FEDERAL REPUBLIC OF NIGERIA
FEDERAL MINISTRY OF HEALTH
Department of Public Health

NATIONAL STRATEGIC FRAMEWORK FOR TB/HIV COLLABORATIVE ACTIVITIES

National Tuberculosis, Leprosy & Buruli Ulcer Control Programme
&
National AIDS & STIs Control Programme

November 2020, Third Edition

FOREWORD

Tuberculosis (TB) is a major public health problem in Nigeria with the country ranked 6th among the 30 high TB burden countries globally and first in Africa. The country is also among the 14th countries that are in all the three WHO Global high-burden country lists for TB, HIV associated TB and Multi-drug Resistant TB (MDR-TB). The TB burden in the country is further compounded by the high HIV/AIDS burden as HIV is a key risk factor for developing TB in Nigeria

TB and HIV/AIDS constitute a lethal combination of diseases that individually have significant impact on public health with each making the situation of the other worse. The stigma and discrimination attached to both diseases have serious psychological and social consequences. Every year, thousands of our people are lost to the co – infection of TB and HIV, families are wiped out and this creates a growing tide of orphans and vulnerable children who are at heightened risk to the diseases. Life expectancies have been tragically shortened and National development stifled as the most productive of citizens continue to die.

As part of efforts of the Federal Ministry of Health to rapidly scale up implementation of TB/HIV Collaborative activities, the National Strategic Framework (NSF) for Implementation of TB/HIV Collaborative Activities was revised in collaboration with all relevant stakeholders to incorporate new WHO recommendations and lessons from programme implementation.

The 2021-2025 National TB/HIV strategic framework will provide the necessary policy guidance for decreasing the burden of TB/HIV among dually infected and affected populations in the country by serving as a useful tool for all stakeholders supporting effective and efficient implementation of TB/HIV collaborative activities in Nigeria.

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Honourable Minister,

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ACKNOWLEDGEMENT

The 2021 – 2025 National TB/HIV strategic framework for the implementation of TB/HIV collaborative activities in Nigeria provides the necessary policy guide for reducing the burden of TB and HIV among dually infected and affected populations in the country towards meeting our National targets and reaching goal three (3) of the Sustainable Development Goals (SDG)

I wish to express my sincere appreciation to the World Health Organization (WHO) and all the technical experts that developed this document after rigorous brainstorming sessions. Our esteemed donor agencies, TB/HIV stakeholders and Implementing Partners are also highly appreciated for their support.

Our special thanks go to the Clinton Access Health Initiative (CHAI) who supported both financially and technically, the process of reviewing the National TB/HIV collaborative strategic framework with the UNITAID funding.

The implementation of this document will no doubt support Nigeria's quest in providing high quality patient-centered care to individuals co-infected with TB and HIV

The 2021 – 2025 National TB/HIV strategic framework for the implementation of TB/HIV collaborative activities in Nigeria provides the necessary policy guide for reducing the burden of TB and HIV among dually infected and affected populations in the country towards meeting our National targets and reaching goal three (3) of the Sustainable Development Goals (SDG)

Dr. M.O Alex - Okoh

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EXECUTIVE SUMMARY

The 2021 National Strategic Framework for TB/HIV collaborative activities is a five-chapter document that serves as a policy guide for the implementation of TB/HIV collaborative activities in Nigeria. It highlights the desired structure and mechanisms for effective collaboration between the two programs

The first chapter introduces the document in general and gives a brief background of the NTBLCP, NASCP and NACA including their mandate towards the control of TB and HIV in Nigeria. It provides the epidemiology of TB, HIV and TB/HIV co-infection as well as highlights the target audience for use of the document

Chapter two provides the situational analysis of TB/HIV collaborative activities in Nigeria and emphasizes the strengths, weaknesses, opportunities and threats to the program.

Chapter three focuses on the goal, objectives and guiding principles of TB/HIV collaborative activities while chapter four dwells on the strategic interventions required to fulfil the set objectives. It goes further to describe the activities required for each of the strategic interventions outlined

Finally, the fifth chapter deals with monitoring, evaluation and research plans for TB/HIV collaborative activities in Nigeria. It specifies the data monitoring system, mechanism for dissemination of data, data quality assurance, supportive supervision, and the indicators for monitoring TB/HIV performance

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ACRONYMS

3Is	Intensify TB Case Finding; Isoniazid Preventive Therapy and Infection Control
ACSM	Advocacy Communication and Social Mobilization
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BHCPF	Basic Health Care Provision Fund
CDR	Case Detection Rate
CPT	Co-trimoxazole Preventive Therapy
CSO	Civil Society Organization
DOTS	Directly Observed Treatment Short Course
FMOH	Federal Ministry of Health
FSWs	Female Sex Workers
GFATM	Global Fund to Fight AIDS TB and Malaria
HCT	HIV Counseling and Testing
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IBBSS	Integrated Biological and Behavioral Surveillance Survey
IC	Infection Control
IPC	Infection Prevention and Control
IPT	Isoniazid Preventive Therapy
KPs	Key Populations
LF - LAM	Lateral Flow Lipo - Arabinomannan
LGA	Local Government Area
LGATBLS	LGA Tuberculosis and Leprosy Supervisor
M and E	Monitoring and Evaluation
MDR-TB	Multi Drug Resistant Tuberculosis
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
NACA	National Agency for the Control of HIV/AIDS
NAIIS	Nigeria HIV and AIDS Indicator and Impact Survey
NASCP	National AIDS and STI Control Programme
NIBUCAA	Nigerian Business Coalition Against AIDS

NPHCDA	National Primary Health Care Agency
NSF	National Strategic Framework
NTBLCP	National Tuberculosis and Leprosy Control Programme
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PP	Private Providers
RTK	Rapid HIV Test Kit
SACA	State Agency for the Control of HIV/AIDS
SAPC	State HIV/AIDS Programme Coordinator
SBC	Social and Behavioural Change
SOMLPforR	Save One - Million Lives Performance for Results
SOP	Standard Operating Procedure
STBLCO	State TB and Leprosy Control Officer
STIs	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
TPT	TB Preventive Therapy
TWG	Technical Working Group
WHO	World Health Organization

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CHAPTER ONE

1.1 INTRODUCTION

HIV is among the key risk factors for developing TB in Nigeria**Error! Bookmark not defined.** with disease attributable risk factor of 11%**Error! Bookmark not defined.**. HIV increases TB incidence and mortality, the risk of developing tuberculosis (TB) is estimated to be between 16-27 times greater in people living with HIV than among those without HIV infection[1], while TB is a leading preventable cause of morbidity and mortality among people living with HIV (PLHIV). To mitigate the dual burden created by interactions between TB and HIV, The Federal Ministry of Health in 2006, in collaboration with all partners, developed the 2006 – 2010 National strategic frameworks for the implementation of TB/HIV collaborative activities in Nigeria. The framework provided a guiding principle for the implementation of TB/HIV collaborative activities.

This third edition of the TB/HIV strategic framework was developed in collaboration with all partners with a time frame of 2021 -2025 to align with the milestones of ending TB and HIV epidemic.

The 2021 – 2025 National strategic framework is targeted at:

- TB and HIV Programme staff at all levels (National, State and LGAs)
- Implementing partners supporting TB/HIV
- Funding organizations (such as GFATM, PEPFAR)
- HIV partners
- TB partners
- Facility staff at all levels

1.2 Background

1.2.1 COUNTRY

Nigeria is a country in West Africa, sharing borders with Benin, Niger, Chad and Cameroon, as well as a coastline on the Gulf of Guinea. It has an area of 923,768 square kilometres and is the most populous country in Africa, with an estimated population of

[1] Risk of developing TB in HIV infected persons. Retrieved from https://www.who.int/hiv/topics/tb/about_tb/en/

201 million in 2020[2]. An estimated 43.9 percent of the population is under the age of 15, with an additional 19.3 percent between the ages of 15 and 24[3]. The official language of Nigeria is English, although there are more than 250 ethnic groups with diverse languages and religious faiths.

Administratively, the country is divided into 6 geo-political zones with 36 states and the FCT and has a total of 774 Local Government Areas.

