Republic of Botswana

BOTSWANA TB/HIV POLICY GUIDELINES

MINISTRY of HEALTH
REPUBLIC OF BOTSWANA

ACHAP

BOT USA

KNCV
TUBERCULOSIS FOUNDATION

Republic of Botswana

MINISTRY OF HEALTH BOTSWANA

TB/HIV COLLABORATIVE POLICY GUIDELINES

TB PROGRAM COLLABORATE TO SAVE LIVES

TWO DISEASES

ONE PATIENT

HIV PROGRAMS COLLABORATE TO SAVE LIVES

Contents

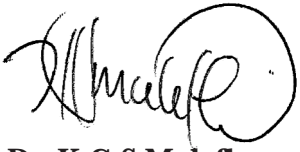
1. List of abbreviations

ACHAP	African Comprehensive HIV and AIDS Partnerships
ACSM	Advocacy Communication Social Mobilization
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retroviral Therapy
BAIS	Botswana HIV/AIDS Impact Survey
BCIC	Behavior Change Information Communication
BNTP	Botswana National Tuberculosis Programme
BONELA	Botswana Network on Ethics, Law and HIV/AIDS
BOTUSA	Botswana USA Project
BUP	Botswana-UPenn Partnership
CDC	Centers for Disease Control and Prevention
CHBC	Community Home Based Care
CPT	Cotrimoxazole Preventive Therapy
DHAPC	Department of HIV/AIDS Prevention and Care
DOT	Directly Observed Therapy
DPH	Department of Public Health
HAART	Highly Active Antiretroviral Therapy
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
ICF	Intensified Tuberculosis Case Finding
IDCC	Infectious Diseases Care Centers
IPT	Isoniazid Preventive Therapy
KNCV	KNCV Netherlands Tuberculosis Foundation
MASA	Botswana ARV Therapy Programme ("New dawn" in Setswana)
MDR-TB	Multi Drug Resistant Tuberculosis
MOH	Ministry of Health
NACA	National AIDS Coordinating Agency
NSF	National Strategic Framework for HIV and AIDS
PIMS II	Patient Information Management System
PLHIV	People living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
RHCT	Routine HIV Counseling and Testing
SMC	Safe Male Circumcision
STI	Sexually Transmitted Infections
TB	Tuberculosis
URC	University Research Corporation
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WWP	Workplace Wellness Programme

2. Foreword

The human immunodeficiency virus (HIV) pandemic presents a massive challenge for global tuberculosis (TB) control. Botswana like other Sub Saharan African countries experiences a huge burden of TB/HIV co-infection. The dramatic increase in TB incidence over the past two decades is due to the increasing prevalence of HIV. At present, the country estimates 60-80% of TB patients are co-infected with HIV. TB is one of the most common opportunistic infections and leading causes of morbidity and mortality in people living with HIV. Historically the TB and HIV programmes in Botswana have evolved separately with distinct mandates. However, the threat of the TB/HIV epidemic requires a new, comprehensive collaboration between the Department of Public Health (DPH) and the Department of HIV/AIDS Prevention and Care (DHAPC). These policy guidelines respond to a demand from all stakeholders involved in the care of dually infected patients for guidance on how best to develop and implement TB/HIV collaborative activities. It also provides a framework for the roles and responsibilities each programme will assume.

An open and participatory approach was followed in the development of this policy. The process was consultative, involving participation of stakeholders from Ministry of Health and, service providers in the private and public sector as well as development partners. The gratitude of the Ministry of Health is expressed to all the people and institutions involved in this process for their time and effort to develop these policy guidelines.



Dr. K.C.S Malefho
Permanent Secretary
Ministry of Health

3. Acknowledgments

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4. Background

Botswana is a democratic, middle-income nation of Southern Africa and shares its borders with the Republic of South Africa, Zambia, Zimbabwe, and Namibia. Although large in geographic area, the population density is relatively low, with almost 2 million people living primarily in the Southern and Eastern parts of the country.

Botswana's health care system is comprised of 26 health districts and is based on the primary health care approach. The health care system is highly decentralized and services are delivered through a network of hospitals, clinics, health posts and mobile health clinics with the intention that no citizen should live more than 15 km from a health facility. Up to 90% of health, services are provided by the government and state-supported mission hospitals, and the remaining 10% is provided by private practitioners, hospitals, and mining companies.

