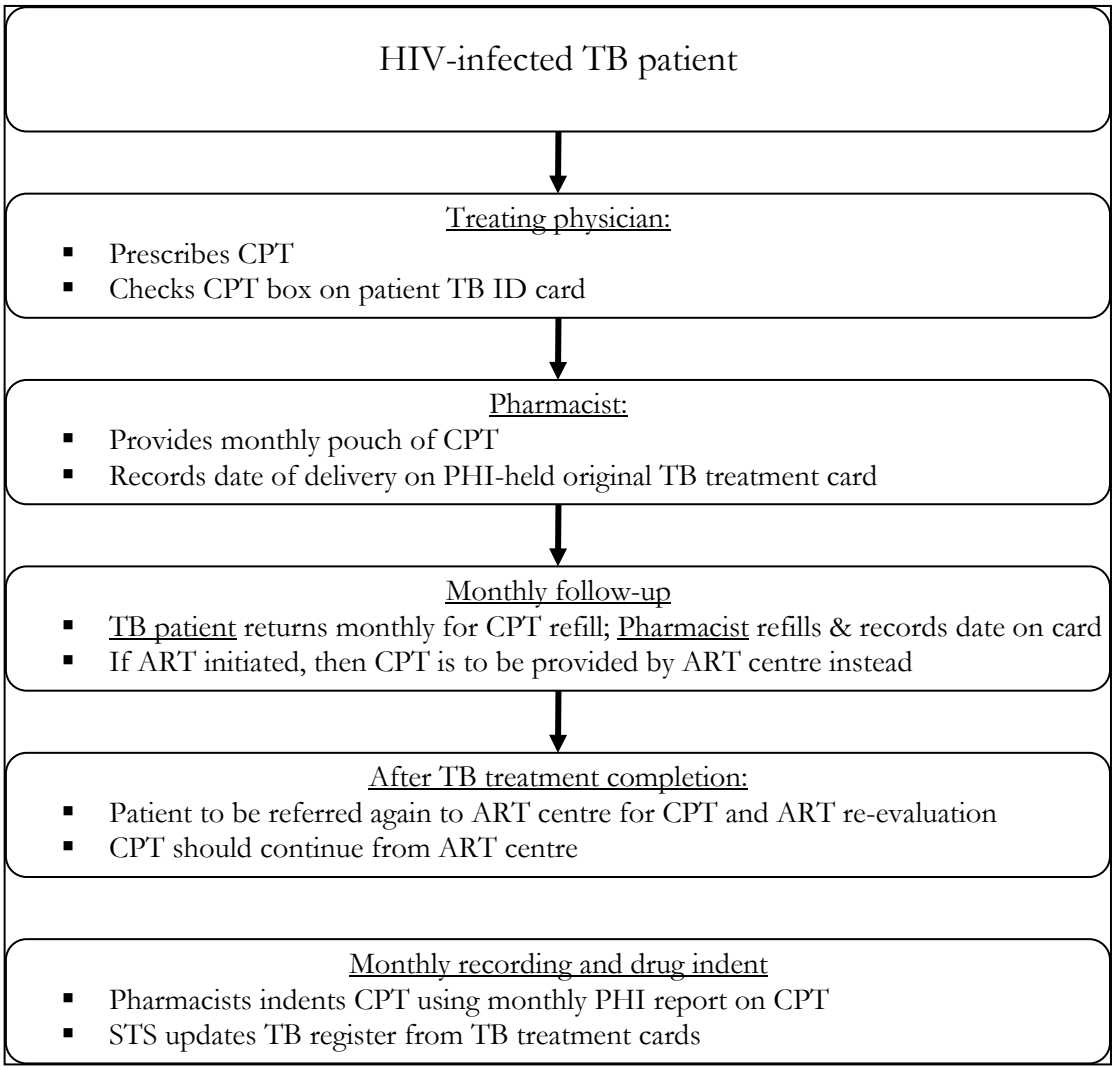
- In case the HIV-infected TB patient is already on CPT before the initiation of TB treatment, CPT can be continued from that source.

- 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.