1.2.2 The National Tuberculosis, Leprosy and Buruli Ulcer Control Programme (NTBLCP) Structure

NTBLCP is structured along the three tiers of government i.e. Federal, State and LGA. At the federal level, the NTBLCP's central unit, a division in the Department of Public Health of the Federal Ministry of Health, is responsible for policy development, resource mobilization, development of human and material resources, provision of technical support to state programs and monitoring and evaluation of the programme. It coordinates and collaborates with other partners to control TB, Leprosy and Buruli ulcer

[2] Country Profile – Nigeria. Global TB Report, 2020

[3] Nigeria population by age groups. Nigeria Demographic and Health Survey 2018

in the country. The TB Technical Committee and other Technical Working Group (TWG) advises the NTBLCP to enable it to achieve its goals. The State TBL programmes coordinate TB, Leprosy and Buruli ulcer activities, and provide technical oversight to programme implementation at the Local government level. The LGA, which is the operational level (basic management unit) of the NTBLCP, coordinates TB, Leprosy and Buruli ulcer activities and provide technical oversight at the facility level through the Local Government TB and Leprosy Supervisor (LGTBLS). All LGA TBL supervisors should have at least one assistant to support programme implementation at the LGA level. The National TB and Leprosy Training Centre (NTBLTC) is responsible for identifying the human resource needs and training various categories of health care staff to implement TB, Leprosy and Buruli Ulcer Control activities

1.2.3 NATIONAL AIDS AND STI CONTROL PROGRAMME (NASCP) AND STRUCTURE:

The National AIDS and Sexually Transmitted Infections Control Programme (NASCP) is a division in the Department of Public Health, Federal Ministry of Health (FMoH). Its mission is to reduce morbidity and mortality from HIV/AIDS and STIs in Nigeria through effective coordination and management of the health sector response. Its mandate is to formulate and ensure effective implementation of policies, guidelines and standard operating procedures for the prevention of new HIV infection and STIs, as well as improve treatment, care and support for those persons infected and affected by these infections. The division operates through eight technical areas (Prevention, HIV and STIs Treatment Care and Support, Strategic Information, Laboratory Services, Procurement and Supply Chain Management, Programme Development and Administration and the Performance Management unit, ACSM) each coordinated by component heads. At the state level the health sector response is coordinated by the State AIDS/STIs Control program Coordinator (SASCP) while at the LGA level the HIV Focal Person coordinates the health sector response and reports to the SASCP.

1.2.4 THE NATIONAL AGENCY FOR THE CONTROL OF AIDS (NACA)

The National Agency for the Control of AIDS (NACA) was established in February 2000 to coordinate the various activities of HIV/AIDS in the country. The agency has the mandate to provide an enabling policy environment and stable ongoing facilitation of

proactive multi sectoral planning, coordinated implementation, monitoring and evaluation of all HIV/AIDS prevention and impact mitigation activities in Nigeria. Its vision is to make Nigeria, a nation of people with functional knowledge of HIV/AIDS who provide care and support to individuals, families and communities.

1.3 TARGET AUDIENCE

Program managers and Coordinators working in the areas of TB and HIV programs at all levels, all General Healthcare workers, public and private healthcare practitioners, implementing partners, Department of Defense, Civil society organizations, Community based organizations.

1.4 THE MAGNITUDE OF TB, HIV & TB/HIV CO-INFECTION IN NIGERIA

1.4.1 TB BURDEN

TB is a major public health problem in Nigeria with the country among the 14 countries that are in all the three WHO Global high-burden country lists for TB, TB/HIV and MDR-TB with an estimated incident rate of 219 per 100,000 population.[1]

The TB treatment coverage, which has stagnated at 24% for about 4 years, for the first time increased to 27% in 2019, with the country recording the highest number of TB cases ever notified since the inception of the NTBLCP. The number of TB cases notified increased by 13% from 106,533 in 2018 to 120,266 in 2019 (see Figure 1). The age group 0-14 years despite constituting 42.5% of the population in the country only accounts for 8% (9,450) with huge number of estimated cases among this group and other age groups not detected. Eleven percent (33,479) of the 319,734 undetected TB cases in 2019 are HIV positive incident TB cases, hence finding the missing TB cases among PLHIV remain a priority intervention in the TB/HIV collaborative activities in the country.

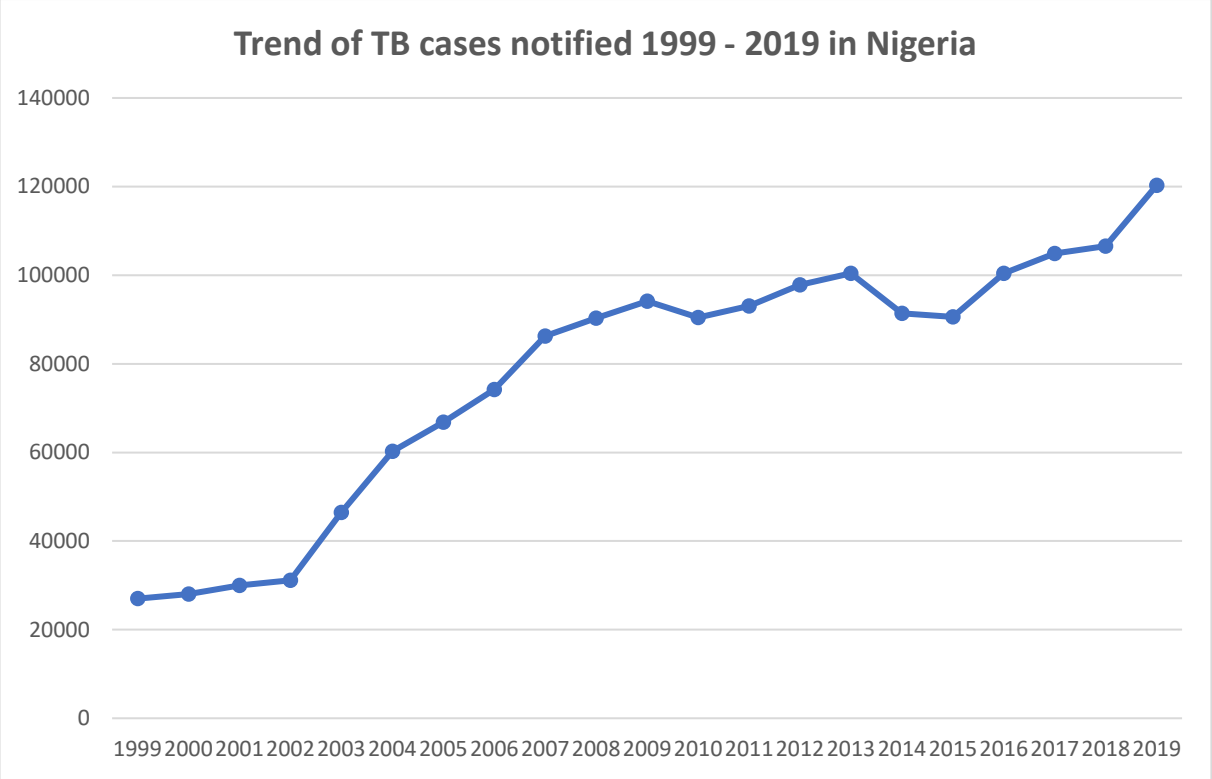

***Figure 1*: Trend of TB cases notified 1999-2019 in Nigeria**

1.4.2 HIV BURDEN

Nigeria ranked 3rd among the high HIV burden countries globally with an estimated 1.8 million people living with HIV (PLHIV), at a current prevalence of 1.4%**Error! Bookmark not defined.**. The HIV prevalence among adults aged 15-64 years was 1.5%. This was lower among men (1.0%) than women (1.8%) and lower in urban (1.3%) areas than in rural (1.5%) areas. HIV prevalence among adults aged 15-49 years was 1.4%. This was lower among men (0.8%) than women (1.7%) and lower in urban (1.1%) than in rural areas (1.4%).

The prevalence varies across regions and states, with the highest prevalence being in the south-south (3.1%) and the north-west having the lowest prevalence (0.6 %). Akwa Ibom state has the highest prevalence (5.5%) while Katsina has the lowest prevalence (0.3%).

According to the 2019 NAIIS report**Error! Bookmark not defined.** heterosexual route still accounts for most HIV transmissions in Nigeria with over 90% of transmissions occurring via unprotected sexual intercourse. A survey report showed that the prevalence of the infection among Men who have sex with Men (MSM) has risen

consistently from 14% in 2007 to 17% in 2010 and 23% in 2014[4]. Mother-to-Child-Transmission (MTCT) is another prominent mode of transmission. Most children less than 15 years living with HIV acquired the infection through mother-to-child transmission.

There has been reduction in new infections through the years and annual HIV/AIDS deaths decreased from 69,000 to 45,000 between 2010 and 2019. From the estimated 1.8 million people living with HIV (PLHIV) in 2019, about 1.1 million people are currently on life-saving anti-retroviral therapy[5].