4.1 The HIV Epidemic: Epidemiology and Response

Botswana has one the highest rates of HIV in the world. Data from the 2008 Botswana HIV/AIDS Impact Survey (BAIS III) shows a prevalence of 17.6% among the general population and a 40% prevalence of HIV among people aged 30-44 years. The first case of HIV/AIDS in Botswana was diagnosed in 1985 and by 2009, there were an estimated 331,000 people living with HIV with over 8,700 annual HIV/AIDS-related deaths. Since the introduction of the national ARV therapy programme, life expectancy has risen from less than 40 years in 2003 to 54 years in 2009. Currently the main route of transmission is through heterosexual sex and an estimated 18,000 new adult infections occur annually. Children have been particularly affected by the HIV epidemic. In 2009, an estimated 19,000 children were living with HIV and 85,000 were AIDS orphans in Botswana.

The HIV epidemic has had a profound impact on all sectors of Botswana society. In response to the crisis, the Government of Botswana established a National Aids Coordinating Agency (NACA) in 1999. A Prevention of Mother to Child Transmission (PMTCT) initiative was introduced the same year to increase access to anti-retroviral therapy (ART) for HIV positive pregnant women. Additional PMTCT objectives are to provide psychosocial support and counseling for HIV positive women and their partners, promote early infant diagnosis and facilitate safe infant feeding practices. The success of PMTCT has been high; with an estimated 94% program uptake and the rate of vertical transmission has fallen from approximately 40% in 2001 to less than 4% in 2009.

In 2001, the national ARV therapy programme (Masa) was established and several models have been used for scale up including outsourcing services to private practitioners, task shifting and utilization of satellite clinics. By 2009, 92% of all eligible people living with HIV were receiving HAART in Botswana, 90% in the public sector. To support this effort substantial resources have been invested in lab and clinical infrastructure development. Over the past decade more, than 7000 health care workers have been trained in HIV care and management, and 33 Infectious Disease Care Centers (IDCC) and 161 satellites clinics are currently providing HIV care and related services. In 2004, Botswana adopted a national opt-out HIV testing strategy that offers routine, non-compulsory HIV testing (RHCT) to all patients presenting for medical care. Together with voluntary counseling and testing centers (VCT), this strategy has resulted in almost 60% of the population being tested for HIV by 2008.

Additional components of the Botswana health sector response targets people living with HIV (PLHIV) within their communities or workplace. The Community Home Based Care (CHBC) programme provides social, counseling, nutrition, and palliative support to PLHIV. In 2005, to meet the needs of over burdened health care workers confronted with both the TB and HIV epidemics, a workplace wellness programme (WWP) was also established.

Overall, the national response to the HIV epidemic in Botswana has been one of the largest and most successful in Africa. However significant challenges remain. A mid-term evaluation of the Botswana National Strategic Framework for HIV and AIDS (NSF) found that while there have been achievements in clinical facility-based interventions such as HIV testing (VCT and RHCT), PMTCT and ART, the future focus must be on prevention. In 2008, to address this challenge the Ministry of Health produced the National Operational Plan for Scaling up HIV Prevention. A major prevention effort over the next several years is Safe Male Circumcision (SMC) with the goal of providing a comprehensive, safe male circumcision package to 80% of HIV-negative men aged 15-29 years by December 2012. Other components of the prevention strategy include initiatives to reduce sexually transmitted infections (STI) and Behavior Change Information Communication (BCIC), which aims to promote safe sex practices including male and female condom use, positive prevention strategies, encouragement of male involvement in sexual health issues and increase of the age of sexual debut in youth.

4.2 The TB Epidemic: Epidemiology and Response

Over the past two decades, Botswana has witnessed a dramatic rise in TB cases. Prior to 1990, efforts to control TB in Botswana were very successful. In 1975, TB notification rates were 506 per 100,000 and declined to 199

per 100,000 by 1989. Unfortunately, this downward trend reversed in 1990 and climbed to a peak of 623 per 100,000 in 2002, one of the highest in the world. Currently (2008) the rate of TB in Botswana is the sixth highest in the world at 536 per 100,000. In addition, the prevalence of multi-drug resistant TB (MDR-TB) is increasing. The trend over four national drug resistance surveys demonstrates an increase in new cases of MDR-TB from 0.2% in 1995 to 2.5% in 2008.

