Botswana

1. **Nationwide scale-up of National TB/HIV collaboration - mechanisms for collaboration**

Ongoing key interventions:

- Dormant national TB/HIV advisory committee
- Well expanded HIV testing, TB treatment and IPT provision at all health facilities (635)
- ART initiation at 45 facilities and ART provision at over 100 facilities
- Intensive training on TB/HIV collaborative activities
- All districts have TB and AIDS coordinators
- Regional coordinators for IPT
- Implementing of revised TB/HIV guidelines in all facilities
- Reporting TB/HIV data (minus CPT)
- Labs in all districts do TB diagnosis, CD4 count machines available in most ART facilities

Challenges:

- Absence of pre ART register
- Scale up of ART to all remaining facilities
- Ensuring collaboration at all levels

Priority actions:

- Establish pre ART register in all facilities
- Make CPT and IPT required fields in the ART electronic database
- Strengthen joint planning at all levels
    - Review together what exist already (ongoing activities, successes and challenges) i.e. what has already done by either side.
    - Determine or identify existing gaps: financial and programmatic gaps (RESOURCE GAPS ANALYSIS)
- Revive the TB/HIV Advisory committee through bringing the PS to chair and to ensure regular meetings and participation.
- Establish technical TB/HIV subcommittee to deal with the day to day activities of the committee
- Cascading similar committees to the district level
- Training of health care workers on TB/HIV collaborative activities
- Ensuring continuous RHT, testing for HIV in TB patients, and screening for active TB for HIV positive (community mobilization)
- TB screening at VCT sites for all clients
- Strengthen referral systems between all these services.

Monitoring scale up of activities:

- Develop joint M/E plan

Technical assistance:

- Monitoring and evaluation from WHO, CDC

Resource mobilization:

Additional financial resources will be required (government, GFATM round 9, PEPFAR, ACHAP)

2. **Screening and diagnosing TB in people living with HIV**

Ongoing activities:

- ICF through IPT programmes is ongoing in all facilities
- Contact tracing for TB patients at outpatient level
- Limited screening in the ART clinics
- Screening for TB in the general out patient departments in all clinics

Main challenges:

- mainly done in IPT but not recorded/reported in ART clinics
- diagnosis through microscopy very low: affect cure rates
- ruling out active TB in children
- screening for TB in ART/PMTCT clinics

Priority actions:

- Enforce screening in ART and PMTCT clinics (training, screening tools, supervision)
- Screening for TB in all VCT clients
- Screening for active TB in children

Monitoring and evaluation of this activity:

- From the harmonized revised tools

Technical support:

- Guidance for effective screening of TB in children

Resources:

Resource gaps will be determined during the gap analysis

3. **Isoniazid Preventive Therapy as part of the package for people**

Ongoing activities:

- Developed training manuals

- Trained health care workers in all districts
- Screening clients for IPT in all facilities
- Enrolling clients on IPT in all facilities
- Monitoring and evaluation of clients
- Supervisory visits and reporting

Challenges:

- Adherence
- Recording & reporting of patients data
- Ruling out of TB in children
- INH in pregnancy
- IT human resource (delayed recruitment process)
- No post IPT monitoring of clients who received IPT
- Review policy on repeat of IPT?
- IPT in pregnancy

Priority actions:

- Come up with good adherence practices (OR)
- Improving R/R of data
- Seeking guidance on ruling TB in children

Technical assistance:

- Need clear guidelines from WHO about use of INH in pregnancy and in children
- Need guidelines from WHO about ruling out TB in children

Resources:

- Solicit resources from GOB, CDC, ACHAP

4. TB Infection control

Ongoing interventions:

- National TB IC committee in place*
- Draft guidelines developed*
- IC Integrated into guidelines for TB case management
- Assessment of some health facilities*
- Trained Consultants in place*
- Recommendations made to renovate old wards into IC wards*
- New TB ward in one district, renovation of old TB ward in another
- **Incorporated into the NTP strategic plan 2008-2011**

(* These were actions undertaken following the TB-CAP consultant training: Gaborone 2007)

Challenges:

- Guidance of health care workers on the use of N95
- Inappropriate structures for IC
- General Apprehensiveness about IC issues
- Resources (e.g. funds for renovating structures)

Priority actions:

- Training of health care workers
- IEC material development and dissemination
- Renovation of sections of some old hospitals
- Mandate consultation of the newly trained IC consultant engineer at design stage of all new and renovated facilities
- Immediate implementation and finalization of draft IC guidelines
- Establishment of IC committees in all facilities
- Development and implementation of facility IC guidelines
- Advocate for establishment of a broader national infection control strategy

Resources:

- Apply for funding from Global fund

Technical assistance:

- To be determined (TB_CAP, WHO, CDC)

5. **Implementing the revised HIV and TB recording and reporting forms and harmonization of HIV/TB indicators**

Key interventions:

- IT officer at national level for TB
- M&E unit in the HIV department
- District M&E surveillance officers for all programmes including TB/HIV
- TB/HIV indicators integrated in TB documents
- Ongoing HIV M&E framework
- Quarterly reporting of TB, and HIV indicators
- Ongoing training of HCWs on M&E

Challenges:

- Integration of different existing M&E systems
- Human resource (data clerks) for TB/IPT
- Inadequate supervision particularly from district level to facilities

Priority actions:

- Integration of existing M&E system
- Recruit data clerks for TB/HIV data entry
- Update HIV registers with TB variables
- Establish a pre-ART register
- Joint programme reviews
- Conduct training in the collection, validation, analysis, interpretation and use of data at all levels
- Set targets for TB/HIV collaborative activities

Monitoring and Evaluation:

- Periodic evaluation of the TB/HIV M&E system

Technical assistance:

- Integration of the different M&E systems

Resources:

- Additional resources will be required (GOB, WHO,CDC, ACHAP,GFATM)

6. Coordination and integration of TB and HIV health service delivery

Ongoing activities:

- Service delivery is already integrated at operational level
- ART services are being decentralized 113/635 facilities
- Task shifting of ART for stable patients to nurses is ongoing
- IPT fully decentralized
- PMTCT and RHT fully decentralized

Challenges:

- Inadequate collaboration between the two programmes particularly at national level
- Full acceptance of task shifting
- Agreement for best place for housing IPT

Priority actions:

- Documentation and sharing of best practices
- Reach agreement on IPT programme placement
- Advocate for full acceptance of task shifting

Monitoring and evaluation:

- As part of the M&E plan for the TB/HIV collaboration

Technical assistance:

- For integration from WHO

Resources:

Adequate resources likely to be available

7. **Road Map**
    - Compile trip report
    - Debriefing at the most top level which will include senior management (MOH). Bring relevant departments (clinical services, environmental health, PPME) including MOLG
    - Revive the advisory committee and establish the technical sub committee
    - Develop a plan for integration (way forward) and implementation of the above action point

Ethiopia

National Plan of Action for the implementation of Three Is

Federal HIV/AIDS prevention and control office, Ethiopia

November 2008, Addis Ababa

Introduction

According to the World Health Organization (WHO) Global Tuberculosis (TB) Control Report 2008, TB is the leading cause of morbidity and mortality in PLHIV. HIV also fuels the TB epidemic where the diseases are highly prevalent. The synergistic impact of the two co-epidemics continues posing a major public health and development threat for the developing world, especially for Sub Sahara Africa. The impact of the co-epidemic is grave in areas where there is up to 70% HIV infection in TB patients.