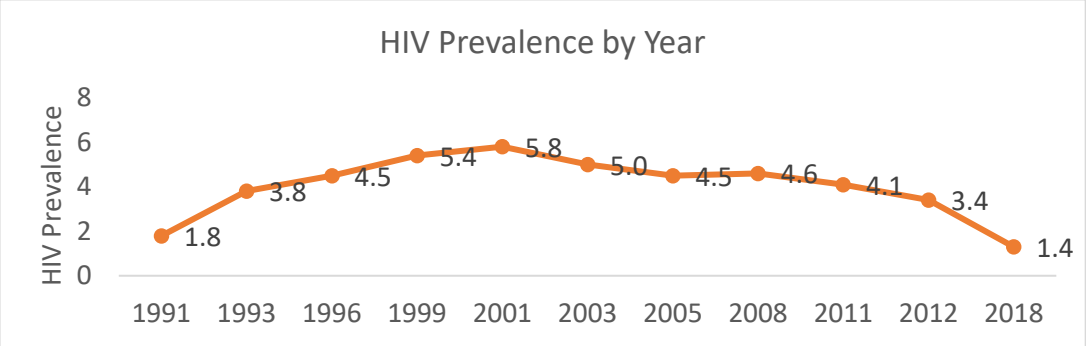

Figure 2: HIV prevalence by year in Nigeria

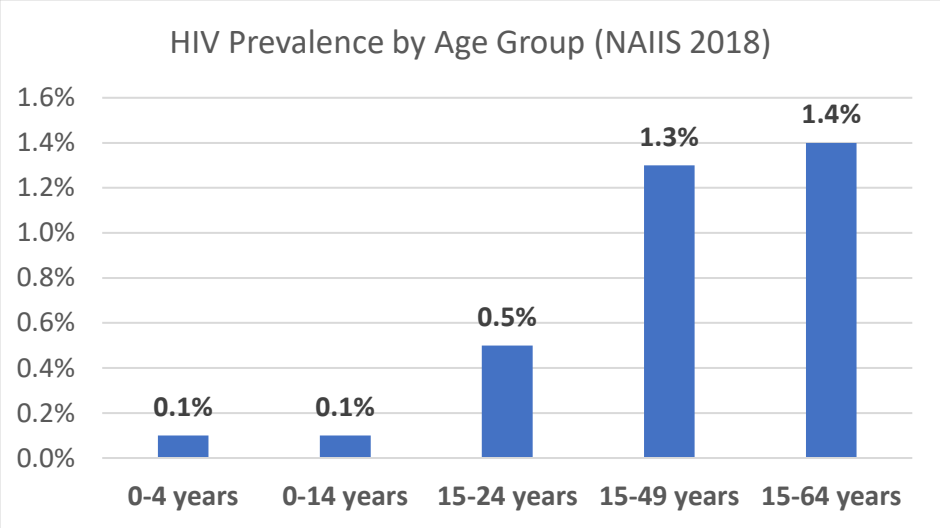

Figure 3: HIV prevalence by age group

[4] Prevalence of HIV among men who have sex with men (MSM). Integrated Biological and Behavioral Surveillance survey, IBBSS 2014

[5] ART among PLHIV. HIV Health Sector Annual Report, 2019

1.4.3 BURDEN OF TB/HIV CO-INFECTION IN NIGERIA

The country is one of the 14 countries that are on the three high-burden country lists for TB, TB/HIV and MDR-TB. According to the Global TB report of 2020, the country has an estimated 46,000 HIV-Positive incident TB cases in 2019, which is about 11% of the estimated TB burden in the country.

1.4.4 HIV BURDEN AMONG TB PATIENTS

Nigeria has consistently maintained a high uptake of HTS among TB patients. In 2019, 97% (116,879) of the TB patients notified had documented HIV status on the TB register, with 11% of them being HIV positive (see figure on Trend in TB/HIV activities 2018 - 2019),

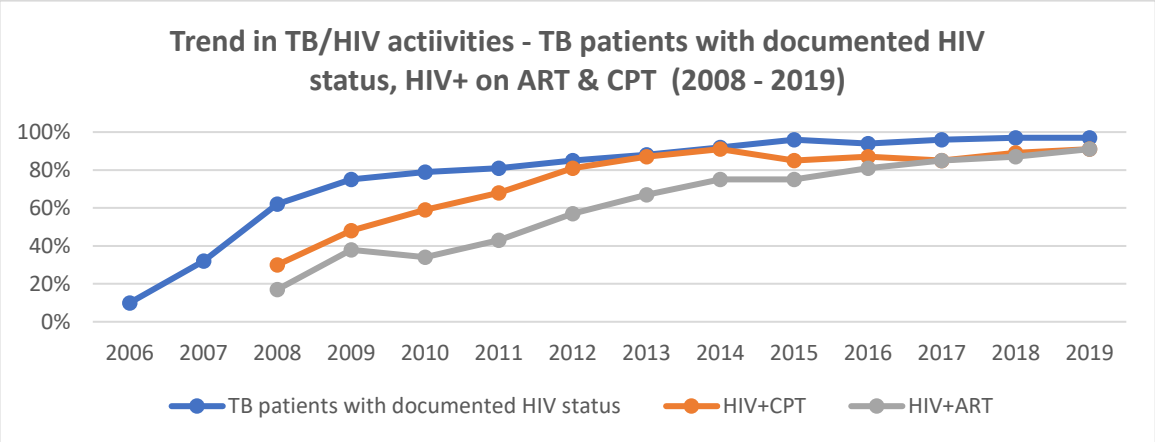

Figure 4: TB patients with documented HIV status, HIV+ on ART & CPT (2008 - 2019)

The HIV positivity rate among TB patients follow a similar trend with the HIV prevalence in 2019. The zone with the highest prevalence of HIV**Error! Bookmark not defined.** also has the highest HIV positivity rate among TB patients (see table below). This is an indication that TB burden will continue to be driven by the HIV burden.

Table 1: Zonal HIV prevalence and HIV+TB rate in 2019

Zone	HIV prevalence (NAIIS)	HIV+TB rate 2019

SS	3.1%	21%
NC	2.1%	19%
SE	1.9%	16%
SW	1.2%	9%
NE	1.1%	8%
NW	0.6%	4%

The number of HIV positive TB cases detected has been on consistent decrease from 17,747 HIV+TB cases in 2010 to 12,521 HIV+TB cases in 2019, despite the increase in number of TB patients with known documented HIV status (see table below). This consistent decline could be a reflection of the Nigeria's HIV prevalence which shows a downward trend since 2001[6] [7]. The HIV prevalence rate in 2019 is 1.3%**Error! Bookmark not defined.**.

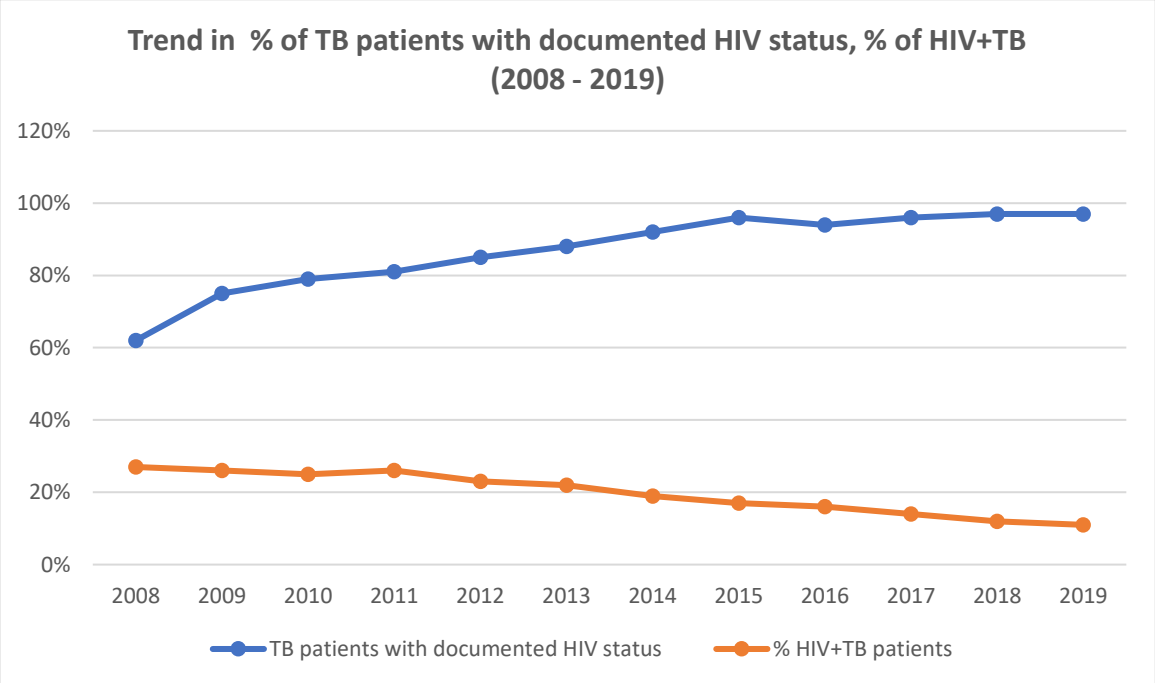

Figure 5: Trend in % of notified TB patients with documented HIV status and HIV positivity rate 2008 - 2019

[6] HIV prevalence in Nigeria. Federal Ministry of Health, 2015

[7] National HIV sero-prevalence sentinel survey among pregnant women attending antenatal clinics in Nigeria. Abuja, FMoH, 2014

The implication of the declining HIV trend is that the country needs to test a large number of TB patients to be able to achieve the target for the estimated number of HIV positive incident TB cases. The country in 2018 was only able to detect 28% of the estimated HIV+ incident TB cases**Error! Bookmark not defined.**. This could be due to suboptimal quality in TB screening among PLHIV and missed opportunity along the cascade of TB care among PLHIV.