This increase in TB notification has been attributed to the high HIV burden in Botswana. To date, the proportion of TB patients among people presenting with HIV infection in health care facilities is unknown. The Botswana National TB Programme (BNTP) was established in 1975 and TB activities were fully integrated into the primary health care (PHC) system. Tuberculosis services are widely available at all facilities in Botswana. Laboratory diagnosis using sputum smear microscopy is the mainstay of TB identification. Laboratory services are available at all 52 district and primary hospitals in Botswana. In 1986, Botswana adopted short-course chemotherapy and in 1993 directly observed therapy (DOT) for all patients for the entire treatment period. The Community TB Care (CTBC) Initiative utilizes community volunteers to assist with various TB control activities including early diagnosis and case finding, DOT and TB education for patients and the community. In the past five years the BNTP has significantly revised the National TB Programme Treatment Manual (2007) and published MDR-TB guidelines (2005 and 2009) and TB Infection Control Guidelines (2009).

The BNTP currently subscribes to the WHO Stop TB Strategy and its central component DOTS, a five-part strategy for TB control in resource-limited settings. The DOTS strategy includes case detection through quality-assured bacteriology, standardized treatment with supervision and patient support, an adequate drug supply and management system, political commitment and sustained financing, and recording and reporting to measure impact. In line with the DOTS strategy, the BNTP outlined several initiatives in its 2008-2012 Strategic Plan including laboratory capacity development, improved TB infection control, support for operational research, effective Advocacy, Communication and Social Mobilization (ACSM) strategies, and introduction of Private-Public Partnerships. Other important objectives are to enhance and expand high quality DOTS services and TB/HIV and MDR-TB activities in all districts by 2012.

Nurse practitioners are allowed to initiate treatment for sputum positive TB patients and follow up TB patient on treatment.

4.3 The TB/HIV Epidemic: Epidemiology and Response

The dramatic rise in TB incidence in Botswana since 1991 reflects the increase in HIV seroprevalence (Figure 1). Due to immune suppression, PLHIV are more likely to reactivate latent TB infection and progress to primary TB disease if infected. Regional evidence shows that recurrent TB in HIV positive individuals is more likely to be re-infection than relapse, suggesting high levels of TB transmission in the HIV population. This has led to an epidemic of TB/HIV co-infection in areas of the world where both diseases are common. Epidemiologic studies have shown that 60-80% of patients with active TB in Botswana are co-infected with HIV. Tuberculosis remains one of the most common opportunistic infection and a major cause of mortality for PLHIV in Botswana with estimates of up to 40% of all HIV deaths attributable to respiratory infections. Moreover, the clinical presentation and natural history of TB differs between HIV positive and negative individuals. People living with HIV are more likely to be sputum smear negative and have atypical clinical and radiographic evidence of TB disease, especially with advanced immune suppression. Treatment of patients with TB/HIV is also challenging, due to the frequency of immune reconstitution inflammatory syndrome (TB-IRIS), drug interactions and toxicity. The TB/HIV epidemic continues to have a negative impact on the health sector in Botswana.

The convergence of the TB and HIV epidemics necessitates a collaborative public health policy approach. However, this has proved difficult as TB, HIV/AIDS control policies, and programmes have evolved separately. In 2004, the WHO outlined an integrated policy designed to bring TB and HIV services together. There are three major objectives of this policy. The first is to create a mechanism for collaboration through a coordinating body for TB/HIV activities at all levels, HIV surveillance among TB patients, joint TB/HIV planning and monitoring and evaluation. The second is to decrease the burden of TB in PLHIV. Commonly known as the "Three I's" this objective includes intensified TB case finding (ICF), isoniazid preventive therapy (IPT), and infection control in health facilities and other congregate settings. The third objective is to decrease the burden of HIV in TB patients through HIV testing and counseling, HIV prevention, and prompt introduction of interventions that decrease mortality in TB/HIV patients: cotrimoxazole preventive therapy (CPT) and ART.

