

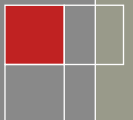


Regional Response Plan for TB-HIV 2017–2021



**World Health
Organization**

Regional Office for South-East Asia



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Regional Response Plan for TB-HIV 2017–2021

Regional Response Plan for TB-HIV – 2017–2021.

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Abbreviations

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
CPT	co-trimoxazole preventive therapy
DOT	directly observed treatment
DST	drug-susceptibility testing
FNAC	fine needle aspiration cytology
GF	Global Fund to fight HIV/AIDS, TB and Malaria
HIV	human immunodeficiency virus
IPT	isoniazid preventive therapy
MDG	Millennium Development Goal
MDR-TB	multidrug-resistant tuberculosis
M&E	monitoring and evaluation
NGO	nongovernmental organization
NTP	National Tuberculosis Programme
PLHIV	People living with HIV/AIDS
SDG	Sustainable Development Goal
SEAR	WHO South-East Asia Region
SEARO	WHO Regional Office for South-East Asia
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
WHA	World Health Assembly
WHO	World Health Organization

1

Background

Globally, in 2015, an estimated 36.7 million people were living with human immunodeficiency virus (HIV); of these, 17.8 million were women over 15 years of age. About 2.1 million people were newly infected with HIV in 2015. 46% of people living with HIV/AIDS (PLHIV) were receiving antiretroviral treatment. AIDS led to 1.1 million deaths in 2015 including 110 000 children (less than 15 years of age). In the SEAR countries, there are an estimated 3.5 million living with HIV/AIDS and approximately 230 000 new infections are added to the pool annually.

In 2015, an estimated 1.2 million (11%) of the 10.4 million people who developed tuberculosis (TB) worldwide were HIV positive. Globally, the number of people dying from HIV-associated TB peaked at 570 000 in 2004 and had fallen to 390 000 in 2015 (32% decrease). In SEAR, an estimated 74 000 people died of HIV-associated TB in 2015.

The SEA Region of WHO is home to 26% of the world's population; however, the Region accounts for 45.6% of the global burden in terms of TB incidence. In 2015, there were an estimated 4.7 million incidence cases of TB, and about 710 000 people died due to TB in the SEA Region. In addition, an estimated 227 000 cases (4.7%) of the 4.7 million incident cases in the Region were HIV positive. This corresponds to an incidence of HIV co-infected TB cases of about 12 per 100 000 population. An estimated 406 000 children in the Region developed TB in 2015.

Globally, 54% of notified TB patients had a documented HIV test result in 2015. Among HIV-positive TB patients notified globally in 2015, 78% were on ART.

People living with HIV are 29 times (26–31) more likely to develop tuberculosis (TB) disease compared with people without HIV and living in the same country. TB is a leading cause of hospitalization and death among adults and children living with HIV, accounting for one in five HIV-related deaths globally.

Table 1: Estimated HIV prevalence among adult population and number of people living with HIV infections in SEAR countries

Country	Incidence rate HIV+ TB only (per 100 000 population per year) 2014	Estimated number of people newly infected with HIV*	Estimated adult (15–49 years) HIV prevalence (%)*	Estimated number of people living with HIV*
Bangladesh	0.39 (0.24–0.59)	1 100	<0.1%	9 600
Bhutan	14 (9.8–18)	NA	NA	NA
Democratic People’s Republic of Korea	1.2 (0.99–1.5)	No reported HIV-positive individual to date		
India	8.3 (7.4–9.3)	86 000	NA	2 100 000
Indonesia	25 (16–36)	73 000	0.5%	690 000
Maldives	0.09 (0.07–0.11)	N/A	NA	NA
Myanmar	37 (28–44)	12 000	0.8%	220 000
Nepal	5.4 (4.2–6.7)	1 300	0.2%	39 000
Sri Lanka	0.26 (0.2–0.32)	<1 000	<0.1%	4 200
Thailand	22 (12–36)	6 900	1.1%	440 000
Timor-Leste	4.9 (3.7–6.3)	N/A	N/A	N/A

Source: Global TB Report, WHO, 2016 and <http://aidsinfo.unaids.org/>

1.1 WHO response to TB-HIV

End TB Strategy: In 2014, the World Health Assembly approved the new strategy to end TB. This Strategy includes (1) bold vision of a world without tuberculosis, and its targets of ending the global tuberculosis epidemic by 2035 with a reduction in tuberculosis deaths by 95% and in tuberculosis incidence by 90%, and elimination of associated catastrophic costs for tuberculosis-affected households; (2) its associated milestones for 2020, 2025 and 2030; (3) its principles addressing: government stewardship and accountability; coalition-building with affected communities and civil society; equity, human rights and ethics; and adaptation to fit the needs of each epidemiological, socioeconomic and health system context.