The proportion of HIV positive TB patients receiving ART increased from 81% in 2016 to 91% in 2019, while the proportion on CPT in 2017 is also 91% as shown in figure below:

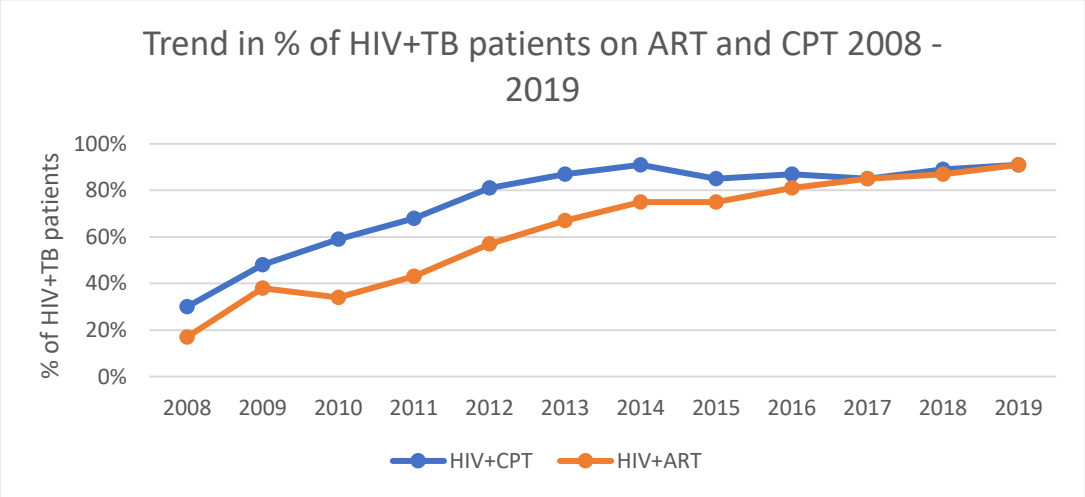

Figure 6: Trend in HIV+TB patients on CPT and ART 2008 – 2019

1.4.5 TB BURDEN AMONG PLHIV

The national prevalence of TB among PLHIV at enrolment in HIV care was 11.2%[8]; this dropped to 4.5% with a 95% CL given as (4.3% - 4.7%) when the last visit to the health facilities was considered.

The 2019 HIV Health sector annual report revealed that 92% of the PLHIV were clinically screened for TB, with 6% of them having presumptive TB and 72% had their sample sent for TB testing (see figure below).

[8] The National study to determine the prevalence of TB among PLHIV, 2018

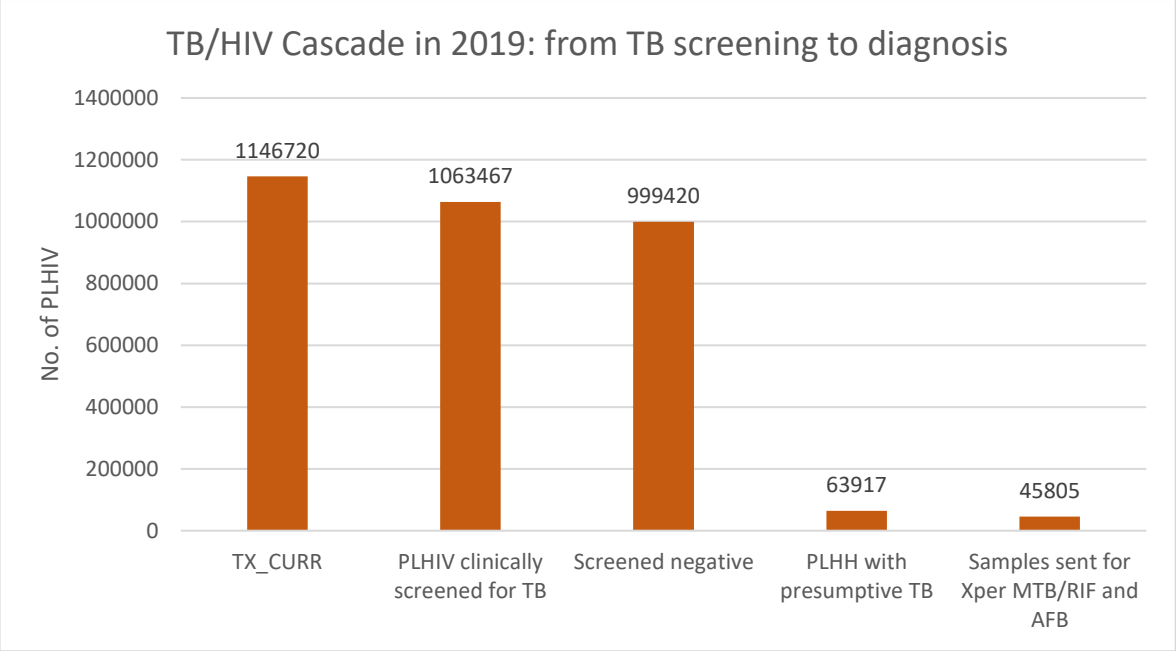

Figure 7: TB/HIV cascade in 2019: from TB screening to diagnosis

The number of newly enrolled PLHIV on IPT increased from 2,257 in 2012 to 11,262 in 2018, representing a low IPT coverage of 73% among the newly enrolled PLHIV in 2019. The trend in number of PLHIV newly enrolled in care on IPT 2010 – 2019 is shown in figure below:

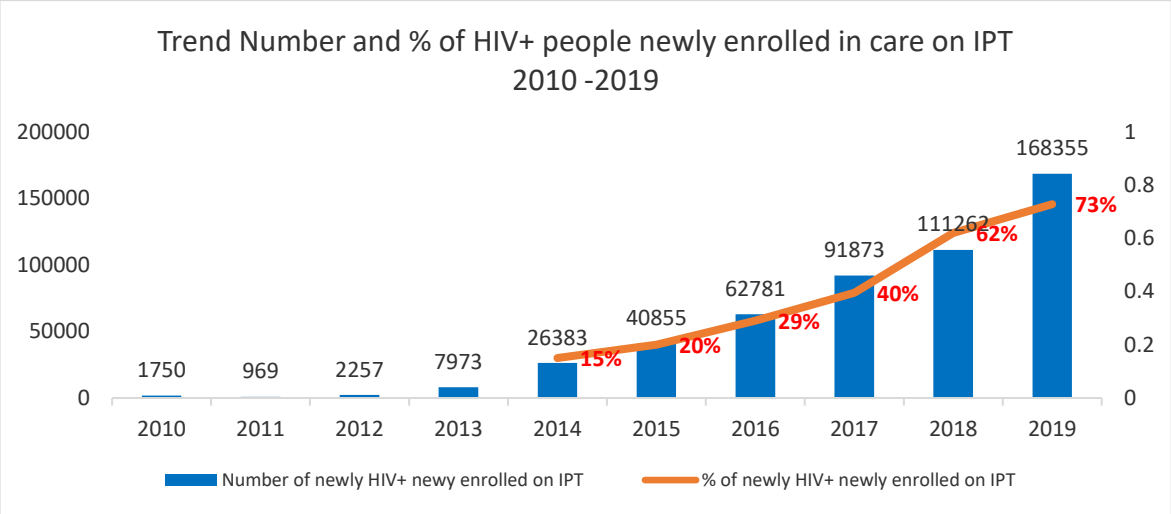

Figure 8: The trend in number of PLHIV newly enrolled in care on IPT 2010 – 2019

1.4.6 TB TREATMENT OUTCOMES AMONG HIV+TB CASES

The TB treatment outcomes in 2019 revealed a higher death rate among HIV+TB patients that is twice the death rate among all forms of TB patients. The HIV+TB patients had a death rate

of 12% compared to death rate of 5% among all forms of TB patients as shown in figure below. This is in line with the National study of TB prevalence among PLHIV 2018, which showed the mortality rate among PLHIV co-infected with TB (11 per 1000 PLHIV population) to be nearly thrice the general PLHIV population (4 per 1000 PLHIV population).

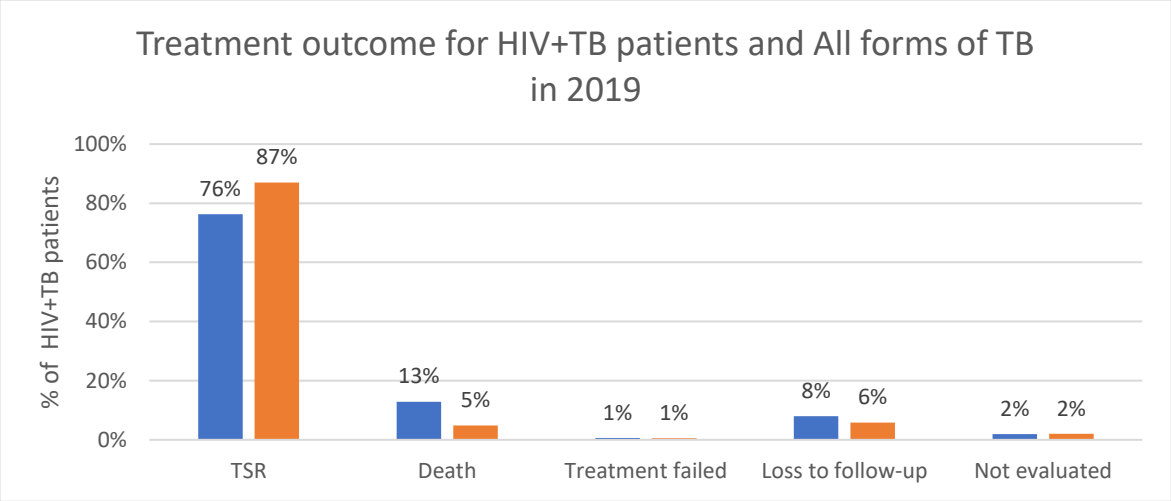

Figure 9: Treatment outcomes of all forms of TB and HIV+TB patients reported in 2019