In the past five years, Botswana has begun the process of TB/HIV integration. A National TB/HIV Advisory Committee was established in 2005. Surveillance of TB/HIV data for national and WHO reporting purposes has been improving over the past several years with DPH routinely tracking data on HIV testing in TB patients. In 2009, the national TB registers

and TB treatment cards were amended to collect information on ARV and Cotrimoxazole (CPT) use. The IPMS and PIMS II database used by Masa for monitoring the ARV Programme has also incorporated TB variables. However, the process for sharing TB/HIV surveillance data between the two programmes has not been well established. At the early stage of TB/HIV integration, such parallel efforts are common. Both the DPH strategic plan and the NSF II clearly outline TB/HIV activities and the major national TB and HIV training programmes for HCW emphasize the clinical and public health relevance of co-infection. However, few joint activities or training effort has taken place. In addition, there is no current mechanism to plan or coordinate TB/HIV activities at the district level.

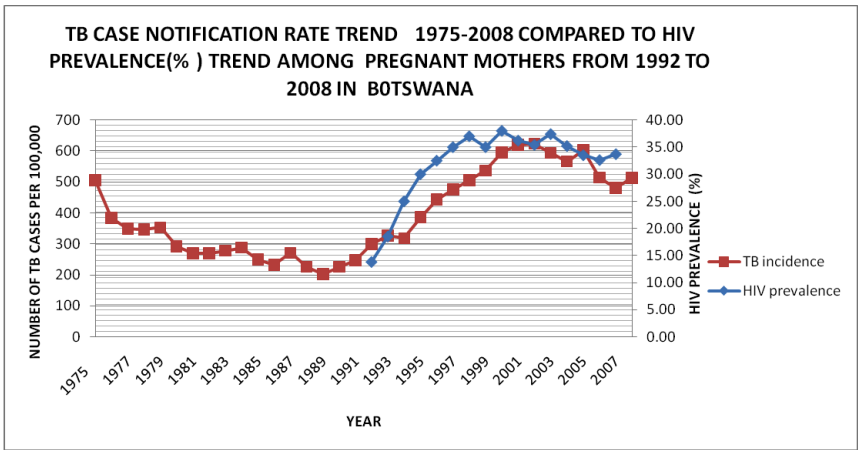
In 2002, Botswana initiated an ambitious IPT programme in which all PLHIV without clinical evidence of TB disease are eligible for 6 months of IPT. By 2005, the IPT programme was implemented in VCT, PMTCT and other ARV centers nationwide and was then administered by the DPH. An external review of the IPT Programme was conducted in 2008 and recommended stronger integration of IPT into routine HIV services and improvement of data management systems. In response, the TB/HIV Advisory Committee formally transitioned the IPT Programme to the DHAPC in 2009. While ICF is recommended and all doctors qualified to administer ART are trained on TB/HIV co-infection identification and management, actual practice has not been well measured. Similarly, the 2009 National TB Infection Control Guidelines have been distributed to health facilities nationwide but implementation has been limited.

Efforts to decrease the burden of HIV in TB patients have been more successful with HIV testing and counseling. According to the 2008 national TB register, 65% of TB patients were tested for HIV. Although this falls short of the BNTP target of 90%, there has been steady improvement since 2006. The success of HAART or CPT for TB/HIV patients is less clear. Routine data has only been collected recently but preliminary analysis shows that only 34% of TB patients are currently receiving HAART. This is most likely due to poor M&E integration and weak patient referral tracking. The implementation of other HIV prevention interventions for TB patients such as HIV education and safe sex counseling has also not been evaluated.

Botswana is well positioned to address the TB/HIV epidemic. Strong political commitment to combating HIV/AIDS combined with resource allocation, has led to one of the most successful HIV programs globally. This provides a very strong platform on which to build collaborative TB/HIV activities. Recent evaluations of the BNTP have enhanced resource allocation for TB and strengthened the position of the BNTP within the Department of Public Health. Both DPH and DHACP have endorsed a TB/HIV strategy, have dedicated TB/HIV personnel and participate equally on the TB/HIV

Advisory Committee. The development of these TB/HIV policy guidelines reflects the commitment of the individual programs to plan and implement joint TB/HIV activities at all levels of the health care system.

Figure 1



Source: MOH, BNTP Annual Report, 2006-2008

5. Key Issues, Problems and Gaps

While the TB/HIV integration has started in Botswana, it is still early in the process of development. It is critical at this stage to identify the key gaps in TB/HIV activities and challenges that must be overcome. The following is a summary of the major issues that must be addressed including recommendations to ensure effective TB/HIV collaboration.