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



CPT Drug supply management

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

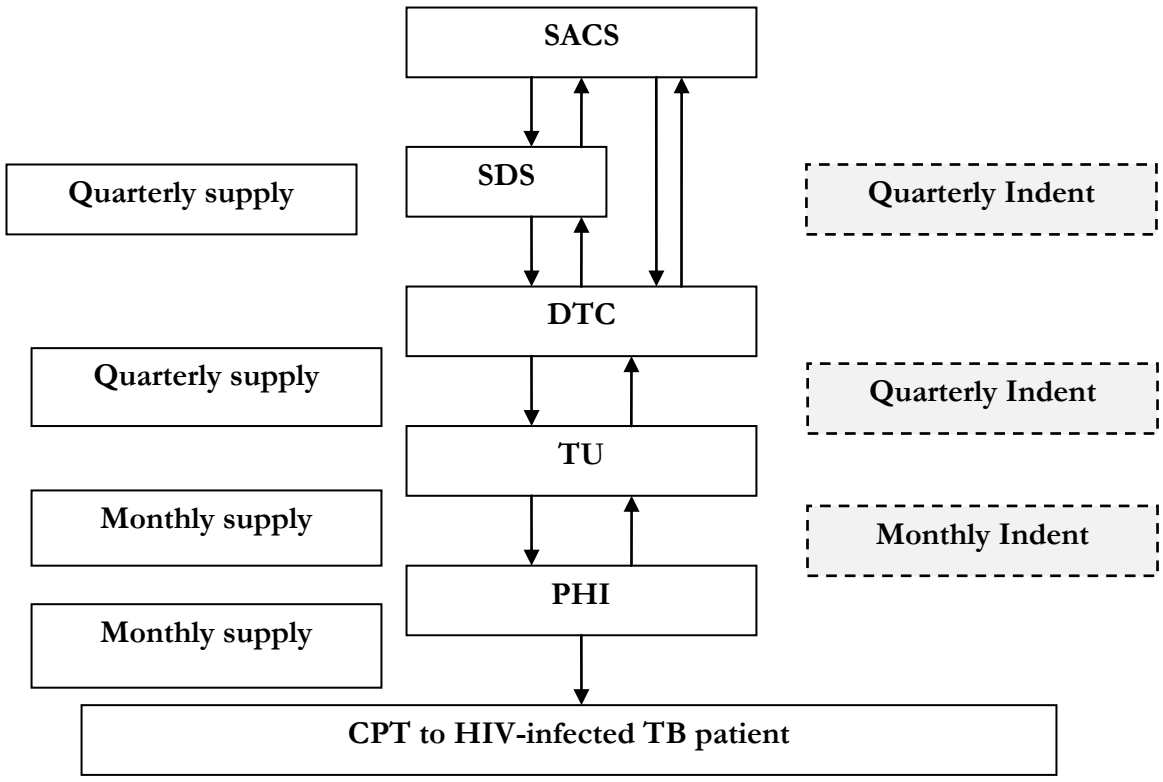
Cotrimoxazole (CTX) for provision of CPT to HIV-infected TB patients are to be procured by the State AIDS Control Societies, packaged in monthly pouches, each containing 30 tablets of Cotrimoxazole 960 mg (800 mg sulfamethoxazole + 160 mg trimethoprim) and supplied to the District TB Centres either directly or through the RNTCP State Drug Store (SDS).

- At the time of initiation of Intensified TB/HIV package in a district:
    - All PHIs should be supplied with 10 CPT monthly pouches, to account for patients immediately eligible for CPT and to have a CPT buffer supply.

- All TUs should maintain a stock of one quarter's requirement, which should be a number pouches equal to [6*(5% of the number of TB patients registered the previous quarter)].
- All Districts should maintain a stock of one quarter's requirement, which should be a number pouches of equal to [6*(5% of the number of TB patients registered the previous quarter)].