The strategy is based on three pillars: (1) integrated, patient-centred care and prevention; (2) bold policies and supportive systems; and (3) intensified research and innovation.

Global Plan to End TB: The Global Plan provides an opportunity for greater alignment among efforts to fight both diseases. Taking inspiration from the UNAIDS target of providing treatment to 90% of people who know their HIV-positive status, the Global Plan calls for countries to find at least 90% of all people with TB in the population that require treatment (including those living with HIV) and place them on appropriate therapy (including TB treatment and preventive therapy for people living with HIV). Reaching these targets will require an accelerated integration of TB and HIV services, as well as strong leadership and political commitment. There also need to be separate but interconnected approaches to address HIV infection in people with TB and to reduce the risk of TB in people living with HIV, in line with the interventions recommended by WHO and UNAIDS for jointly addressing HIV and TB.

This Global Plan provides detailed investment scenarios needed to accelerate collaborative efforts to address TB-HIV co-infection in different settings.

Global Health Sector Strategy on HIV 2016–2021 maps the way forward along five strategic directions:

- using accurate strategic information to understand HIV epidemics and focus responses;
- defining the essential packages of high-impact HIV interventions along the continuum of HIV services;
- effectively delivering the cascade of HIV services to different populations and locations to achieve equity, maximize impact and ensure quality;
- implementing sustainable funding models for HIV responses and reducing costs; and
- innovating new HIV technologies and ways of organizing and delivering services.

Ending TB in the South-East Asia Region: Regional Strategic Plan 2016–2020: the guiding principle of the regional strategy is laid on the bedrock of government stewardship; TB prevention, care and control as part of health system strengthening based on primary health care; fostering partnerships at all levels; and promoting ethical values and human rights principles.

1.2 Global response plan

Between 2005 and 2014, an estimated 5.8 million lives were saved by TB-HIV interventions.

WHO has provided clear recommendations about the interventions needed to prevent, diagnose and treat TB among PLHIV since 2004, collectively known as collaborative TB-HIV activities. They include: establishing mechanisms for collaboration between HIV and TB programmes (joint planning, coordinating bodies, surveillance, and monitoring and evaluation); reducing the HIV burden among TB patients (HIV testing and counselling, provision of ART and CPT to TB patients living with HIV, and HIV prevention, care and support services for TB patients); reducing the burden of TB among PLHIV with the “Three I’s for HIV/TB” (intensified TB case-finding among PLHIV, isoniazid preventive therapy for PLHIV who do not have active TB, and infection control in health care and congregate settings). Variable progress has been made towards these goals in countries of the South-East Asia Region.

1.3 Progress made

Integration of HIV and tuberculosis services reduced the annual number of people dying from HIV-associated TB globally from 500 000 [460 000–530 000] in 2000 to 390 000 [350 000–430 000] – a 22% decline in 2014. During this period, 5.9 million lives were saved in Africa.

By 2014, 17 of the 41 countries with the highest burden of HIV and TB co-infection are estimated to have met the target of reducing the number of people dying from HIV-associated TB by at least 50%. This is the result mainly of important improvements in the reach, quality and linking of HIV and TB services. Despite these achievements, TB remains a leading cause of HIV-associated hospitalization and death among people living with HIV worldwide. TB accounted for 31% of the estimated 1.4 million HIV-related deaths globally in 2015.

Globally, 55% of notified TB patients had a documented HIV test result in 2015. This represented an 18-fold increase in testing coverage since 2004. The figure was highest in the African Region, at 81%, and the Americas at 82%. In 2014, coverage of antiretroviral therapy (ART) for notified TB patients who were known to be co-infected with HIV reached 78% globally. Further efforts are needed to reach the target of 100%. This is especially the case given that the number of HIV-positive TB

patients on ART in 2014 represented only 33% of the estimated number of people living with HIV who developed TB in 2014.