Ethiopia ranks 7th out of the top 22 High Burden Countries in terms of total number of TB cases notified. The estimated incidence of all forms of TB and PTB+ was 379 and 168 per hundred thousand populations, respectively. The case detection rate of PTB+ cases was 34%, nearly half the global target of 70% and treatment success rate is 85%, just hitting global target. Ethiopia has 75% DOTS coverage in public health facilities. However, given the limited health infrastructure in the country, only approximately 60-70% of the population has access to DOTS services.

Ethiopia's national adult HIV prevalence for 2008 was estimated at 2.2 percent, with a 7.7 percent urban rate and a 0.9 percent rural rate. There are an estimated 1,037, 267 people living with HIV. A total of 125, 147 new infections are estimated to happen in 2008. More than 289, 734 People Living with HIV (PLHIV) need ART in 2008. Currently there are 165,000 PLHIV on ART and 300,000 in chronic HIV/AIDS care.

Ethiopia established its TB/HIV Advisory Committee (THAC) in 2002, which includes key stakeholders from the TB and HIV programs, major multi- and bilateral donor organizations, research institutions, academic institutions and professional associations. THAC provides technical and policy guidance to the Federal Ministry of Health (FMOH) and other partners. Establishing TB/HIV Technical Working Group (TWG), mandated on technical issues and with its own TOR and meeting regularly, has revitalized THAC, since April 2007. Since then there are major progresses.

The TB/HIV Collaborative Activities have been piloted in 9 TB/HIV pilot sites in four (4) regions late in 2004. These pilot sites have served as important testing grounds to develop training materials, reporting formats, referral systems, implementation guidelines, and standard operating procedures. After tentative capacity building and other efforts, in collaboration with partners in the country (WHO, German Leprosy and TB Relief Association (GLRA), Italian Cooperation, Royal Netherlands Embassy (RNE), CDC-its 4 US Universities, USAID, MSH, FHI , UNAIDS and others) there are 573 health facilities rendering TB/HIV services.

There are adequate global evidences that implementing Intensified TB case Finding, TB infection Control and Offering INH (three Is) for the eligible HIV chronic care clients can improve the life of the affected. Ethiopia is committed in the implementation and strengthening of the three Is at National level and cascading to all HIV chronic care facilities. To that end FHAPCO plays key role in implementing the three Is, in collaboration with stakeholders in the area, Regional Health Bureaus, Health Facility staff and end user clients to diagnose and manage TB early in PLHIV, reduce TB transmission and improve their quality of life.

Goal: To intensify early diagnosis and treatment of TB, prevent its transmission and improve quality of life of PLHIV

General objective: To intensify TB case finding in PLHIV, offer IPT for eligible HIV chronic care clients and implement TB infection control interventions.

Specific objectives:

- To implement TB case finding, using TB diagnostic algorithm among PLHIV in all (100%) HIV chronic care facilities by the end of 2009
- To establish TB infection control committee with IC plan in all (100%) HIV chronic care facilities to decrease transmission of TB in PLHIV by the end of 2009
- To offer INH prophylaxis therapy (IPT) at least for 70-80% of the eligible HIV chronic care clients in all chronic care facilities by the end of 2009
- To establish a separate/parallel M&E system (HIV chronic care facility, woreda, RHB and FHAPCO) to monitor activities of the three Is, by mid 2009

Specific Activities

I. Intensified TB Case Finding in PLHIV

This is the activity which is being done for chronic care clients, who are registered in Pre-Art and ART services. **All (100%)** clients who are enrolled in HIV chronic care (Pre-ART and ART services) should be screened for TB, using the recently revised TB screening tool, from the TB/HIV Implementation Guideline.

Indicator: Proportion of HIV chronic care clients screened for TB, using revised algorithm.
Denominator: All clients enrolled in chronic care in the given time period

II. INH Prophylaxis Therapy

This is the service given for HIV chronic care clients who are screened for active TB and found free from active TB. INH should be given to this group of clients, after TB screening, and they should have no contra indication for INH. IPT should be offered for at least **70- 80%** of eligible clients.

Target: All HIV chronic care clients, free from active TB after proper TB screening
Indicator: Proportion of clients put on IPT
Denominator: All HIV chronic care clients who are free from active TB

III. TB Infection Control

This is a cross-cutting activity to be implemented at facility level, in order to decrease TB transmission. To implement all the three pillars of TB infection control, stakeholders in the area should actively be involved and they have to have clear understanding of the issue and the activity. TB infection control plan has to be implemented in all health facilities, with the involvement of all stakeholders after proper orientation.

Target: All HIV chronic care facilities
Indicator: Proportion of HIV chronic care facilities with infection control committee and plan
Denominator: All HIV chronic care facilities

Monitoring and Evaluation:

Interventions should be regularly monitored and evaluated to see whether the interventions are implemented as per the set plan, benefit the end users and bring impact.
Monitoring and evaluation of implementation of the three Is is the most important activity besides implementing the interventions. As it is known, the M&E aspect of TB/HIV Collaborative Activities at national level needs further strengthening.

I. Supportive supervision: There will be regular and coordinated supportive supervision, involving partners, from FHAPCO/TLCP/FMoH to RHBs, to specific districts and health facilities.

II. Review Meeting: During the national TB/HIV review meeting, the issue of three Is should be an important agenda item for review, discussion and to track the progress of the three Is interventions.

III. Reporting: For the particular M&E activities of the three Is, there is a need to establish a separate/parallel system of reporting mechanism on quarterly basis from HF to the next higher level, from RHBs to FHAPCO and then from FHAPCO to be communicated to concerned stakeholders.

To put such system in place, discuss and convince RHBs, FHAPCO should work closely with partners and come up with realistic and feasible approach to bring data to national level through FHPCO reporting system.
The TB/HIV data in general and that of the three Is in particular at each level of the health system should be analyzed, interpreted and guide and serve as a base for further actions at each level. To that end FHAPCO in collaboration with partners will arrange M&E training to strengthen the recoding and reporting system.