- The CPT should be stored in the Pharmacy of the PHI; the Pharmacist is to maintain a record of stock in the regular PHI Stock Register.
- On a regular monthly basis, PHIs should obtain CPT pouches from the concerned TU based on their actual requirements, considering the number of CPT pouches consumed, and the number HIV-infected TB patients detected. Regular re-supply of CPT pouches are requested from the TU headquarters using the monthly PHI CPT Indent **(Annex 3).**
- TU will supply CPT monthly pouches to the PHI on the basis of the number of pouches requested.
- The stock and requirement of the TU for CPT monthly pouches should be reported by the TU to the district level in **Quarterly TU CPT Report** (**Annex 4**).
- The District TB cell based on these requests, supplies CPT monthly pouches to TU.
- On a quarterly basis, the District TB Cell is to indent supply requirement of CPT monthly pouches from the SDS/SACS by the '**Quarterly District CPT Report' (Annex 5)**.
- In addition, emergency indent can also be made in case of urgent requirements.

Flowchart depicting the procurement and distribution of CPT pouches



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

Anti-retroviral drugs act by blocking the action of enzymes that are important for replication and functioning of HIV. The drugs must be used in standardized combinations (usually three drugs together). Anti-retroviral therapy (ART) results in reductions in morbidity and mortality in HIV-infected people. For ART to remain effective, extremely good adherence is required. Intensive counselling, support, and monitoring are 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 <u>not yet on ART</u> 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 NACO 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 6)**, 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 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 MEDICAL OFFICER

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.
2. Prescribe CPT to all known HIV-infected TB patients without contraindications. Counsel HIV-infected TB patients who have been prescribed CPT on possible side effects of Cotrimoxazole.
3. Refer HIV-infected TB patients to the nearest ART Centre, preferably after at-least two weeks of TB treatment (especially smear positive pulmonary TB). Use the ART referral form.
4. Monitor the updation of information on HIV status, CPT and ART delivery to HIV-infected TB patients on the TB treatment card.
5. At the end of TB treatment refer all HIV-infected TB patients not already taking ART again to the ART Centre for continuation of CPT and for re-evaluation of eligibility for ART. Use ART referral form.
6. Ensure HIV status of the TB patients remains confidential with in the health system.

ROLE OF MO-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 with in 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 staff attend the monthly co-ordination meetings with RNTCP staff regularly.

ROLE OF STATE TB CELL AND STDC

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

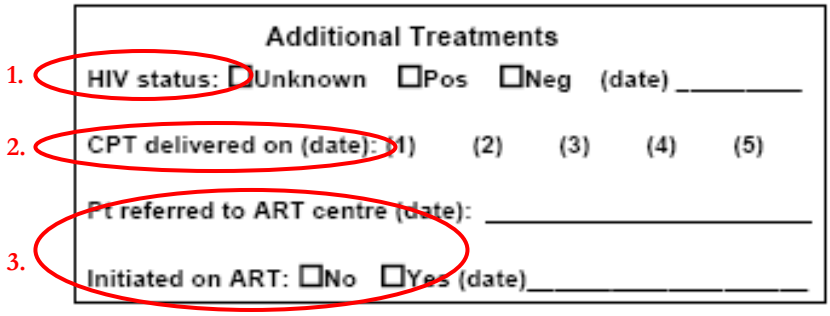
ROLE OF SACS

1. Organize training of trainers for DTOs and DNOs in coordination with State TB Cell on intensified TB/HIV package.
2. In coordination with DNOs, organize training for MOs-TCs, MOs, STS, Counsellors, ART centre staff and Pharmacist on intensified TB/HIV package
3. Overall supervision and ensuring smooth implementation of intensified TB/HIV package, as per National framework of joint TB/HIV collaborative activities
4. Ensure optimal availability of HIV test kits, Cotrimoxazole (in monthly packs), training modules and referral forms (for referral of all TB patients for VCT and referral of HIV-infected patients to ART centre).

RECORDING: KEY POINTS TO REMEMBER

Original TB treatment card

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



1. HIV Status:

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

ii. If HIV status of the patient is known, tick the appropriate box ('Pos' or 'Neg') and record the date of test along with PID Number if available. If the HIV status is not known, don't tick any box initially.