CHAPTER TWO

2.1 SITUATION ANALYSIS OF TB/HIV COLLABORATIVE ACTIVITIES

The process of developing the 2021 - 2025 National Strategic Framework (NSF) for TB/HIV Collaborative activities in Nigeria included a situation analysis of TB/HIV collaborative activities in Nigeria. The compilation of the Strength, Weakness, Opportunities and Threats (SWOT) analysis is as tabulated below:

Table 2: SWOT Analysis of TB/HIV Collaborative Activities in Nigeria

Strengths	**Weaknesses**
1. Availability of infrastructure and human resource for TB/HIV collaborative activities. 2. Availability of TB/HIV policy documents/guidelines. 3. Established structure for the implementation of TB/HIV collaborative activities at the national, state, Local Government Area (LGA) and health facility levels. 4. Existence of a National Technical Working Group (TWG) for TB/HIV collaborative activities at the National level. 5. Existence of integrated TB/HIV services within most Anti-Retroviral Therapy (ART) facilities. 6. Significant improvement (15% in 2014 to 74% in 2019) Isoniazid-based TB Preventive Therapy (TPT) provided to PLHIV. 7. High rates of HIV testing among diagnosed TB patients (97% in 2019)	1. Sub-optimal integrated TB and HIV Advocacy, Communication and Social Mobilization (ACSM) at all levels. 2. Sub-optimal functionality of TB/HIV working groups at all levels. 3. Sub-optimal implementation of one-stop shop model. 4. Sub-optimal functionality of GeneXpert machines due to inadequate power supply and module failure. 5. Weak capacity for management of TB/HIV co-infection and other co-morbidities among health care workers. 6. Non-availability of shorter TPT regimen (e.g. rifapentine and isoniazid). 7. Sub-optimal collaboration for commodities and logistics management. 8. Occasional stock-out of isoniazid, HIV Rapid Test Kits (RTKs) and GeneXpert cartridges. 9. Inadequate National guidelines, integrated algorithms, Socio-Behavioural Change (SBC) materials and SOPs. 10. Sub-optimal quality of care for TB/HIV co-infected patients.

8. High ART coverage (91% in 2019) among TB/HIV co-infected patients in the country.[2]	11. Sub-optimal viral load testing for PLHIV. 12. Inadequate coverage of approved new diagnostic innovation e.g Lateral Flow Lipo - Arabinomannan (LF - LAM) assay for TB diagnosis. 13. Sub-optimal implementation of Infection Prevention and Control (IPC) at all levels. 14. Sub-optimal capacity for TB/HIV research 15. Low engagement of stand-alone private laboratories and other private outfits in TB/HIV services.
Opportunities 1. Presence of partners provides opportunity for strengthening various aspects of TB/HIV collaboration. 2. Presence of private sector for further expansion of TB/HIV collaborative activities. 3. Presence of advocacy bodies and champions such as the First Lady of Federal Republic of Nigeria, STOP TB Partnership, TB legislative caucus and Nigerian Business Coalition Against AIDS (NIBUCAA). 4. Presence of funding opportunities at National and State level (such as Save One - Million Lives Performance for	**Threats** 1. Donor dependence 2. Donor fatigue 3. Inadequate human resource - high staff attrition rate and non-replacement of staff. 4. Security challenges in some parts of the country. 5. Health emergencies e.g. COVID - 19 pandemic. 6. Industrial actions by labour force. 7. Stigma and discrimination. 8. Poor health-seeking behavior among Nigerians 9. Quackery in the Nigerian health sector

Results (SOMLPforR), Basic Health Care Provision Fund (BHCPF). 5. Presence of traditional and alternative medicine providers as well as religious bodies. 6. The Integrated Health Sector COVID-19 pandemic response plan provides an opportunity for strengthening TB/HIV service delivery as well as IPC practices at all levels. 7. A good number of tertiary and research institutions that can support training and research among Health Care Workers (HCW).	

CHAPTER THREE

3.1 GOALS, OBJECTIVES AND GUIDING PRINCIPLES OF TB/HIV COLLABORATIVE ACTIVITIES

The goal and objectives of TB/HIV collaborative activities in Nigeria were set to address the identified programmatic gaps, ensure sustained collaborative efforts towards implementation of interventions aimed at attaining national and global targets for TB/HIV integration

3.1.1 THE GOAL

The goal of TB/HIV collaborative activities is to decrease the burden of TB and HIV in people at risk of or affected by both diseases in Nigeria[9] [10]

3.1.2 OBJECTIVES OF TB/HIV COLLABORATIVE ACTIVITIES

The objectives are:

1. To strengthen the mechanisms for collaboration between HIV and TB-control programmes at national, state and LGA levels
2. To reduce the burden of TB in people living with HIV, their families and communities
3. To reduce the burden of HIV in patients with presumptive and diagnosed TB, their families and communities

3.1.3 GUIDING PRINCIPLES

The implementation of the TB/HIV Collaborative activities at all levels will be guided by the following principles:

- Ownership and leadership of the strategy at National, State and LGA levels
- Partnership and collaboration with communities and other stakeholders at all stages of programme development and implementation to increase acceptability

[9] National Tuberculosis Leprosy and Buruli ulcer Control Programme (NTBLCP). National Strategic Framework for Implementing TB/HIV Collaborative Activities in Nigeria (2013–2015). 3rd ed. Nigeria: Federal Ministry of Health; 2012

[10] WHO policy on collaborative TB/HIV activities : guidelines for national programmes and other stakeholders World Health Organization. Geneva: 2012.

of interventions, expand access to services, and advocate for additional resources for programme implementation.

- Well defined roles and responsibilities of all stakeholders
- Equitable and universal access to patient-oriented TB /HIV interventions[9]

CHAPTER FOUR

4.1 STRATEGIC INTERVENTIONS AND COLLABORATIVE TB/HIV ACTIVITIES

In line with the Goal and objectives of TB/HIV activities in Nigeria, a number of strategic interventions and activities have been outlined. These are consistent with the NSPs of both TB and HIV. The NTBLCP and NASCP will leverage on each other's strength in the provision of quality assured TB/HIV joint services in an integrated and patient centered manner to affected individuals and families and the vulnerable populations.

4.1.1 OBJECTIVE 1: TO STRENGTHEN THE MECHANISMS FOR COLLABORATION BETWEEN HIV AND TB CONTROL PROGRAMMES AT NATIONAL, STATE AND LGA LEVELS

The following interventions have been designed to strengthen the mechanisms for collaboration between both programmes:

1. Strengthen the coordinating body for collaborative TB/HIV activities at National, State and LGA levels (including communities)
2. Determine HIV prevalence among TB patients and TB prevalence among people living with HIV
3. Carry out joint planning to integrate the delivery of TB and HIV services at all levels
4. Strengthen TB/HIV monitoring and evaluation (M&E) system

4.1.1.1 STRATEGIC INTERVENTION 1: STRENGTHEN THE COORDINATING BODIES FOR COLLABORATIVE TB/HIV ACTIVITIES AT NATIONAL, STATE AND LGA LEVELS (INCLUDING COMMUNITIES)

a) Reactivate and strengthen technical working group at all levels for accountability and to monitor optimization of TB/HIV collaborative activities
b) Ensure sustained support for routine meetings of the TB/HIV Working Groups/technical committees
c) Capacity building of programme staff and HCWs to coordinate effective delivery of TB/HIV collaborative activities

4.1.1.2 STRATEGIC INTERVENTION 2: DETERMINE HIV PREVALENCE AMONG TB PATIENTS AND TB PREVALENCE AMONG PEOPLE LIVING WITH HIV

The following interventions will be carried out to determine these:

a) Manage routine TB/HIV data from TB and HIV service delivery points
b) Incorporate HIV testing into TB prevalence surveys
c) Promote the integration of testing protocols for HIV and TB at service delivery points
d) Support systems for routine screening of all PLHIV for TB at every clinic visit at all levels.
e) Harmonize and Leverage TB/HIV testing at the private sector (community pharmacies, private hospital)

4.1.1.3 STRATEGIC INTERVENTION 3: CARRY OUT JOINT PLANNING AND IMPLEMENTATION TO INTEGRATE THE DELIVERY OF TB AND HIV SERVICES.