Detailed plan of action for the implementation of the three Is in 2009 in Ethiopia

I. Activities for ICF

S. No	Activity	Number	Cost (Birr)	Responsible	Outcome	Time Frame, 2009				Remark
						QI	QII	QIII	QIV	
1.	Intensified case finding in PLHIV	300,000		FHAPCO/ RHBs and HFs	PLHIV screened for TB	x	x	x	x	
2	Introducing fluorescent microscopy	5	2,000,000	EHNRI	Fluorescent microscopes distributed to five places	x	x			
3	Print standard provider tools (IPT algorithm, TB screening questions) and wall chart	2500	60,000.00	FHAPCO/Partners	Printed provider tools wall charts	x				December 2008. Potentially, ICAP
4.	Distribution of printed provider tools and wall charts	2500	-	FHAPCO/RHBs/Partners	Distributed wall charts, to all HIV chronic care facilities	x				
5.	Introducing standard TB screening activities in all HIV chronic care facilities	-		HF staff	All HIV chronic care clients screened for active TB, using algorithm	x	x	x	x	

II. Activities for IPT implementation

S. No	Activity	Number	Cost (Birr)	Responsible	Outcome	Time Frame, 2009				Remark
						QI	QII	QIII	QIV	
1.	Quantification and procurement of INH	-	540,966.00 190,793.00	FHAPCO/ PEPFAR	INH Quantified and procured					Drugs are procured, ready for distribution
2	Distribution of INH to HFs,	-	-	FHAPCO/ Partners	INH distributed	x				
3	Offering INH to eligible HIV chronic care clients, with follow-up	95,939 clients	-	HF staff	Eligible clients received INH	x	x	x	x	

III. Activities for TB Infection Control

S. No	Activity	Number	Cost (Birr)	Responsible	Outcome	Time Frame, 2009				Remark
						QI	QII	QIII	QIV	
1.	Communication of RHBs about TB infection control in HIV chronic care facilities: -Administrative control measures -Environmental control measures and -Health workers/personal protective measures	11 RHBs	-	FHAPCO/FMoH	Draft TB infection control plan developed	x	x			
2	Implementing TB infection control: ▪ Good suspect/patient management ▪ Triaging of suspects/patients ▪ Educating suspects/patients on cough hygiene ▪ Ventilating rooms, opening windows and doors ▪ Proper suspect/patient placement	All HIV chronic care facilities	-	Health Facilities	Proper TB infection control activity implemented	x	x	x	x	

IV. Cross-cutting activities

S. No	Activity	Number	Cost (Birr)	Responsible	Outcome	Time Frame, 2009				Remark
						QI	QII	QIII	QIV	
A. Capacity Building										
1	TB/HIV TOT with more emphasis on three Is	60 staff	240,000.00	FHAPCO/Partners	TOT given for 60 participants	x				
2	TB/HIV training, with more emphasis on three Is for GHWs (at Regional level)	900 Health Workers	-	RHBs and Partners	Training given on three Is for at least 888 staff	x	x	x	x	Including Uniformed and prisons
3	One National sensitization workshop for Program managers and RHBs on three Is	60 Participants	200,000.00	FHAPCO/Partners	Sensitization workshop conducted	x				January, 09

B. Monitoring and Evaluation										
4	Establishing Reporting system and drafting tool for three Is	-		FHAPCO/RHBs	Reporting system established from HFs to FHAPCO	x	x			
5	Printing and distributing a tool for the three IS	2000 reporting formats	100,000.00	FHAPCO/Partners	Tool for three Is printed and distributed	x				
6	Quarterly reports from HFs, Districts and RHBs to FHAPCO on quarterly basis			HFs, Districts and RHBs	Quarterly report received by FHAPCO on quarterly basis	x	x	x	x	
7	Supportive supervision from FHAPCO, Partners and RHB to Districts and HFs	-		FHAPCO/MOH/ Partners	Supportive supervision conducted	x	x	x	x	
8	TB/HIV Review meeting, with emphasis on three Is	Two review meetings & 100 Participants	150,000.00	FHAPCO/Partners	Review meeting conducted, twice		x		x	Potentially WHO

Kenya

Priority actions for accelerated implementation of interventions to reduce TB burden among PLHIV (Three Is for HIV/TB)								
					Timelines 2009			
Activity	**Currrent status**	**Next steps**	**Indicators**	**Bud get**	Q1	Q2	Q3	Q4
Setting national targets	Present, needs revision	Hold a consensus meeting of key partners	Al national targets in place					
Creating conducive policy environment	IPC Policies in place but need finalization, need to develop other materials	Finalize IPC guidelines	Final Guidelines available					
		Print IPC guidelines and disseminate	No. of Guidelines printed					
		Develop training manuals and protocols	Training manual and protocols ready					
		Print manuals and protocols	No. of manuals and protocols printed					
	Laboratory guidelines being finalized	Finalize and print lab guideliens	No. of Guidelines printed					
Stakeholders engagement	On going	Need strengthening	Miniutes of joint meetings available					
Expanding HIV testing facilities	Taking place at all sites including OPD, wards etc	Strengthen and expand QA activities	QA system in place					
		Need to evaluate testing of suspects (develop protocol)	A report available					
Capacity building of staff	On going	Train more staff on TB HIV	No. of staff trained					
M and E	On going	Continue support supervision	No. of supervision conducted					
		Print more M and E tools	No. of districts performing TB HIV activities as a package					
	Beginning	Revise M and E tools for HIV settings	Proportion of HIV clients screened for TB					
Ensure commodity security	On going	Strengthen joint planning for procurement of test kits	Proportion of health facilities reporting stock outs in last 3 months					

Priority actions for accelerated implementation of interventions to reduce TB burden among PLHIV (Three Is for HIV/TB)								
Specific actions for intensified TB case finding					**Timelines 2009**			
Activity	**Currrent status**	**Next steps**	**Indicators**	**Budget**	Q 1	Q 2	Q 3	Q 4
PLHIV are screened for TB	Done but not documented	Develop M and E tools	Proportion o f PLHA screened for TB					
		Agree on national targets	Targets available					
Develop simplified algorithms and job aids for TB screening and diagnosis	Available but not routinely used	Print and disseminate tools	No. and type of tools available					
	Joint planning weak	Strengthen joint planning	Minutes of meetings available					
	Referral policy not properly articulated in relevant policy guidelines	Ensure referral policy is entrenched in all relevant policy documents	Policy in policy guidelines					
Conduct national mapping of diagnostic capacity for TB	TB Diagnostic and treatment services available	Update list	Updated list available					
	Mapping for CXR not available	Conduct survey	Map of CXR available					
	Mapping for biopsy not available	Conduct survey	Map of CXR available					
Provide all investigations including smear microscopy, CXR and rapid culture for those with suspected TB	Problem with costs for CXR and biopsy							
	Strengthening feedback system after referral	Conduct joint planning	Minutes of meetings available					
	Referral tools availabel: HF to community and HF to HF and vice versa	Print and disseminate tools	No. of referred patients available					