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

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

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

2. CPT (Cotrimoxazole Prophylactic therapy) delivery

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

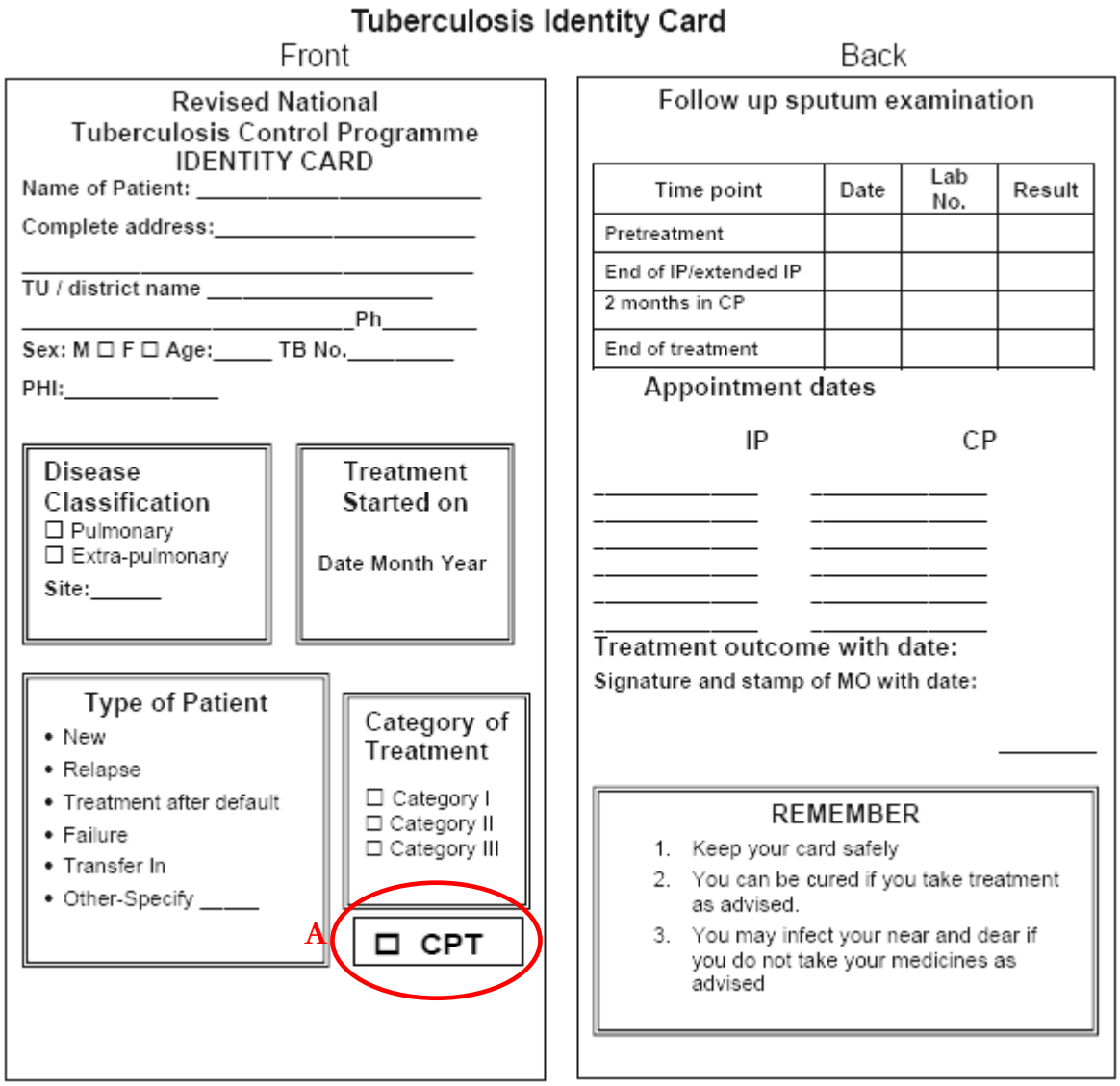
ii. If CPT provided from the PHI, record dates of each monthly delivery in the space provided.

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

3. Referral and initiation on ART

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

Figure 2: TB Identity card



A. CPT:

- If the patient is HIV-infected, and not already being provided CPT from any other source, MO (PHI) is to prescribe CPT by ticking in the section on CPT in TB ID Card.

- Institutional DOT provider on seeing the ticked box provides monthly supply of CPT and records the same on Original treatment card.