Coverage of co-trimoxazole preventive therapy (CPT) among HIV-positive TB patients remains high, and increased slightly to 87% globally and 89% in the African Region in 2014. The number of people living with HIV who were treated with isoniazid preventive therapy (IPT) reached 933 000 in 2014, an increase of about 60% compared with 2013. However, provision of IPT was reported by just 23% of countries globally, including only 13 of the 30 high TB-HIV burden countries. As in previous years, a large proportion of the people living with HIV who were initiated on IPT were in South Africa (59%), although in most countries that reported data in 2013 and 2014, coverage levels grew.

The rate of mother-to-child transmission of HIV has been cut by more than half between 2000 and 2014. Mother-to-child transmission has been eliminated in Thailand.

Table 2: TB-HIV collaborative activities in SEAR Member States, 2015

Country	Percentage TB patients with known HIV status (%)	Number of TB patients with known HIV status who are HIV-positive	HIV-positive TB patients on antiretroviral therapy (ART)	Percentage HIV-positive people (newly enrolled in care) on preventive treatment
Bangladesh	<1	92	82	NA
Bhutan	67	6	6	100
DPR Korea	0	0	0	0
India	67	44 652	40 925	NA
Indonesia	11	3 523	757	2
Maldives	100	0	0	0
Myanmar	65	7 918	3 034	10
Nepal	7	179	133	93
Sri Lanka	84	25	17	4
Thailand	98	7 819	5 389	NA
Timor-Leste	83	24	24	NA

Source: Global tuberculosis report 2016, World Health Organization, Geneva 2016. ISBN 978 92 4 156539 4.

1.4 Challenges and gaps

The progress in implementation of TB-HIV collaborative activities has varied substantially among countries.

Some of the key challenges have been:

- Dual burden of stigma and discrimination suffered by people and families with the disease
- Slow and conservative uptake of evidence-based global TB and HIV policies by programmes (e.g. timely provision of ART for TB patients living with HIV, isoniazid preventive therapy (IPT)).
- Insufficient planning and resources for wider roll-out of national policies and evidence-based practices once developed (e.g. resource needs for nationwide training, supplies such as antiretroviral drugs (ARVs), IPT and HIV test kits).
- Insufficient coordination among NGOs working in TB and HIV projects in the Region including poor linkage of NGOs working for men who have sex with men (MSM), commercial sex workers (CSW) and intravenous drug users (IDU) to TB sites.
- Absence of adequate community-based care and support to the co-infected cases in terms of early detection, early treatment initiation, adherence education and stigma reduction.
- Initiatives such as self-screening (of both risk and symptoms) and self-referral to service delivery sites as part of community empowerment are limited.
- Lack of human rights and rights-based approach in co-infection management.
- Affected communities and children have insufficient access to rapid diagnostic facilities for early detection of TB.
- Insufficient facilities for timely diagnosis of extra-pulmonary TB, which is more common in PLHIV than HIV-negative people with TB.
- Logistical and administrative challenges to programme scale-up including drug supplies.
- Mismatch between TB and HIV prevention, treatment and care services (e.g. increased access and coverage of HIV testing for TB patients and minimal access to ART and other interventions).

- Non-harmonized, non-standardized and duplicative TB and HIV monitoring and evaluation systems.
- Delayed cross-referral of TB cases to HIV testing facilities and also HIV-positive people to TB facilities. Furthermore, many of the referred cases are lost during movement in the referral chain.
- Limited behavior change communication activities and tools focusing on TB-HIV co-infection and management.
- Limited efforts to build capacities of HIV programme managers in TB case management and TB programme managers in HIV management.
- Inadequate resource allocation to TB-HIV activities.
- Lower success rates of anti-TB treatment with high case of fatality rates in PLHIV.

2

Goals

2.1 Vision and goal

The goal for TB control in the SEA Region is to *End the TB epidemic in the Region by 2035*, by adopting and adapting the vision, milestones and targets as outlined in resolution WHA67.1. A specific goal related to TB-HIV response is to end HIV-associated TB in the Region.