5.1 Coordination and Linkages

There is weak coordination between the DPH and the DHAPC and implementing partners beyond the mechanism provided by the TB/HIV Advisory Committee. There is no joint planning or implementation of TB/HIV activities at the district level. Therefore, it is necessary to strengthen the collaboration and coordination between DPH, DHACP and implementing partners at the national and district level.

5.2 HIV Testing and Counseling for TB Patients

While HIV testing and counseling for TB patients is improving, it is not always offered, accepted or documented. Therefore, it is necessary to develop an effective strategy to implement HIV testing and counseling to all TB patients, and ensure that HIV test results are recorded in the TB register.

5.3 ART for TB Patients

Screening for TB among people living with HIV and presenting at IDCC sites is inadequate. The proportion of TB patients currently receiving HAART is rarely documented. Therefore, the referral process and tracking of TB patients for ART must be improved for eligible TB/HIV co-infected patients.

5.4 Infection Control Measures and Implementation

National TB Infection Control Guidelines exist and have been widely circulated, yet facility based implementation plans and quality management systems are not in place. Wider implementation of TB infection control at all facilities is strongly recommended.

5.5 Intensified TB case finding among PLHIV in ART Clinics and other relevant settings

Active TB case finding among PLHIV is not performed systematically at all IDCC or ARV satellite clinics. Other settings such as VCT centers, PMTCT, WWP and Child Welfare Clinics are ideal places to screen PLHIV for TB. A system for intensified TB case finding among PLHIV in ARV clinics and other relevant settings must be developed, including a method for monitoring.

5.6 Integration of TB/HIV care into Community Health Care Services and Civil Society

There is weak TB/HIV service provision at the community level due to inadequate resources and weak collaboration. Community TB Care and Community Home Based Care have significant potential for integration but remain separate programmes to date. Expansion of TB/HIV services into civil society has been limited. Enhanced coordination between existing community care programmes and integration of TB/HIV care into civil society is recommended.

5.7 Monitoring and evaluation

Surveillance of TB/HIV indicators is performed separately and there is no process for sharing data between the DPH, DHAPC and implementing partners. There is a lack of nationally standardized tools for capturing data at TB and HIV service care points, which has led to poor quality TB, and TB/HIV data at district and national level. Therefore, monitoring and evaluation systems must be strengthened and harmonized at the national and district level, and a mechanism must be established to share surveillance data for planning and implementation of TB/HIV activities.

5.8 Access to Health Services

Tuberculosis services are available at all health facilities in Botswana. Most HIV/AIDS services are available in most facilities in Botswana except for antiretroviral therapy, which is accessible in less than 400 facilities. This difference in level of access will need to be addressed to allow effective TB/HIV service integration.

6. Goals, Objectives and Framework

6.1 Purpose of the National TB/HIV policy guidelines

To ensure that all stakeholders involved in TB and HIV/AIDS care widen the scope of their activities to integrate comprehensive TB/HIV care for dually infected patients. These policy guidelines will further provide the basis for enhanced coordination and collaboration of all programs, stakeholders and partners in the National TB/HIV Response.

6.2 Goal and Objectives of the National TB/HIV policy guidelines

The goal of the national TB/HIV policy guidelines is to reduce mortality and morbidity in TB and HIV infected patients through collaborative TB/HIV activities.

Objectives

1. To strengthen the health care system to respond effectively to the TB/HIV epidemic
2. To decrease the burden of TB in people living with HIV
3. To decrease the burden of HIV in TB patients

4. To Establish a monitoring and evaluation system for TB/HIV collaborative activities

6.3 Strategic Framework

In order to achieve the above goal and objectives, the DPH and DHAPC shall continue the primary responsibilities for their respective programme areas, while collaborating on all aspects of TB/HIV activities. The overall strategic framework will therefore consist of all activities, which influence the improvement of TB/HIV service delivery by both programmes.