Figure 3: TB Register

Left side of the TB register

Revised National Tuberculosis Control Programme – TB Register Quarter_____ Year_____

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

A

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

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

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

Right side of the TB register

Revised National Tuberculosis Control Programme – TB Register Quarter_____ Year_____

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

B

DOTS SUMMARY	Cured	Comp Tx.	Died	Default	Failed	Transfer Out
NSP						
NSP [M/F]	M F	M F	M F	M F	M F	M F
NSN						
NEP						
New Others						
Relapse						
TAD						
Failure						
Cat II Others						

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

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

A: HIV status:

- HIV Status (as provided in the original TB treatment card) should be recorded in the space provided at the time of registration. Record 'P' for HIV-positive; 'N' for HIV-negative; If the HIV status is not known at the time of registration leave the cell blank.
- At the time of the case finding report preparation, all 'blank' entries in the HIV Status column in the TB register should be counted as 'Unknown' for the purposes of reporting.
- If the HIV status is later ascertained and updated on the treatment card during the course of TB treatment, the same should be updated in the TB register.
- By the time of Results of Treatment quarterly report preparation, ALL TB treatment cards should have an entry for HIV status (P, N, or U). Similarly, the TB register should reflect the entry on the TB treatment cards. If the HIV status information on the TB treatment card for whatever reason remains blank, that is to be recorded as 'Unknown'(U) in the TB register.

B: CPT and ART delivery:

- The section is to be filled up for all TB patients known to be HIV-infected and should be left blank for others.
- CPT and ART information should be updated on the register as the information gets recorded in the treatment card but not later than the time of recording the treatment outcome i.e. within a month of TB treatment completion.
- Record CPT started as 'yes', with the date, if at least one month of CPT delivery is recorded in the original treatment card.
- Record ART started as 'yes' if recorded as 'yes' in the original TB treatment card. Record the documented approximate date of ART initiation from the original TB treatment card.
- For patients who were already taking CPT or ART at the time of TB diagnosis, the dates for CPT and/or ART initiation would be expected to be earlier than the date of initiation of TB treatment.
- This information on the evaluation and initiation of ART may also be obtained from the 'TB/HIV register' maintained at ART centre during the monthly co-ordination meetings or during the visits of STS to the ART centre. The same information should be communicated to the concerned MO-PHI for updation of the treatment card.

Reporting in RNTCP case finding report: Key points to remember

Block 3: TB/HIV Collaboration

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

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

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

- In cell **'b'**, enter the sum of all TB patients registered in this quarter, with their HIV status recorded as positive (P) in the TB register.

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

Reporting in RNTCP treatment outcome report: Key points to remember

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

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

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

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

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

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

During TB treatment

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

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

MONITORING INDICATORS

1. Case finding report

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

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

Optimal: Majority of TB patients with known HIV status

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

Possible actions:

- ✓ Check if all the staffs are trained or not; Re-sensitize MOs and other staff on the policy of offering of VCT to all TB patients and timely recording of HIV status on the TB treatment card in the routine district level meetings of MOs conducted by CDHO/ DHS.
- ✓ Check whether VCT is being offered at all PHIs to all TB patients using standard referral form.
- ✓ Conduct interviews among randomly selected TB patient with unknown HIV status to find out reasons for non-acceptance of HIV testing or unwillingness to share the HIV status with MO-PHI.
- ✓ Check if all the ICTCs are functional (Counsellors and LTs are in place and trained; uninterrupted supply of testing kits and consumables) and conveniently located. Discuss with DNO/DAPCU officer to institute corrective measures.
- ✓ Check if all ICTC counsellors are aware of the policy of the 'shared confidentiality' and providing feedback on HIV test to the referring physician. Discuss the same with DNO/DAPCU officer to ensure compliance.
- ✓ Check whether the information related to TB/HIV is being updated on the original TB treatment cards
- ✓ Check whether the information is being updated in the TB register regularly by STS and reported accurately.