Encourage maximal use of 'one-stop' services	Started in some HF	Learn while implementing	No. of HF ofering OSS					
Capacity building of HCW to roll out implementation of revised and newly developed policies and guidelines.	On going	Increase frequency of training	No. of HCF offering ICF activities					
Increase uptake during pre-service training and revise pre-service training curricula	At initial status	Accelerate interaction with training institutions	No. of meetings held with training insitutions					
Ensure community engagment								

Priority actions for accelerated implementation of interventions to reduce TB burden among PLHIV (Three Is for HIV/TB)

Specific actions for integration services					**Timelines 2009**			
Activity	**Currrent status**	**Next steps**	**Indicators**	**Budget**	Q1	Q2	Q3	Q4
Develop national directive where to provide ART for HIV infected eligible TB patients.	Done for CPT Pilotting in some settings for ART in TB clinics	to be further discussed on ART bearing in mind the environment	National directives in place					
Ensure adequate space for HIV counseling and testing at TB clinics .	DTC ongoing	Need for improved infrastructure	No of additional facilities expanded					
Establish policy to decentralize HIV/ART services and task shift other health cadres	Still under discussion	Develop consensus on policy	No of TB treatment centers offering ART					

Ensure uninterrupted supply of TB/HIV commodities	Cotrim OK but need to revisit the other logistics especially joint planning	Joint planning	Proportion of districts reporting stock outs					

Priority actions for accelerated implementation of interventions to reduce TB burden among PLHIV (Three Is for HIV/TB)								
Specific actions for M and E					**Timelines 2009**			
Activity	**Currrent status**	**Next steps**	**Indicators**	**Budget**	Q1	Q2	Q3	Q4
Training and deployment of non clinical data clerks for timely collection of data .	**HR not enough – people there but not emplyed**	**Advocate for more resources**	No of clerks employed					
Uniform data handling policy in DLTLD and NASCOP	TB data policy in draft form	Engage NASCOP to come up with one document	TBHIV data policy in place					
Capacity building for HCW	TBHIV training curriculum in use	Revising the curiculum	Revised curiculum in place					
Develop a system of providing regular feedback to health facilities that collect the data and use it for improvement of performance at local level.	Supportive supervision ongoing	Use of PDA in supervision	PDA in use					
Ensure data validation prior to analysis	DQA ongoing in some districts	covering all the districts with DQA	Proportion of districts DQA done					
Update HIV registers with TB variable	Not in place	To collaborate with NASCOP	HIV registers with TB variables					

Priority actions for accelerated implementation of interventions to reduce TB burden among PLHIV (Three Is for HIV/TB)								
Specific actions for intensified TB case finding					**Timelines 2009**			
Activity	**Currrent status**	**Next steps**	**Indicators**	**Budget**	Q1	Q2	Q3	Q4
Consensus of national and local TB and HIV policy makers and affected communities.	Policy in place	Need to increase knowledge on IPT	No of PLHWA on IPT					
		Need to develop M and E tools						
HIV care and treatment services to include a comprehensive approach to preventing, diagnosing and treating TB.	Policy in place	To incorporate this in HIV M and E tools	HIV M and E Tools with TB screening					
		Print screening tools	No. printed					
Define responsibilities between TB and HIV/AIDS programs on who do what	Not agreed, two meetings held	Consesus meeting	Meeting report					
Make IPT responsibility of all health workers	Not yet fully done	Include this and emphasize on training	No. of people started on IPT					
Ensure recording and reporting on patients put on IPT	Not being	Develop specif M and E tools or incorporate where neccesary	Tools in place					
Infection Control								
IC implementation committees at different levels	Some facilities with ICC	Sensitize high volume facilities to form ICC	No. HF sensitized					
		Develop IC assessment tools	assessment tool in place					
		Ensure nomination of IC officer	Officers in all selected HF					
		Support IC meetings	Minutes of metings					
		IC to develop IC specific plans	HF with plans					
		Finalize IC Guidelines	Guidelines printed					

Integration of service provision	Starting	Develop guidelines on integration	No. of health facilities offering integrated care					
		Mainstreaming IC activities in curriculum of training institutions	IC materials in curriculum of training institutions					
		Develop TB workplace program	Policy in place					
		Print and distribute policy	No. of policy printed					
Capacity building	Not emphasized	Develop HCW training packages	Training package available					
		Print and distribute training packages	No. Printed					
Education of communities on IC	At infancy	Develop IC materials for community and patients	IC materials in place					
		Print and distribute IC materials	No. of materials printed					
Address stigma of TB	On going	Increase ACSM activities	No. of advers aired					
M and E of IC activities	Not carried out	Develop materials for M and E	Drafts available					
		Print and distribute M and E materials	No. Printed					

Malawi

Working in integrated fashion with joint TB/HIV planning, implementing and reviewing

Setting national targets

- Convert percentage targets into numeric targets
- Harmonize TB and HIV targets
- Set infection control targets for the districts

Mobilizing political commitment

- Write meeting report and present to MOH leadership
- Brief senior management on recommendations from meeting

Engaging stakeholders

- Refine TB/HIV subgroup
- Engage ministry departments, NGOs, community-based, interfaith, PLWHA, media organizations in TB/HIV plan
- Hold high-profile annual meeting for consensus-building around TB/HIV
- Special community engagement

Expanding TB/HIV testing facilities

- Conduct mapping exercise to identify HTC, ART, TB registration, TB microscopy sites
- Use mapping to strategize planning of TB/HIV co-location activities with attention to infection control
- Revise HTC algorithm to include all TB suspects (PITC)
- Train TB officers in HTC and train ART providers in TB screening

Increasing training and supervision

- Revise M&E tools, including registers and mastercards to harmonize TB and HIV data collection
- Revise curricula and trainings to include components of intensified-case finding, infection control, IPT, and to consider referral links
- Harmonize TB and HIV trainings
- Pilot joint TB/HIV supervision visits
- Consider creative approaches to task-shifting (data clerks)

Ensuring drugs and commodities

- Strengthen the supply chain of commodities
- Encourage inclusion of light microscopes in district budgets