7. Policy on Collaborative TB/HIV Activities

7.1 To strengthen the health care system to be able to effectively respond to the TB/HIV epidemic

- Establish a mechanism for collaboration between the DPH and the DHAPC
  - o Strengthen the TB/HIV Advisory/Coordinating Committee at the national level
  - o Establish a TB/HIV Technical Working Group (TWG) at the national Level
  - o Joint planning, supervision, budgeting, resource mobilization and research
  - o Establish TB/HIV Coordinating Committees at the district Level (annex 3)
  - o Wider implementation of TB infection control in health care and other settings – High Priority
- Enhance TB/HIV Advocacy
- Develop age and gender focused TB/HIV interventions
- Expand opportunities for community TB/HIV care by engaging all care providers including community based organizations and civil society
- Enhance TB/HIV diagnostic capacity
- Establish private-public partnerships for TB/HIV treatment and care
- Develop capacity of HCW to address TB/HIV support and care
  - o Harmonize curriculums and training plans between programs
  - o Conduct joint supportive supervision

7.2 To decrease the burden of TB in people living with HIV/AIDS

The DPH and the DHAPC will implement the following activities to reduce the morbidity and mortality due to TB in PLHIV:

- Expand ICF in PLHIV in ARV clinics and other relevant settings - High Priority
- Improve implementation of IPT for all eligible patients
- Improve TB infection control in health care and other settings – High Priority

7.3 To decrease the burden of HIV/AIDS in patients with TB

The DPH and the DHAPC will implement the following activities to reduce the morbidly and mortality due to HIV in TB patients:

- Address how to best implement 100% HIV testing in all TB patients
- Strengthen RHCT in TB suspects and other high risk groups (HCW, congregate settings)
- Establish timely referral and linkages to ARV for TB/HIV patients
- Improve CPT for TB/HIV patients
- Enhance HIV/AIDS care and support for TB/HIV patients
- Strengthen HIV prevention efforts for TB patients

7.4 Establish a monitoring and evaluation system for the TB/HIV collaborative activities

Collaborative TB/HIV activities will be recorded and reported locally, nationally and internationally to inform planning and policy at all levels. To facilitate this process the DPH and the DHACP will:

- Strengthen monitoring and evaluation systems at the national and district level
- Harmonize data collection tools and local, national and international TB/HIV indicators (Annex 1 and 2)
- Improve coordination between the different stakeholders and implementing partners
- Ensure national ownership of all TB/HIV data generated by stakeholders

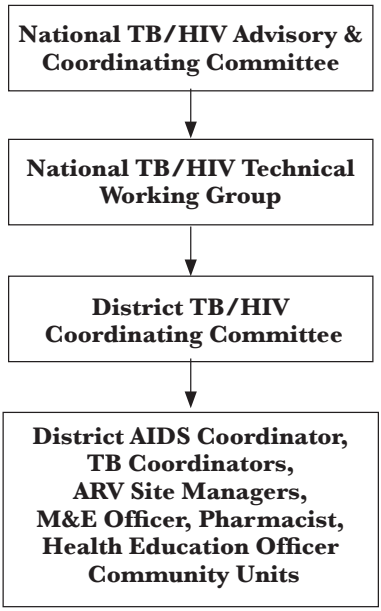
• Develop a mechanism for TB/HIV data collection, analysis and dissemination at the facility, district and national level
  - o Improve data collection mechanisms
  - o Establish mechanisms for information technology integration
  - o Strengthen existing reporting structures within and between programmes

• Ensure use of TB/HIV data to inform policy, planning and program improvement

8. Coordination and Partnership Framework for TB/HIV Activities

The role of the Coordinating Committee is to ensure implementation of the collaborative TB/HIV strategic plan, by supporting strong and transparent partnerships, strengthening resource mobilization and enhancing TB/HIV advocacy at all levels. The committee shall also be charged with the responsibility of monitoring the implementation of TB/HIV collaborative activities at their respective level.

8.1 Organogram of TB/HIV Coordinating Committees and Technical Working Groups



8.2 Partnership Framework

To ensure that TB/HIV collaborative activities are implemented effectively there must be a clear mechanism for coordination of partners engaged separately by the DPH and the DHAPC. To facilitate this process under the supervision of the National TB/HIV Advisory and Coordinating Committee, DPH and DHAPC will jointly:

- Develop a partnership coordination and implementation plan
- Ensure data ownership nationally
- Encourage collaborative research effort and dissemination

8.3 Mechanisms for reporting

The Coordinating Committees at national and district level will be responsible for reporting on the progress of TB/HIV collaborative activities. The Coordinating Committee will form a task group that will ensure that relevant reports and data are captured and reported to the proper authorities locally and nationally.

8.4 Monitoring and Evaluation Framework

District health facilities will submit data on monthly and quarterly basis to national and district management teams. The reports shall contain but are not limited to the national indicators set by the Ministry of Health for national and international monitoring and evaluation purposes (Annexes 1 and 2).