Planning and implementation will focus on the following areas:

a) Joint Domestic Resource Mobilization (JDRM)
    i. Joint development of operational plans, budget and grant application at federal and state levels.
    ii. Joint advocacy for improved resources - human, material, financial, etc. - for implementing TB and HIV collaborative activities from the government, partners and private sectors.
    iii. Ensure partners implementing TB and HIV activities are part of the federal or state plans.
    iv. Conduct Annual National TB/HIV review meetings with key stakeholders. (M&E)
b) Joint Training and capacity building at all levels
    i. Adopt a unified approach to building capacity to strengthen TB/HIV activities
    ii. Jointly review, develop, disseminate, and ensure use of guidelines, job aids, SOPs, and training materials for TB/HIV services
    iii. Promote joint mentoring of programme and clinical staff
    iv. Advocate for incorporation of TB/HIV collaborative services into TB and HIV pre-service curriculum and continuing professional education.

c) Multi-disease testing platform
    i. Leverage on and promote integrated diagnostic platforms e.g. GeneXpert and other PCR machines for TB, HIV, HPV, HCV, COVID-19 and other diseases.
    ii. Support the joint development and management of service maintenance agreements for the integrated diagnostic platforms
    iii. Ensure adequate human resource and supportive systems for integrated disease testing
    iv. Map laboratory network and sites for HIV and TB specimen referral networks and results reporting system for diagnostic network optimization.
d) Integrated Service delivery (One-stop-shop)
    i. Provide an integrated and comprehensive package for diagnostic and treatment services to improve patient-centered care
    ii. Establish TB services in all facilities offering ART
    iii. Scale-up 'one-stop-shop' services to as many locations as feasible.
    iv. Provide integrated TB/HIV interventions for vulnerable and key populations. These include women, children, PWID, MSM, FSW, inmates of correctional services, slums, hard to reach areas, IDPs.
e) Advocacy, Communication and Social Mobilization (ACSM)
    i. Develop and review joint TB/HIV SBC and community mobilization strategies that address the role and needs of patients and communities affected
    ii. Produce and disseminate SBC materials in English and local languages for appropriate target audience such as communities, CBOs and health facilities.
    iii. Engage the media to promote increased access to TB/HIV services in the form of radio jingles, TV adverts, social media platforms and print media.
    iv. Sensitize the community; especially support groups for PLHIV, CSOs and CBOs providing home-based care on collaborative TB/HIV activities
    v. Engage community structures to advocate for resources to implement joint TB/HIV activities
f) Strengthen Research on TB/HIV collaboration

i. Establish a joint TB/HIV research committee in collaboration with the academia, research institutes, Health Management Board, Department of Health Planning Research and Statistics
ii. Engage a dedicated research focal person for both programmes.
iii. Capacity building of programme officers at all levels on Research
iv. Support research for evidence-based scale up and improve TB/HIV services in the country.
v. Disseminate findings from research to relevant stakeholders to inform policy decisions for improved TB/HIV programming

g) Procurement and Supply Chain Management
i. Ensure the availability and accessibility of effective, safe and qualitative health commodities at all time, through effective and accurate forecasting, quantification and procurement.
ii. Institute mechanisms for Post Market Validation (PMV) for medicines and commodities.
iii. Ensure practice of good warehousing and rational distribution of commodities.
iv. Promote rational use and usage accountability through robust logistic monitoring and supervision.
v. Strengthen pharmacovigilance and active drug safety monitoring and management (aDSM).
vi. Strengthen Logistic Management Information System (LMIS) of health commodities.
vii. Establish effective pharmaceutical waste management systems

4.1.1.4 STRATEGIC INTERVENTION 4: STRENGTHEN INVOLVEMENT OF CSOS/CBOS IN THE COMMUNITY MANAGEMENT OF TB/HIV CO-INFECTION

a) Advocacy to community/religious leaders and other relevant stakeholders for community support for TB and HIV activities.
b) Integrate HIV/TB messaging into CSO/CBO community outreaches to sensitize community members on both HIV and TB diseases and services.
c) Provide platform to ensure presumptive and diagnosed TB cases are tested for HIV within the community and vice versa.

d) State and LGTBLS and HIV focal persons to support CSOs and CBOs to manage and monitor co-infected patients in the community and assist in the active tracking of patients interrupting treatment and lost-to-follow-up.
e) Conduct contact investigations for all co-infected index patients.

4.1.1.5 STRATEGIC INTERVENTION 5: INVOLVEMENT OF THE PRIVATE SECTOR IN THE MANAGEMENT OF TB/HIV CO-INFECTION (PUBLIC PRIVATE MIX)

a) Engage the umbrella bodies of private health care providers for TB/HIV services.
b) Engage private for-profit hospitals, faith-based health facilities, community pharmacists and PPMVs for TB/HIV services.
c) Provisions of guidelines, SOPs and commodities.
d) Strengthen monitoring and supervision of TB/HIV activities.
e) Capacity building of private health care providers to provide joint TB/HIV services.

4.1.1.6 STRATEGIC INTERVENTION 6: STRENGTHEN TB/HIV MONITORING AND EVALUATION (M&E) SYSTEM

The following activities will enhance the M&E system:

a) Develop, disseminate and ensure use of harmonized TB and HIV reporting tools by all stakeholders.
b) Build capacity of TB/HIV service providers for collection, collation and analysis of TB/HIV data at all levels.
c) Joint TB/HIV supervision, monitoring and evaluation at all levels.
d) Conduct TB/HIV data quality assessment at national and state levels.
e) Ensure TB/HIV information adequately captured in electronic systems for TB and HIV program.
f) Institute continuous quality improvement mechanisms at the service delivery points and at program levels.

4.1.2 OBJECTIVE 2 - TO REDUCE THE BURDEN OF TB AMONG PEOPLE LIVING WITH HIV/AIDS (PLHIV)

In line with the NSPs for TB and HIV, the following interventions will be implemented to achieve this objective.

4.1.2.1 STRATEGIC INTERVENTION 1: INTENSIFY TB CASE-FINDING AND ENSURE HIGH QUALITY ANTI-TB TREATMENT

The screening of all PLHIV (adult and children) for TB at every visit; the process and steps for doing this are well described in the National Guidelines on TB and HIV. This intervention entails:

a) Routine screening of PLHIV (including positive pregnant women) for TB and documentation of status at every visit.
b) Routine TB screening for every PLHIV receiving community care.
c) Routine TB screening for household members, families and partners of PLHIV.
d) Appropriate TB testing (e.g. Xpert MTB/RIF assay, Truenat, LF-LAM) for PLHIV with presumptive TB and linkage to continuum of care

4.1.2.2 STRATEGIC INTERVENTION 2: ACCELERATE PROVISION OF TPT FOR ALL ELIGIBLE PLHIV

This entails the following activities:

a) Provision of TPT as part of comprehensive package of care for eligible PLHIV including pregnant women.
b) Uninterrupted supply of TPT regimens (6H, 3HP and 1HP) in all HIV service delivery points.
c) Advocacy and sensitization to health care workers and professionals to enhance TPT uptake among PLHIV.
d) Create awareness among PLHIV to demand for TPT services.

4.1.2.3 STRATEGIC INTERVENTION 3: TB INFECTION PREVENTION AND CONTROL IN HIV SERVICE DELIVERY SETTINGS

Settings offering HIV services should ensure the establishment of infection prevention and control (IPC) intervention which should be targeted towards reducing transmission of TB and other communicable diseases e.g. COVID-19. Measures and activities for IPC are described below.

a) Administrative measures:
   i. Develop facility-specific TB infection control policies/plans
   ii. Appoint TB Infection Control Focal Person
   iii. Hold regular TBIC meetings
   iv. Create awareness on cough etiquette
   v. Ensure patient triage among PLHIV

vi. Provide uninterrupted supply of personal protective equipment (PPE) and other infection control materials.

vii. Establish effective waste management systems for infection, prevention control and leverage infrastructure for the provision of TB/HIV collaborative activities.

vii. Produce and disseminate IC IEC materials for use in such settings

b) Environmental/Engineering measures:

i. Provide sputum collection areas for PLHIV presumed to be co-infected if not available

ii. Engage professionals responsible for the design and construction of health facilities such as architects and engineers to take cognizance of IC in their designs

iii. Ensure cross-ventilation at every service delivery point for PLHIV

iv. Provide other forms of environmental protection against TB e.g. Ultraviolet Germicidal Irradiation, standing fans, extractors.

c) Personal Protective Measures:

i. Ensure the correct, consistent and complete use of standardized, recommended protective equipment

ii. Encourage the appropriate use of face masks, handkerchiefs or tissue paper while coughing. In the absence of these, the elbow can be used to cover the mouth.

iii. Ensure hand hygiene at all time

iv. Leverage on other available forms of personal protection such as goggles, coats, face shield as much as possible

4.1.2.4 STRATEGIC INTERVENTION 4: GENDER AND HUMAN RIGHTS

a. Advocacy for increase in political commitment to rights, including the rights of key populations to access patient centered TB/HIV services.
b. Incorporate TB/HIV services into gender components for TB and HIV programs.
c. Develop and implement an integrated TB/HIV gender and human rights plan.

d. Strengthen community structures to drive gender and human rights interventions.

4.1.3 OBJECTIVE 3: TO REDUCE THE BURDEN OF HIV AMONG PRESUMPTIVE AND DIAGNOSED TB PATIENTS

The following strategic interventions and activities will be implemented to achieve the stated objectives:

4.1.3.1 STRATEGIC INTERVENTION 1: INTENSIFY HIV CASE FINDING IN PRESUMPTIVE AND DIAGNOSED TB CASES:

a. Provide HIV testing services for all presumptive and diagnosed TB cases.
b. Provide HIV testing services for partners of known HIV-positive TB patients with mutual disclosure.
c. Provide HIV RTKs and consumables for HTS in the DOT clinic.
d. Provide ART and CPT for all HIV positive TB patients.