2.2 Objectives

The objectives of TB-HIV collaboration are as follows:

- Provide universal access to HIV care continuum for all people with TB and TB care for all people with HIV/AIDS.
- Reduce HIV-related TB mortality.
- Reduce suffering and socioeconomic burden associated with TB-HIV.
- Protect vulnerable populations from TB and HIV infections.
- Roll out new tools and enable their timely and effective use.
- Protect and promote human rights in TB-HIV prevention, care and control.

The strategic directions, areas of interventions and activities to reach the overall goal, vision, objectives and targets to End TB are grouped under the following three strategic directions in line with the pillars of the End TB Strategy:

- (1) Integrated patient-centred care and prevention
- (2) Bold policies and supportive systems
- (3) Intensified research and innovation.

Implementation of strategies and interventions under the three strategic directions requires the combined efforts as well as close coordination and collaboration among and by the NTP and multiple stakeholders within and outside the government including affected individuals and communities.

All actions and interventions under these three pillars would follow five basic principles:

- (1) Government stewardship and accountability with monitoring and evaluation: government stewardship is fundamental to implement actions and achieve targets that are agreed. Such stewardship is to be inclusive involving health and other sectors and at all administrative levels.
- (2) Strong coalition with civil society organizations and communities: inclusion of beneficiaries' perspectives is essential to ensure effective planning, accelerated implementation and intense monitoring of efforts. To bend the disease curves, planning and implementation for TB-HIV joint actions should be mainstreamed within the UN agenda and specific workplan for TB and HIV among marginalized populations, unorganized sector of industries, mines and others.
- (3) Protection and promotion of human rights, ethics and equity: a rights-based approach that respects ethical values and equity is an essential principle for such national response.
- (4) Adaptation of the strategy at the country level, with global collaboration: Robust and effective implementation of the strategies would require contextualization and coordination with all stakeholders and resources providers.
- (5) To build in and strengthen monitoring and evaluation (M/E) within programme context and accord appropriate focus.

2.3 Strategic direction 1: Integrated patient-centred care and prevention

As has been well highlighted in all earlier plans, joint strategic planning is essential for ensuring that TB-HIV activities are effectively implemented, monitored and funded at all levels of the health-care delivery system.

1.1 Early diagnosis:

- 1.1.1 Improve awareness among affected people and communities: generating awareness among communities should be part of the overall information education and communication efforts of both TB and HIV programmes. Efforts must be made to use all opportunities to convey accurate, sensitive and understandable messages on the subject of TB-HIV.
- 1.1.2 Improved and easy access to integrated services: barriers to care need to be reduced by expanding coverage of services, improving service quality, strengthening linkages with reproductive, maternal, newborn and child health (MNCH), harm reduction services and high-risk groups interventions.
- 1.1.3 Immediate HIV screening of diagnosed TB patients: HIV testing and counselling services should be offered to all diagnosed TB cases including in the private sector and if required to their close contacts and even those with presumptive TB.
- 1.1.4 Ensure TB screening of all people living with HIV: all adults, adolescents and children living with HIV should be screened for TB using recommended screening tools.
- 1.1.5 Ensure access to WHO recommended rapid diagnostics and drug susceptibility testing (DST) services for early detection of TB/DR-TB among PLHIV and also modalities to diagnose extra pulmonary TB in PLHIV (FNAC, biopsy).
- 1.1.6 Effective and timely referral and notification practices: timely horizontal and vertical referrals must be offered in a friendly reliable manner.
- 1.1.7 Targeted interventions to address the needs of marginalized communities including CSWs, IDUs and other hard-to-reach groups.

1.2 Preventive and curative actions:

- 1.2.1 Reduce excessive TB mortality in HIV-positive people by routine HIV testing among presumptive and diagnosed TB cases and TB screening among people living with HIV, early ART and provision of TB preventive treatment.