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

Possible actions:

- ✓ Ensure that the reporting is being done cohort wise. TB patients registered in 2q09 but tested for HIV in 3q09 should not be reported in 3q09!
- ✓ Check if 'unknown' HIV status is being incorrectly recorded/reported as 'HIV negative'. Ensure this doesn't happen by sensitizing the staff concerned.
- ✓ Ensure that while all TB patients are offered HIV testing, the process remains voluntary and no TB patient is forced to undergo HIV testing
    - Conduct random TB patient interviews;
    - Ask all field staff elicit information on the issue from TB patients and check if there was any coercion for getting HIV tested.
- ✓ In case of any instances of coercion:
    - Reassure the TB patient
    - urgently discuss and clarify the policy with the concerned officials

2. Results of treatment report

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

Optimal: Declining trend over successive quarters

Explanation:

- The basic purpose of the intensified TB/HIV package is to 'promptly' identify all HIV infected TB patients and provide them access to HIV care.
- The difference between the number of patients knowing their HIV status at the end of TB treatment and at the time of compilation of case finding report indicates delay in ascertainment of HIV status of TB patients leading to delayed opportunity to access HIV care. This may result in increased morbidity and mortality.
- As HIV testing is a voluntary procedure, some TB patients might not to get them selves tested for HIV. Some TB patients may choose to get them selves HIV tested beyond the first quarter of TB treatment.
- Also, there may be some delay on account of delay in communication of HIV test result from ICTC and also delay in its recording on the original TB treatment card.
- **Efforts should be made to decrease the difference between the two figures over the successive quarters.**

Possible actions:

- ✓ Check whether VCT is being offered at all PHIs to TB patients using standard referral form as soon as possible after TB diagnosis, preferable during the first few weeks of TB treatment
- ✓ Check if the TB patients being offered HIV testing are explained the importance early determination of HIV status and sharing the same with medical officer
- ✓ Check if all ICTC counsellors are aware of the policy of the 'shared confidentiality' and providing feedback on HIV test to the referring physician. Discuss the same with DNO/DAPCU officer to ensure compliance.
- ✓ Check whether the information related to TB/HIV is being updated timely on the original TB treatment cards
- ✓ Check whether the information is being updated in the TB register regularly by STS and reported accurately.

3. TB Register & TB treatment cards

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

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

Optimal: All HIV infected TB patients given CPT, and >70% given ART

Explanation:

- The basic purpose of the intensified TB/HIV package is to promptly identify all HIV infected TB patients and provide them access to HIV care.
- All known HIV infected TB patients should be initiated on CPT and referred for ART as soon as possible preferably within the first month of TB or ascertainment of HIV status- which ever is earlier. Delay in initiating them on HIV care is known to lead poor TB treatment outcomes.

- All HIV infected TB patient are likely to have low CD4 count (<350) and be eligible for ART. However, a sub-group of these patients (~20%) might have higher CD4 count and might not be eligible for ART.
- Data on HIV infected TB patients being initiated on CPT and ART is reported in the RNTCP results of treatment report. However, this should be monitored at the district and sub-district levels on a monthly basis from the TB registers and TB treatment cards and all known HIV infected TB patients not initiated on CPT and not referred for ART should be promptly initiated on CPT and referred for ART.

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

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

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

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

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

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

ART Centre (location, address):

Dear Doctor,

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

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

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

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

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

TU Name:

Details regarding ART

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

Pre-ART Registration Number:_____

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:

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

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

ITEM	**Unit of Measurement**	**Stock on first day of quarter (a)**	**Stock received during the quarter (b)**	**Consumption during the quarter (c)**	**Closing stock on last day of the quarter (d) d=(a+b-c)**	**Quantity Requested (e) =(c/3)*4-d**
Cotrimoxazole	Monthly pouch (30 tablets)					

Annex 5 Quarterly DTC report on CPT for HIV-infected TB patients (To be sent to DAPCU/SACS as a separate sheet)

ITEM	**Unit of Measurement**	**Stock on first day of quarter (a)**	**Stock received during the quarter (b)**	**Transfer in (c)**	**Transfer out (d)**	**Consumption during the quarter (e)**	**Closing stock on last day of the quarter (f) f=(a+b+c)-(d+e)**	**Quantity Requested (g) g=(e/3)*4-f**
Cotrimoxazole	Monthly pouch (30 tablets)							

Annex 6

ART CENTRE TB-HIV REGISTER

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