4.1.3.2 STRATEGIC INTERVENTION 2: HIV PREVENTION IN TB SETTINGS.

a. Ensure the implementation of comprehensive HIV prevention services for TB patients and their partners.
b. Provide HTS for health-care providers.
c. Facilitate prompt referral of all HIV-positive pregnant women attending TB clinic to PMTCT services[11,12]

[11] Global TB programme, Department of HIV/AIDS. Considerations for Adoption and use of Multi-disease Testing Devices in Integrated Laboratory Networks. Geneva: WHO, 2017.

[12] National Tuberculosis Leprosy and Buruli ulcer Control Programme (NTBLCP). National Strategic Plan for Tuberculosis Control 2021-2025. Abuja: Federal Ministry of Health; 2020.

CHAPTER FIVE

5.1 MONITORING, EVALUATION AND RESEARCH PLAN FOR TB/HIV COLLABORATIVE ACTIVITIES

Monitoring and evaluation (M&E) provide the mechanism for answering questions about the performance and effectiveness of any project or programme. It is aimed at measuring and collecting information on what is being done and what changes are happening over time in response to certain activities. M&E plays an important role in the management of health programmes, ensuring that the resources going into a programme are being utilized, services are being accessed, activities are occurring in a timely manner and expected results are being achieved.

Research is needed to define how best to provide high-quality integrated TB and HIV interventions at facility and community levels to inform global and national policy and strategy development.

5.2 OBJECTIVES OF THE TB/HIV M&E

This section seeks to ensure consistency of data systems across all agencies and stakeholders within a set of internationally accepted indicators for M&E of programme performance and enhance the effectiveness and efficiency of TB/HIV collaborative activities.

Objectives:

1. Adapt the core indicators for global monitoring and reporting
2. Define the core indicators for national and sub-national monitoring and reporting of TB/HIV collaborative activities.
3. Provide guidance on areas of research for the national programme.

5.3 DATA MANAGEMENT SYSTEM

5.1.1 RECORDING & REPORTING SYSTEM

The TB and HIV programme collect data using the hybridized method of paper-based and electronic systems. Data reporting tools are placed at service delivery entry points in the health facilities to facilitate timely, complete and accurate data collection. The entry points are illustrated below:

Flow of information

Data flow

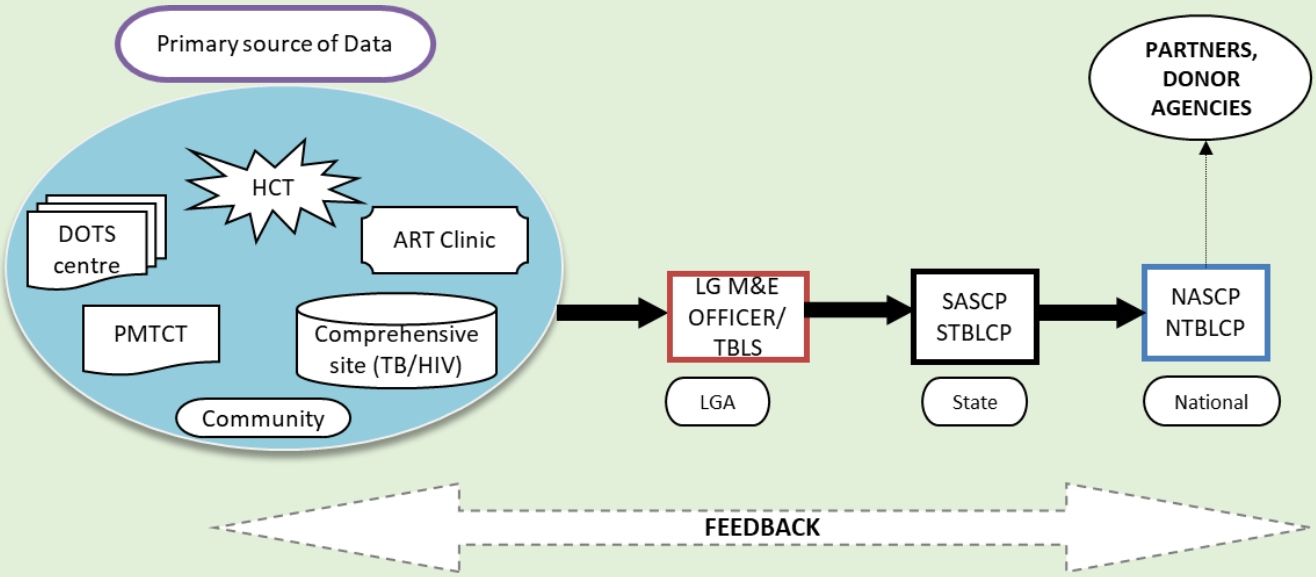

Figure 10: Description of the Data flow for the TB/HIV program

5.1.2 DATA STORAGE

Hard copies of TB/HIV data should be kept in waterproof files and stored in fireproof locations. All electronic data and databases from State to National level should be systematically backed up using an external hard drive. External backup/hard drives that are used for storage/backup must be stored securely in a locked safe and at a sufficient distance away from the original data to ensure both the original and backup copies are not compromised. Backups should be done at the pre-determined interval (monthly or quarterly). In line with the Federal Government of Nigeria's policy of document archival, all project and patient medical records must be kept safe for at least 5 years after the expiration of the project.

The electronic data system of both programmes are hosted on the Galaxy backbone cloud server, which provides sufficient back up for all patient-level information.

5.1.3 DATA ACCESS

The Federal Ministry of Health (NTBLCP & NASCP) is the sole custodian of all TB/HIV data in the country. However, systems have been put in place, which guarantees access to data for programme planning, decision-making and research purposes. The system captures patient-level information, which must be managed in line with the principle of confidentiality.

Individuals or groups who intend to access TB/HIV data should follow the standardized data accessing process which entails that a formal request is submitted to the National Coordinator(s) of both programmes or either of them.

5.4 DATA PRODUCTS DISSEMINATION AND USE

This will be guided by the national data dissemination and use framework for programme improvement at all levels (facility, LGA, State and Federal/National). In addition, M&E reports will be disseminated, in collaboration with donors and technical partners, during the following events:

- Zonal and National review meetings
- HIV and TB conferences and other relevant professional meetings
- HIV and TB technical and planning meetings
- Meeting with donor agencies and major implementing partners
- Health policy meetings with Commissioners of Health, among others.

5.4.1 DATE USE TO IMPROVE QUALITY OF SERVICE AND PROGRAMME PERFORMANCE

This should occur at the following levels:

Facility:

- Monitoring and identification of patients/clients in need of extra interventions, referrals or care and to alert or remind Health care workers of clients/patients with particular needs, thus improving HIV and TB services.
- Identify trends and highlight successes
- For administrative purposes to improve access, coverage, quality of services and efficient use of resources.
- Quantification and ordering of drugs and supplies.

- For planning, developing and ongoing improvement of TB and HIV Interventions

LGA:

- Acquisition and distribution of resources
- Budgeting and allocation of resources.
- Assisting local authorities to plan interventions and monitor activities at the health service delivery points, ward and village levels.

State:

- Acquisition and distribution of resources accordingly
- Assessing state performance
- Planning for future interventions according to trends seen from the indicators
- Budgeting and allocation of resources

Federal/National:

- Monitoring the trends of HIV and TB epidemic
- Commodities quantification
- Planning and Policy formulation
- Resource mobilization, acquisition and allocation
- Informing strategic decisions for scale up and improvement of interventions
- Information on service coverage and human resource capacity
- Inform areas of research

5.5 DATA QUALITY ASSURANCE

Quality data help to identify gaps in service delivery and inform the design, implementation and evaluation of interventions. In the implementation of collaborative TB/HIV activities, the following strategies will be used to strengthen data quality:

5.4.2 DATA QUALITY ASSESSMENT (DQA)

State Level:

- A joint TB/HIV DQA should be conducted biannually.

National Level:

- TB/HIV indicators should be integrated into the DQA of both programmes

- DQA should be on a quarterly basis in NASCP and biannually in NTBLCP
- Joint TB/HIV DQA will be conducted annually at the national level.

5.6 SUPPORTIVE SUPERVISION

5.4.3 JOINT TB/HIV SUPPORTIVE SUPERVISION

At the National and State Level:

- Quarterly supportive supervision by both NTBLCP and NASCP
- Joint biannual supervision by both NTBLCP and NASCP.

5.4.4 REVIEW MEETINGS

The programme, as part of its strategy to improve programme performance and assure data quality, conducts review meetings periodically at the facility, state and zonal levels. The purpose of the meetings is three-pronged, namely; (i) to ensure that data is collated and reported timely, (ii) that reported data are analyzed to inform decision-making and improve performance (iii) as an avenue for information sharing and capacity building.