- 1.2.2 IPT for people living with HIV who do not have active TB: adults and adolescents living with HIV who have an unknown or positive tuberculin skin test (TST) status and are unlikely to have active TB should receive at least six months of IPT as part of a comprehensive package of HIV care. IPT should be given to such individuals irrespective of the degree of immunosuppression, and also to those on ART, those who have previously been treated for TB and pregnant women.
- 1.2.3 Provide TB and MDR-TB treatment to all diagnosed cases living with HIV: the first priority for HIV-positive TB patients is to initiate TB treatment, followed by co-trimoxazole and ART.
- 1.2.4 Provide ART to HIV-positive TB patients: antiretroviral therapy improves survival in HIV-positive patients and also reduces TB rates by up to 90% at an individual level. ART should be initiated for all people living with HIV with active TB disease irrespective of CD4 cell count. Standardized, simplified ART regimens may be used so that HIV treatment programmes can reach as many people living with HIV as possible.
- 1.2.5 Scale up access to CPT for HIV-positive TB patients: in all HIV-positive TB patients, co-trimoxazole preventive therapy should be initiated as soon as possible and given throughout TB treatment. Trained staff and drugs should be available at appropriate health facilities.

2.4 Strategic direction 2: Bold policies and supportive systems

- 2.1 Ensure political commitment
 - 2.1.1 Strengthen integrated TB-HIV planning that is country lead and involves all stakeholders including disease-affected people and communities; and the private sector, including corporates, businesses and work places.
 - 2.1.2 TB-HIV operational plans to be part and parcel of the national strategic plans and adequate resources allocated for the same.

- 2.1.3 Involvement of NGOs and communities: perspective of civil society is essentially to be incorporated in any planning and implementation process.
- 2.2 Contribute to health systems strengthening and policy/plan linkages
 - 2.2.1 Review and update existing national TB-HIV guidelines incorporating latest global recommendations and considering complimentary national-level evidence.
 - 2.2.2 Integrated training: training coordinated by both the TB and HIV programmes should integrate reciprocal elements in respective training curricula and training materials.
 - 2.2.3 Integrated supervision and monitoring: robust systems for supportive supervision, regular monitoring including review meetings at various levels and evaluations at regular intervals are key to ensuring programmatic efficiencies.
 - 2.2.4 Convergent reporting as per recommended indicators on harmonized platforms.
 - 2.2.5 Integrated TB-HIV action-plan involving service-providers and community representatives.

2.5 Strategic direction 3: Intensified research and innovation

- 3.1 Promote TB-HIV research including operations research
- 3.2 Develop prioritized agenda to TB-HIV response
- 3.3 Support innovations in communication, diagnosis and management.

Table 3: WHO recommended collaborative TB-HIV activities

A.	Establish and strengthen the mechanisms for delivering integrated TB and HIV services
A.1	Set up and strengthen a coordinating body for collaborative TB-HIV activities functional at all levels
A.2	Determine HIV prevalence among TB patients and TB prevalence among people living with HIV
A.3	Carry out joint TB-HIV planning to integrate the delivery of TB and HIV services
A.4	Monitor and evaluate collaborative TB-HIV activities

- B. Reduce the burden of TB in people living with HIV and initiate early antiretroviral therapy (the three I's for TB-HIV)
 - B.1 Intensify TB case finding and ensure high-quality anti-tuberculosis treatment
 - B.2 Initiate TB prevention with isoniazid preventive therapy and early antiretroviral therapy
 - B.3 Ensure control of TB infection in health-care facilities and congregate settings
- C. Reduce the burden of HIV in patients with presumptive and diagnosed TB
 - C.1 Provide HIV testing and counselling to patients with presumptive and diagnosed TB
 - C.2 Provide HIV prevention interventions for patients with presumptive and diagnosed TB
 - C.3 Provide co-trimoxazole preventive therapy for TB patients living with HIV
 - C.4 Ensure HIV prevention interventions, treatment and care for TB patients living with HIV
 - C.5 Provide antiretroviral therapy for TB patients living with HIV

Source: WHO policy on collaborative TB-HIV activities.

Table 4: Regional targets and milestones

Targets	Baseline (2015)	2018	2020
Countries in the Region have put in place a coordinated workplan for universal access to HIV care for all people with TB and TB care for all people with HIV/AIDS	90%	100%	100%
Proportion of registered new and relapse TB patients with documented HIV status	45%	80%	90%
People receiving HIV care should be periodically screened for TB using a symptom-based clinical algorithm	N/A	80%	100%
HIV-positive TB patients on ART (%)	–	80%	90%
HIV-positive TB patients on CPT (%)	–	80%	90%

3

Monitoring and evaluation of TB-HIV

The Guide to monitoring and evaluation for collaborative TB-HIV activities 2015 was developed to assist TB and HIV programme managers and other stakeholders to monitor and evaluate TB-HIV collaborative activities. This guide describes core and optional indicators for monitoring and also methodologies for M&E for TB-HIV collaborative activities. The guide remains valid at present and should be essentially referred to.