Strengthening laboratory

- Expand and decentralize TB microscopy sites

Other

- Co-locate TB/HIV services and strengthen referral systems (with community involvement)
- Decentralize infection control activities
- Document lessons learned and good practices

Mozambique

Priority actions for accelerated implementation of interventions to reduce TB burden among PLHIV (Three Is for HIV/TB) in Mozambique

I. General actions for nationwide scale-up of collaborative TB/HIV activities

- **Setting national targets** for collaborative TB/HIV activities (IPT for PLWHIV without TB and TARV for PLWHIV with TB)
- **Creating conducive policy environment** with the development of appropriate policy and operational guidelines in the HIV program in line with international guidelines and consistent with the national TB program.
- **Stakeholders engagement** : Strengthening TOE of national TB-HIV task force and engagement of national HIV program in task force; expansion of joint TB-HIV meetings to all provinces (as is practiced in Zambezia province, which has weekly meetings of large group of stakeholders and monthly meeting of smaller group)
- **Secure new funds to continue supportive supervision** of health workers by provincial coordinators of TB, HIV, malaria and STIs.
- **Revising HIV registers** to include TB components (TB screening, TB diagnosis, IPT).
- **Effective and constant supply** of HIV test kits reagents, INH, TARV drugs, sputum containers, gloves, masks and N95 respirators.
- **Continued laboratory strengthening** of existing diagnostic methods and developing standard operating procedures for non existing tools.

II. Specific actions for intensified TB case finding

- Ensure that all PLHIV are screened for TB in assessing for ART eligibility and at follow up visits (develop M&E tool and reporting mechanism to capture proportion of patients screened).
- Ensure distribution and use of national algorithm and tool for TB screening and diagnosis in all HIV care facilities.
- Ensure execution of existing plan for expanding availability of smear microscopy and culture.
- Conduct combined annual planning and review meeting by TB and HIV programs and stakeholders at all levels
- Evaluate feasibility of use of 'one-stop' services through pilot projects (with due emphasis on TB infection control)
- Assess level of community involvement in all districts

III. Specific actions for Isoniazid preventive therapy

- Clarify guidelines on repeat IPT
- Support implementation of IPT policy
- Ensure recording and reporting of patients put on IPT (update HIV register)

IV. Specific actions for TB infection control

- TB infection control policy should be established to ensure the inclusion of TB infection control either as a general facility or as a TB specific plan. The policy should define who has the responsibility and authority to enforce it (programs or Departimento de Enfermagem).
- Advocate for participation of member from national TB and HIV programs in development of national TB infection control guidelines
- Implement infection control measures in the plans for rehabilitation of hospitals to be reference centres for TB.
- Education of communities (HCWs, volunteers, PLWH organizations etc.) is important to ensure understanding and commitment to implementation of TB-IC;
- TB-IC should be mainstreamed in good clinical work practice of every health worker and should be integrated in pre- and in-service training on TB, HIV/AIDS, IC, MDR-TB management;
- Existing national recommendations on surveillance of TB in HCWs should be implemented;
- National infection control plans must be prioritised with intensified monitoring and supervision for example through the use of infection control officers.
- Promote outpatient treatment of TB and ensure assignment of adequate human resources to rapidly assess/triage patients.
- Address stigma of TB through careful patient flow consideration
- Separate potentially infectious cases from susceptible patients such as PLHIV.
- Conduct training of health workers in infection control using WHO guidelines and existing training materials.
    - Include a TB infection control component in HIV training materials.
    - Make sure that the IC guidelines adopted and the national IC plan include the following:
        - Screen all patients for TB
        - Implement respiratory hygiene/cough étiquette
        - Ensure well ventilated waiting areas
        - Speed up management of patients
        - Ensure rapid diagnostic investigation of TB suspects
        - Use and maintain environmental control measures
        - Train and educate staff
        - Provide voluntary and confidential HIV counseling and testing for staff and access to treatment
        - Monitor the TB infection control plan's implementation

V. Specific actions for monitoring and evaluation

- Training and deployment of non-clinical data clerks for timely collection of data and to relieve the clinical staff from their non-core functions.
- Develop consensus (e.g. through meetings or memorandum of understanding)

between NTP and NAP and other stakeholders (e.g. Track 1.0 PEPFAR ART programme partners) about one national system including WHO recommended TB/HIV indicators and data access agreements.

- Encourage and build capacity for the utility of data for planning purposes (by health facilities and laboratories) through regular supervision, mentoring and combined training.
- Develop a system of providing regular feedback to health facilities that collect the data and using it for improvement of performance at the local level in coordination with Department of Health Information Systems.
- Ensure data validation prior to analysis
- Support TB/HIV monitoring and evaluation
  - Ensure HIV care, ART, VCT and PMTCT registers are consistent with revised WHO registers
  - Strengthen data collection system through allocation of adequate human resources, supply of forms and supportive supervision from national to facility level.
  - Encourage internal and external joint TB and HIV program reviews.
- Update HIV registers with TB variable
  - TB symptoms (Y/N)
  - If TB symptoms Y- treat for TB
  - If TB is excluded- IPT

VI. Specific actions for integrated service delivery

- Explore possibility of developing policy to task shift to nurses and other health cadres
- Document best practices and lessons learnt on different modalities integrated service delivery
- Ensure uninterrupted supply of key TB/HIV commodities and supplies e.g. HIV test kits, INH, cotrimoxazole, etc at all service sites. Ensure that mechanisms for rocurement and supply are followed and secure long term funding.

Namibia

Priority actions for accelerated implementation of interventions to reduce TB burden among PLHIV (Three Is for HIV/TB)

First action point: up on return the team will share this meeting report and draft action points with the national technical working group and relevant MoH bodies

I. General actions for nationwide scale-up of collaborative TB/HIV activities

- **Setting national targets:** need to develop national target as priority intervention
- **Creating conducive policy environment:** Namibia already has of appropriate policy and operational guidelines, training manuals and protocols in line to international guidelines.
- **Stakeholders engagement:** Strengthen existing stakeholders engagement by activating existing forum and ensuring involvement of both TB and HIV patients
- **Expanding HIV testing facilities:** Monitor to what extent this is implemented,

analyse existing data and scale up towards set targets

- **Intensive, continuous training and supportive supervision:** Include TB infection control in trainings (need to adapt the TB infection control training in the already country adapted IMAI modules), integrate trainings, scale up IMAI trainings, strengthen integrated supportive supervision at national level,
- **Implementing revised recording and reporting formats:** HIVQUAL initiative includes the screening for TB at last visit for routine reporting, TB infection control need to be included, the national working group will look at the national indicators *vis a vis* newly recommended indicators
- **Laboratory strengthening:** has external quality assurance for all laboratory services, not major area of concern. There is plan to introduce Rifampicin INH resistance services, in collaboration with CDC