9. Conclusion

These policy guidelines are intended to provide a comprehensive foundation upon which further technical guidelines may be developed for specific TB/HIV activities. Under the leadership and guidance of the DPH and the DHAPC, these policy guidelines will develop effective mechanisms for collaboration and coordination among all key stakeholders to reduce the mortality and morbidity of TB/HIV co-infected patients.

Annexes

Annex 1: Indicators of success

1.Prevention of TB in PLHIV	Number of health facilities and congregate settings implementing TB infection control guidelines/total number of health facilities and congregate settings
2.Prevention of HIV in TB patients	Number of TB patients tested for HIV /total number of TB patients notified
3.Prevention of HIV in TB patients	Number of TB Patients HIV positive/total number TB patients notified
4.Intensive case finding in PLHIV	Number of new TB cases found by screening patients receiving HIV treatment and services/ total number of patients receiving HIV treatment and services
5.Total number of PLHIV receiving TB care services	Number of patients receiving HIV treatment and care who were screened for TB symptoms/ total number of patients receiving HIV treatment and care
6.Prevention of OIs in PLHIV	Number of TB/HIV patients receiving CPT during TB treatment/total number TB/HIV patients receiving TB treatment
7.HIV Care and Support to TB/ HIV	Number of TB/HIV patients referred for HIV care and support services during TB treatment/ number of TB/HIV patients receiving TB treatment
8.Provision of ART for TB patients	Number of TB/HIV patients on ART during or at end of TB treatment/number of TB/ HIV patients receiving TB treatment

Annex 2: Reporting Department for Standard TB/HIV indicators

INDICATOR	HOW TO MONITOR	DEPARTMENT
% of PLHIV screened for TB	Annual review, monitored continuously from pre ART and ART registers	DHAPC
% of PLHIV receiving TB treatment	Continuous monitoring quarterly collected and annually reported to WHO. Obtained from pre ART and ART registers	DHAPC
% of PLHIV started on TB treatment within the same year	Continuously monitored quarterly and reported annually	DHAPC
% of PLHIV started on IPT (new cases adults and children)	Obtained from pre ART registers and reported quarterly	DHAPC
% of health facilities providing services for PLHIV that have infection control including TB	Reported annually, during external reviews and in checklist for facilities	DHAPC
% of HCW who develop TB while within HIV care setting	Annually reported	DPH
% of TB patients with known HIV status	Continuously monitored quarterly and during cohort reporting	DPH
% of TB patients with documented HIV status which is positive	Continuously monitored quarterly and during cohort reporting	DPH
TB case detection for HIV positive (total registered/ estimated cases in PLHIV)	Continuously monitored quarterly and annually	DPH
Availability of condoms at TB clinics and number of facilities with condoms	Monitored annually	DPH
Proportion of HIV positive TB patients who receive CPT	Continuously monitored and analyzed quarterly in reports	DPH
HIV positive TB patients enrolled in HIV care	Continuously monitored, reported in quarterly reports	DPH
% of TB patients receiving ART	Continuously monitored, reported in quarterly cohort and outcome data.	DPH

Annex 3

ESTABLISHMENT OF TB/HIV COORDINATING COMMITTEES

1. Membership

The national TB/HIV advisory committee will oversee the national level coordinating activities. It is recommended that districts should establish TB/HIV coordinating committees.

At the district level to comprise of the following officials:

- District public health specialist (DPHS)
- TB coordinator (TBC)
- HIV coordinator (HIVCO)
- District public health nurse/Matron or equivalent
- District public health officer/ or equivalent
- Representatives from NGO, FBO, CBO working with TB/HIV
- Representative from PLWHIV, TB clubs etc
- District medical laboratory technician (DMLT) or equivalent

Note: All TB/HIV stakeholders within the region should be included.

2. The role of these committees includes the following activities:

- Planning of HIV/TB collaborative activities
- Resource mobilization for TB/HIV
- Training and other capacity building activities
- Advocacy, communication and social mobilization
- Enhancing community participation
- Oversee successful implementation of TB/HIV collaborative activities
- Monitoring and evaluation of TB/HIV activities

Ministry of Health
Gaborone, Botswana
Tel: +267 363 2500
Fax: +267 317 0150