The core indicators are summarized below.

- A. Global and national indicators:** These are essential indicators to monitor and report progress at both global and national levels
 - A.1 Proportion of registered new and relapse TB patients with documented HIV status
 - A.2 Proportion of registered new and relapse TB patients with documented HIV-positive status
 - A.3 Proportion of people living with HIV newly enrolled in HIV care with active TB disease
 - A.4 Proportion of HIV-positive new and relapse TB patients on ART during TB treatment
 - A.5 Proportion of people living with HIV newly enrolled in HIV care, started on TB preventive therapy
 - A.6 Mortality among HIV-positive new and relapse TB patients
 - A.7 Risk of TB among health-care workers relative to the general population, adjusted for age and sex

B. National indicators: In addition to the core indicators in section A, the following are also core indicators essential for national-level monitoring and reporting. They have been grouped into various categories:

Indicators to measure intensified TB case finding

- B.1 Proportion of people living with HIV who are screened for TB in HIV care or treatment settings
- B.2 Proportion of people living with HIV who are TB symptom screen positive out of those who are screened for TB
- B.3 Proportion of people living with HIV who are tested for TB out of those who are symptom screen positive
- B.4 Proportion of people living with HIV diagnosed with active TB out of those who are tested
- B.5 Proportion of people living with HIV who are started on TB treatment out of those diagnosed as having active TB

Indicators to measure access to TB diagnostic test for people living with HIV

- B.6 Proportion of people living with HIV having TB symptoms who receive a rapid molecular test as a first test for diagnosis of TB
- B.7 Proportion of people living with HIV having TB symptoms who receive a TB culture test as a first test for diagnosis of TB

Indicators to measure access to early ART for HIV-positive TB patients

- B.8 Proportion of HIV-positive new and relapse TB patients who are started on ART within 8 weeks of TB diagnosis
- B.9 Proportion of HIV-positive new and relapse TB patients having profound immunosuppression (CD4 cell count < 50) who are started on ART within 2 weeks of TB diagnosis
- B.10 Proportion of HIV-positive new and relapse TB patients detected and notified out of the estimated number of incident HIV-positive TB cases
- B.11 Proportion of HIV-positive new and relapse TB patients who receive co-trimoxazole preventive therapy

- B.12 Proportion of health-care facilities providing services for people living with HIV that have TB infection control practices
- B.13 Proportion of people living with HIV who complete a course of TB preventive therapy

Indicators to measure quality of TB care and community engagement

- B.14 Proportion of HIV-positive new and relapse TB patients who are started on Anti-TB within 7 days of diagnosis
- B.15 Proportion of HIV-positive new and relapse TB patients who received treatment from a community DOT provider
- B.16 Proportion of co-infected cases notified by non-NTP private providers
- B.17 Proportion of co-infected cases notified through community referrals
- B.18 Countries of SEA Region that developed and utilized BCC materials for TB-HIV co-infection management

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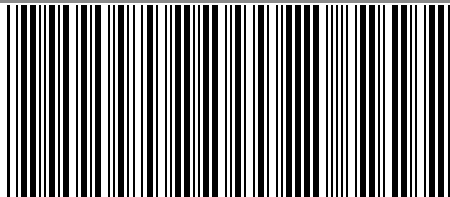
In line with the End TB Strategy, the Global Health Sector Strategy on HIV 2016–2021 and other key strategic documents, WHO aims to reduce the burden of HIV-related TB in the South-East Asia Region by promoting collaborative TB-HIV activities. Considering the regional differences in epidemiology and resources, a Region-specific plan and targets for TB-HIV are critical for planning and implementation by national programmes.

This Regional Response Plan for TB-HIV 2017–2021 is a product of wide consultation with national and regional partners. It is intended to provide strategic directions to countries on prioritizing interventions and setting reasonable targets. It will guide how interventions can be further expanded and made efficient by strengthening health systems, and improving coordination and synergy to ensure universal access and equity.



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