II. Specific actions for intensified TB case finding

Currently: TB screening is routinely done at VCT (for those tested HIV positive), HIV care clinic, PMTCT clients (when referred at HIV care clinic)

- Expanding the VCT screening for all clients to be discussed at national level, TB screening in PMTCT settings (happens only to those who are referred to HIV clinic),
- Develop and ensure availability of simplified algorithms and job aids for TB screening and diagnosis in all HIV care facilities (Work in progress)
- Provide all available investigations including smear microscopy, CXR for those with suspected TB (already being done, resistance assay for suspected resistance cases in progress)
- Establish national targets for the proportions of patients who are screened and diagnosed in different settings (see above).
- Conduct combined annual planning and review meeting by TB and HIV programs and stakeholders at all levels (is being done)
- Encourage maximal use of 'one-stop' services depending on local situation and with due emphasis for TB infection control
- Conduct massive integrated training to roll out the implementation of revised and newly developed policies and guidelines.(discussed above)
- Develop national guidelines for improved referral systems (strengthen referral system)
- Include in (and Increase uptake during) pre-service training and revise pre-service training curricula to include collaborative TB/HIV activities (pre-service training for nurses is done)
- Conduct biannual external review missions (work in progress, and also discuss at the stakeholders committee)
- Ensure community engagement (strengthen community engagement in TB, creating TB literacy using HIV community infrastructures)

III. Specific actions for Isoniazid preventive therapy

- Build consensus of national and local TB and HIV policy makers as well as people from affected communities (IPT is already in the national guideline and received well, implementation review at national level with all stakeholders)
- HIV care and treatment services should include a comprehensive approach to preventing, diagnosing and treating TB .

- Define responsibilities between TB and HIV/AIDS Programs on who do what (done)
- Make IPT responsibility of all health workers (IPT is received often as TB and HIV programs, other health workers should also be brought on board by orienting all care providers)
- Ensure not only recording but also reporting of patients put on IPT (needs to be enforced as a priority action point)

IV. Specific actions for TB infection control

"Perfect" should not be the enemy of "Good"; get started with simple practical things and move on to perfection; (TB-IC to be incorporated in the national IC guideline, the general TB policy including TB IC in process)

Action points:

- To form IC implementation committees at different levels that assume responsibility for TB-IC and undertake Health Facility assessments;
- Prioritize actions based on practical simple interventions and location - high-to-low risk health facility assessments (scale up implementation, and strengthen follow up supervision)
- Integration of service provision is important with due caution of separation of TB patients (with or without HIV) from PLWH (without TB) is important; (to be strengthened in facilities that are not implementing it)
- Education of communities (HCWs, health facility managers, PLWH organizations etc.) is important to ensure understanding and commitment to implementation of TB-IC; (ongoing activity)
    - TB-IC should be mainstreamed in good clinical work practice of every health worker and should be integrated in pre- and in-service training on TB, HIV/AIDS, IC, MDR-TB management;
    - Surveillance of TB in HCWs should be implemented as part of a TB workplace program and occupational health to win the support of HCWs in implementing and adhering to good TB-IC work place practice (to also be discussed at national and facility level to build consensus on implementation);
        - TB infection control policy should be established to ensure the inclusion of TB infection control either as a general facility or as a TB specific plan. The policy should define who has the responsibility and authority to enforce it.(included in general TB policy)
    - Decision makers in Ministries of Health should be sensitized to threats posed by poor infection control policies
        - Isoniazid Preventive Therapy should be widely implemented as part of TB infection control activity as it involves screening for TB, which in turn stops transmission (ongoing);
    - National infection control plans must be prioritized with intensified monitoring and supervision for example through the use of infection control officers (integrate in supportive supervision, agree on indicators and monitor implementation, needs discussion to sort out who will be responsible) also strengthen the monitoring and evaluation of collaborative TB/HIV activities in national HIV control programs, including TB infection control activities.
        - TB screening among PLHIV should be encouraged, evaluated and data used to inform program regularly.(as above in ICF)

        - Promote outpatient treatment of TB (yes in general, but needs to be discussed for MDR patients) and ensure assignment of adequate human resources to rapidly assess/triage patients (the IMAI recommendation for triage in HIV care is being implemented, include triage in supportive supervision checklist). Address stigma of TB through careful patient flow consideration (TB related stigma is not a major problem in Namibia).
- Separate potentially infectious cases from susceptible patients such as PLHIV. (rapid diagnosis and separate in the inpatient ward need to be strengthened)
    - Conduct training of health workers in infection control using WHO guidelines and existing training materials such as the ones from South Africa. (as above)
    - Include a TB infection control component in HIV training materials.(as above)
    - Increase community awareness about infection control.(as above)
- A sample infection control plan can include the following:
    - Screen all patients for TB
    - Implement respiratory hygiene/cough étiquette
    - Ensure well ventilated waiting areas
    - Speed up management of patients
    - Ensure rapid diagnostic investigation of TB suspects
    - Use and maintain environmental control measures
    - Train and educate staff
    - Provide voluntary and confidential HIV counseling and testing for staff and access to treatment
    - Monitor the TB infection control plan's implementation

V. Specific actions for monitoring and evaluation

- Training and deployment of non clinical data clerks for timely collection of data and to relieve the clinical staff from their non-core functions (already done).
- Develop consensus (e.g. through meetings or memorandum of understanding) between NTP and NAP and other stakeholders (e.g. Track 1.0 PEPFAR ART programme partners) about one national system, policy development around it and data access agreements (ongoing).

Action point: Encourage and build capacity for the collection and utility of data by all health workers at all levels through regular supervision, mentoring and combined training. (as discussed above to include 3Is)

Ongoing Action point: Develop a system of providing regular feedback to health facilities that collect the data and use it for improvement of performance at local level (encourage health workers at facility level to also use the data, and also provide feedback on the spot at district level) it is happening and should continue to happen

- Ensure data validation prior to analysis (validation on TB register done in TB program quarterly, also done in HIV programs)
- Conduct periodic evaluation of the TB/HIV reporting System (as above, following update on some of the indicators))
- Set national targets for the implementation of collaborative TB/HIV activities through national consensus and establish a monitoring system to track them (as above).
- Agree on adoption and regular reporting on TB/HIV indicators including WHO

recommended TB/HIV indicators (as above)

- Support TB/HIV monitoring and evaluation
  - Establish TB/HIV teams within the M and E unit/department of the MoH (there are TB and HIV focal persons in the M and E department)
  - **Action point:** Revisit and update existing tools (based on the revised WHO registers).
    - VCT registers
    - Pre ART and ART registers
    - HIV care/ART card
    - TB registers and patient card (already done)
    - PMTCT Registers
  - Conduct training with special emphasis on collection, analysis, interpretation and use of data(ongoing activity)
  - Strengthen data collection system through allocation of adequate human resources, supply and supportive supervision from national to facility level (Ongoing).
  - Suggested frequency of monitoring is monthly at facility, quarterly at district level and biannual at national level (part of routine health system reporting)
  - Harmonize and coordinate the monitoring and evaluation activities across donors based on nationally agreed indicators and targets (3 ones)(work in progress)
  - Encourage internal and external joint TB and HIV program reviews (as above).