Facility Monthly TB/HIV Review Meetings

- Ensure monthly meeting of health care workers providing TB and HIV care services to review key performance indicators.
- Meetings should be jointly coordinated by both TB and HIV focal persons

State Monthly TB/HIV Review Meetings

- Ensure monthly meeting of both programmes at the state level to review TB/HIV key performance indicators,
- Meetings should be jointly coordinated by both TB programme managers and SAPCs.
- Validation of TB/HIV data should be conducted during the meeting.

5.4.4.1 CENTRAL COORDINATION MEETINGS

National TB/HIV Working Group

- The National TB/HIV Working Group should meet quarterly

- Participants at this meeting should include Key stakeholders from TB and HIV programmes, including community stakeholders
- The secretariat will be provided by both NTBLCP and NASCP

National TB/HIV Joint Annual Review Meeting

- The NTBLCP and NASCP will organize a joint annual programme review meeting to review achievement and implementation of joint TB and HIV activities in the preceding year.
- The participants will include NTBLCP, NASCP, NACA, State TB and HIV programme managers, WHO and other relevant partners.
- The secretariat will be provided by both NTBLCP and NASCP

5.7 M&E COORDINATION

To effectively strengthen TB/HIV collaborative activities at all levels, the following coordination meetings should be held:

1. National TB/HIV M&E TWG meeting: The TWGs of both programmes should extend invitation to officers from the other programme during its quarterly M&E TWG meeting.
2. Annual Joint TB/HIV national data harmonization meeting: This meeting should focus on the harmonization of TB and HIV data at the national level.
3. State quarterly TB/HIV data validation meetings: This should be a quarterly meeting held at the state level to review state TB and HIV data with the aim of harmonizing the data before sharing with the national programmes.

5.8 RESEARCH FOR TB/HIV COLLABORATIVE ACTIVITIES

The research agenda for TB and HIV programme addresses the TB/HIV component. The key research areas will include amongst others:

- TB prevention among PLHIV
- Intensified TB case finding in PLHIV
- Diagnosis of NTM among PLHIV
- TB treatment in people living with HIV
- Drug-resistant TB and HIV

- Childhood and Maternal TB and HIV
- Integrated TB and HIV services
- Infection, prevention and control

The TB/HIV research will be strengthened by:

- Capacity building at all levels to implement research
- Monitoring of implementation of the research agenda of both TB and HIV programmes
- Collaboration with academia and research institutions
- Mobilizing resources for research funding

5.9 M&E FRAMEWORK FOR TB HIV COLLABORATIVE ACTIVITIES

To ensure an effective monitoring and evaluation of collaborative TB/HIV activities a core group of indicators from both TB and HIV programmes will be measured and reported. These below indicators measure the efforts made by the country towards prevention, early detection and prompt treatment of HIV-associated TB along with its impact on mortality.

INDICATORS	DEFINITION How is it calculated?	BASELINE What is the current value? (2019)	TARGET What is the target value?	DATA SOURCE How will it be measured?	FREQUENCY How often will it be measured?	RESPONSIBLE Who will measure it?
Percentage of PLHIV on ART (including PMTCT) who were clinically screened for TB in HIV treatment Settings	Numerator: Number of persons on ART whose TB status was assessed and recorded at their last visit during the reporting period Denominator: Total number of persons currently receiving ART during the reporting period	82%	100%	Enrollment register, ART registers, EMR, Programme data	Bi-annually	SASCP/NASCP
Percentage of PLHIV on ART with a Presumptive diagnosis of TB during the reporting period	Numerator: Number of PLHIV on ART with symptoms suggestive of TB among those whose TB status was assessed and recorded during the reporting period. Denominator: Total number of PLHIV on ART whose TB status was assessed and recorded during the reporting period			Care card /ART registers Programme data	Monthly	SASCP/NASCP
Percentage of PLHIV on ART with Presumptive TB and were Tested for TB	Numerator: Number of PLHIV on ART with presumptive TB who were tested for TB and recorded at their last visit during the reporting period Denominator: Number of PLHIV on ART with symptoms suggestive of TB among those whose TB		100%	Presumptive TB Register, ART registers. EMR, Programme data	Monthly	SASCP/NASCP

INDICATORS	DEFINITION How is it calculated?	BASELINE What is the current value? (2019)	TARGET What is the target value?	DATA SOURCE How will it be measured?	FREQUENCY How often will it be measured?	RESPONSIBLE Who will measure it?
	status were assessed and recorded during the reporting period					
Percentage of PLHIV on ART who have Active TB Disease.	Numerator: Total number of PLHIV on ART who have active TB disease during the reporting period. Denominator: Total number of PLHIV on ART tested for TB during the reporting period.			Presumptive TB register, Programme data	Monthly	SASCP/NASCP
Percentage of PLHIV on ART with active TB disease who initiated TB treatment	Numerator: Count all HIV positive patients with TB who initiated TB treatment during the reporting period Denominator: Count the number of PLHIV on ART with active TB during the reporting period	82%	100%	ART Register, TB LGA/Facility Register, Programme data	Bi-annually	SASCP/NASCP
Percentage of eligible PLHIV on ART who initiated TB preventive treatment (TPT initiation)	Numerator: Number of PLHIV on ART and eligible for TPT who initiated TPT during the reporting period			ART register, TPT register, EMR, Programme data	Monthly	

INDICATORS	DEFINITION How is it calculated?	BASELINE What is the current value? (2019)	TARGET What is the target value?	DATA SOURCE How will it be measured?	FREQUENCY How often will it be measured?	RESPONSIBLE Who will measure it?
	Denominator: Number of PLHIV on ART who are eligible for TPT during the reporting period					
Percentage of PLHIV on ART who completed a course of TB preventive treatment among those who initiated TPT	Numerator: Number of PLHIV on ART who completed a course of TPT during the reporting period Denominator Number of PLHIV on ART who initiated any course of TPT during the reporting period			ART registers, TPT Register, EMR, Programme data	Monthly	
Proportion of registered new and relapse TB patients with documented HIV status	Numerator: Number of registered new and relapse TB patients with documented HIV status. Denominator: Number of registered new and relapse TB patients	97%	100%	TB Facility Central register Quarterly Report on TB Case Finding	Quarterly Annually	STBLCP/NTBLCP
Treatment coverage of HIV + incident TB cases	Numerator: Number of TB patients with documented HIV status. Denominator: Number of estimated HIV + incident TB cases	27%	70%	TB Facility Central register	Quarterly Annually	STBLCP/NTBLCP

INDICATORS	DEFINITION How is it calculated?	BASELINE What is the current value? (2019)	TARGET What is the target value?	DATA SOURCE How will it be measured?	FREQUENCY How often will it be measured?	RESPONSIBLE Who will measure it?
ART coverage among HIV-Positive New and Relapsed TB PLHIV during TB Treatment.	Numerator: Total number of HIV-positive new and relapsed TB PLHIV started on TB treatment du oring the reporting period who are already on ART or started on ART during TB treatment. Denominator: Total number of HIV-positive new and relapsed TB PLHIV registered during the reporting period.	92%	100%	TB Facility Central register Quarterly Report on TB Case Finding	Bi-annually	SMOH/ FMOH
Proportion (%) of presumptive TB cases with documented HIV status	Numerator: Total number of presumptive TB cases with documented HIV status. Denominator: Total number of presumptive TB cases notified over the same period.	Provide baseline	100%	TB Facility Central register Quarterly Report on TB Case Finding	Quarterly Annually	STBLCP/NTBLCP
Proportion (%) of TB-HIV co-infected cases on co-trimoxazole preventive therapy (CPT) during TB treatment	Numerator: Total number of TB-HIV co-infected cases on co-trimoxazole preventive therapy (CPT) during TB treatment. Denominator: Total number of TB-HIV co-infected cases recorded	91%	100%	TB Facility Central register Quarterly Report on TB Case Finding	Quarterly Annually	STBLCP/NTBLCP

INDICATORS	DEFINITION How is it calculated?	BASELINE What is the current value? (2019)	TARGET What is the target value?	DATA SOURCE How will it be measured?	FREQUENCY How often will it be measured?	RESPONSIBLE Who will measure it?
	in the TB register over the same period.					
Proportion (%) of TB-HIV co-infected cases on ART during TB treatment	Numerator: number of TB-HIV co-infected cases on ART during TB treatment. Denominator: Total number of TB-HIV co-infected cases recorded in the TB register over the same period.	91%	91%	TB Facility Central register Quarterly Report on TB Case Finding	Quarterly Annually	STBLCP/NTBLCP.
Treatment success rate of co-infected new and relapse TB patients	Numerator: Number of registered new and relapse co-infected TB patients successfully treated (cured + treatment completed) Denominator: Number of registered new and relapse co-infected TB patients over the same period	76%	90%	TB Facility Central register Quarterly Report on TB Case Finding	Quarterly Annually	STBLCP/NTBLCP
Proportion of HCWs (all facility staff) who develop	Numerator: Number of HCWs with TB			Annual report	Annually	NTBLCP

INDICATORS	DEFINITION How is it calculated?	BASELINE What is the current value? (2019)	TARGET What is the target value?	DATA SOURCE How will it be measured?	FREQUENCY How often will it be measured?	RESPONSIBLE Who will measure it?
TB in a health care setting	Denominator: Total number of HCWs					