- Update TB registers with HIV variables (done)
  - HIV test performed (Y/N/previous test with data)
  - HIV result (+/-)
  - HIV care (Y/N/end date)
  - CPT (Y/N/start date)
  - ART (Y/N/Start date/ARV number)

- Update HIV registers with TB variable (as above)
  - HIV test performed (Y/N/for HIV + refer to HIV care)
  - TB symptoms (Y/N)
  - If TB symptoms Y- treat for TB
  - If TB is excluded- IPT

Action point: Conduct TB/HIV co-management review
  - Establish a system to reconcile patients
  - Check for quality of care

VI. Specific actions for integrated service delivery

Action points:

- Develop a clear national directive where to provide ART for HIV infected eligible TB patients (either in ART or TB service, or in both delivery points, where to start TB treatment when a patient on chronic HIV care is diagnosed of TB. Develop clear national directive to define which service will be provided where? HIV testing and counseling, CPT, IPT, (to revisited)
  - Ensure the infrastructure of adequate space for HIV counseling and testing at TB clinics and other point of care facilities (in progress)

- Establish policy to decentralize HIV/ART services and task shift to nurses and other health cadres (ongoing)
- Strengthen joint supportive supervision and clinical mentoring to ensure quality of care (ongoing)include MDR in the training of clinical mentors
- Ensure that TB infection control is part of good clinical practice, and monitor facility staff routinely adhere to such practices (as above).
- Build in to national service delivery, regular joint supervision to ensure quality of care (as above)
- If feasible, HIV testing should be done at point of care. When HIV testing is not available on-site at the TB clinic, the patient or the specimen should be referred to an HIV test site. While sending patients for test to HIV test sites strict infection control measures should be applied. (all public facilities provide HIV testing and counseling services)

- Document best practices and lessons learnt on different modalities integrated service delivery
  - Ensure uninterrupted supply of key TB/HIV commodities and supplies e.g. HIV test kits, INH, cotrimoxazole, etc at all service sites. Define mechanisms for procurement and supply, and funding.(As above)

Nigeria

ROADMAP TO SCALE UP TB/HIV COLLABORATIVE ACTIVITIES IN NIGERIA

1. Nationwide scale-up of HIV/TB collaborative activities with focus on mechanisms for collaboration.

   - **Setting national targets**
     - National target for infection control. Is missing.

   - **Creating conducive policy environment**
     - Strengthening the SASCP at state level.
     - Monthly Management meetings at state level.
   - **Stakeholders engagement**
     - Active engagement of community support group and CBOs.
     - Capacity building for Communities

   - **Expanding HIV testing facilities**
     - GHWs in DOTS centers to be trained to offer HCT.

   - **Intensive, continuous training and supportive supervision**
     - Retraining of GHWs
     - Joint itinerary for 2009

   - **Implementing revised recording and reporting formats**
     - Need to harmonize the reporting and recording formats

   - **National policy**

2. Screening and diagnosing TB in people living with HIV.

3. IPT as part of the package of care for people living with HIV.
4. TB infection control
5. Implementing the revised HIV and TB recording and reporting forms, and harmonization of HIV/TB indicators.
6. Coordination and integration of HIV and TB health service delivery.

	Activities	Timeline	Resources needed	Responsible
General Actions for nationwide scale up of collaborative TB/HIV activities				
1	Set target for TB infection control	Dec 2008.	Nil	NTBLCP & NASCP
2	Institute regular Managerial meetings at state level	Dec 2009	Funds for monthly meetings.	NTBLCP & NASCP
3	NASCP to actively engage the NACA, WHO HIV/AIDS for strengthening NASCP in providing leadership for health sector response.	Dec 2008	Nil	NASCP
4	Strengthen the SASCP at state level.	2009	Funds required	NASCP
6	Engage Community support organizations and activist in TB/HIV collaborative activities. (identify support groups and activities, invite them to the quarterly meetings working group meeting)	By 4th quarter National TBHIV working group meeting	Resources available (USAID, GFATM)	FMOH
7	Build capacity of community support group on TB/HIV	March 2009	Funds required	FMOH, Partners
8	Train programme officers at National level (NASCP & NTBLCP) on the supervision of TB/HIV collaborative activities	Dec 2008	Funds not required.	FMOH
9	Develop Joint supervisory itinerary. for TB/HIV collaborative activities for 2009	Dec 2008	Funds not required	FMOH Partners
10	NTBLCP to direct STBLCO to share the supervisory itinerary with SACP at state level.	Dec 2008 (during the annual TBLCO meeting in Kaduna)	Funds available	FMOH, Partners
11	NTLCP and NASCP to have Joint Review meeting for state Programme officers (the SACP & STBLCO) in 2009.	2009	Funds required	FMOH, Partners
12	NASCP to conduct R&R harmonization	Feb 2009	Funds required	NASCP

	meeting to produce one standard recording and reporting formats			
13	NASCP to supply test kits for testing TB suspects and patients in all DOTS centers.	Ongoing	Funds available	NASCP
14	Check National Lab policy (Prof Tomori committee) to ensure that it addresses TB/HIV. Access the status of the lab	Feb 2009	Minimal funds requires	NASCP & NTBLCP
Specific actions for intensified TB case findings				
15	Harmonize the screening tool for TB screening among PLHIV	Dec 2008	Funds required	FMOH Partner.
16	FMOH should ensure that all PLWHA at HCT centers (Pre-ART register) are also screened for TB during each follow up visit	1st quarter 2009	Nil	FMOH Partner
17	NTBLCP and NASCP to develop and ensure availability of simplified algorithms and job aids for TB screening and diagnosis in all HIV care facilities.	Circulate draft by December 2008 and finalize by Jan - Feb 2008	Funds required for the finalization meeting and printing	FMOH, Partners.
18	Conduct national mapping of diagnostic capacity for TB (CXR, culture, biopsy) and earmark resources to improve and establish diagnostic facilities depending on the assessment and need. (**Note**: Funds available to conduct comprehensive mapping of HIV service delivery sites, therefore TB should be incorporate into this)	First meeting to harmonize the methodology by 10th December 2008. The detail mapping by Jan- Feb 2009)	Funds available (NIMR, UNICEF HS 2020/USAID) – (Akin Atobatele – USAID)	FMOH, Partners
	Prize for best thesis on TB/HIV collaborative activities in the medical schools	July 2009	Resources required	FMOH
	NTBLCP to procure IPT and give to NASCP	By Dec 2008		
19	Provide all available investigations including smear microscopy, CXR and rapid culture for those with suspected TB (Mapping,			

	Encourage maximal use of 'one-stop' services depending on local situation and with due emphasis for TB infection control			
	Develop national guidelines for improved referral systems	Jan 2009		FMOH
	Include in (and Increase uptake during) pre-service training and revise pre-service training curricula to include collaborative TB/HIV activities			
	Prize for best thesis on TB/HIV collaborative activities in the medical schools	July 2009	Resources required	FMOH
	NTBLCP to procure IPT and give to NASCP	By Dec 2008		
	Implement TB IC in the existing 251 comprehensive centers.(facility assessment,) Prioritize actions based on practical simple interventions and location - high-to-low risk health facility assessments -			
	Funding organization to ensure further expansion is done to conform with TB-IC			
	Provide guidance to hospital			
	Hospital administrators involvement			
	Education of communities (HCWs, health facility managers, PLWH organizations etc.) is important to ensure understanding and commitment to implementation of TB-IC;			
	TB-IC should be mainstreamed in good clinical work practice of every health worker and should be integrated in pre- and in-service training on TB, HIV/AIDS, IC, MDR-TB management;			
	Surveillance of TB in HCWs should be implemented as part of a TB workplace program and occupational health to win the support of HCWs in implementing	May 2009	Funding required	NTBLCP

	and adhering to good TB-IC work place practice; (work with NIBUCA, Ministry of Labour,			
	Memo to TMC, FEC, CMDs, on IC	November 2008	Nil	FMOH
	National infection control plans must be prioritized with intensified monitoring and supervision for example through the use of infection control officers			
	Develop consensus (e.g. through meetings or memorandum of understanding) between NTP and NAP and other stakeholders (e.g. Track 1.0 PEPFAR ART programme partners) about one national system, policy development around it. And data access agreements.	Harmonizing		
Specific actions for monitoring and evaluation				
	Encourage and build capacity for the collection and utility of data by all health workers at all levels through regular supervision, mentoring and combined training.			
	Develop a system of providing regular feedback to health facilities that collect the data and use it for improvement of performance at local level. Train STBCLO and SAPC on feed back. Monitoring and supervision.			
	Conduct periodic evaluation of the TB/HIV surveillance/reporting System (annual)			
	Establish TB/HIV teams within the M and E unit/department of the MoH			

South Africa

TB/HIV Accelerated Activities Republic of South Africa

Establish the Mechanism for Collaboration		
Activity	**Description**	**Steps that are required**
Formalization of the reconstituted national TB/HIV committee	To be chaired by DDG, Involvement of members who can determine priorities, incorporate information, make and carry out decisions ,improve communication between all levels(national,provincial,district and all relevant partners)	1. Meeting held on 18 November between department and partners, objectives were to share good practice in TB/HIV control, develop plans for scaling up good practice and to identify areas of collaboration 2. The meeting participants resolved to establish working teams to further deliberate and plan on identified key issues 3. The report of the meeting is being finalized and will be submitted as soon as it is approved by senior management
Intensified case finding	Screening for TB of all clients who utilize HIV services	Design and develop Standardized TB screening tool. 3Is team to review existing tools and draft standardized tool by mid-December 2008
Isoniazid Preventive Therapy	Treating latent TB in HIV+ve clients	Current guidelines being reviewed, meeting of experts in TB/HIV planned for 2d week of December 2008 to address amongst others: necessity of PPD test, need of Chest Xray to exclude active TB, indication for IPT in pregnant women and for patients who are on ART Funding of review: NDOH and Belgian Technical Cooperation

Review of Recording and Reporting tools for HIV entry point	HIV recording and reporting tools currently not standardized in capturing information on TB/HIV collaborative activities, multiplicity of registers confusing during data capturing	Discussion, review revision and standardization of R&R tools, HIV entry point: meeting planned 2d week of December 2008 (including review of existing good practice. The TB register will also be reviewed as there has been a lot of issues raised since it has been introduced.
Infection control	Reduction of exposure to TB of vulnerable clients(e.g.HIV+ve) in institutional and community settings	3Is strategy team to review ,revise and harmonize current IC guidelines, submit recommendations December 2008
Conduct Operational research on TB/HIV collaborative activities	Many questions remain about the management of the co infected patient. It is hoped that OR will provide answers for some of this questions.	Letters of interest in conducting OR in TB/HIV; 20 expression of interest received in November 2008 Request full proposals after review of letters of interest. Studies to be conducted from January 2009. Funding available from Global Fund and Belgian technical Cooperation

Sudan

Sudan Situation & Priority Actions for accelerating the implementation of collaborative TBHIV activities

General actions for nationwide scale-up of collaborative TBHIV activities:

Current situation:

- There is high political commitment, the president declared HIV a national emergency, & the minister of health worked in south Africa & did postgraduate studies in HIV/AIDS & is truly committed to the cause
- In place already are:
  1. Draft joint policy
  2. Draft joint strategy & framework of action
  3. Draft TBHIV Guidelines
  4. Draft M & E including national unified recording & reporting format as well as roles & responsibilities at all levels
  5. National TBHIV joint targets are already in place & some are overachieved. If achieved they will lead to the global target achievements
- All stakeholders are already involved in the Joint TBHIV committee which was established in 2006

- Financial resources are already available particularly at the SNAP side

Bottlenecks

- Implementation is not ambitious enough especially with regards to availability of HIV/ART care & support services when compared to TB services (numbers & trained staff for TBHIV management)
- Targets are not ambitious enough to achieve the global targets expected for the region & country
- Insufficient CD4 testing services.
- Unavailability of VL machines & means to diagnose drug resistance as well as 2nd line ART
- TB lab technicians are not trained in DST due to unavailability of the service widely enough across the 15 states.

Solutions & Action Points for scale up:

1. Targets on staff training should be scaled up rapidly & become ambitious enough to match the global targets required.
2. Technical assistance from stakeholders namely WHO is required & needs to be stated
3. Avail the Full scale-up plan by the 1st quarter 2009 agreed upon by all stakeholders
4. CD4 count & VL machines have been requested officially from the WHO, & promised to be available soon
5. Funding for improving & availing TB diagnostic services namely DST will be requested
6. Training of staff needs to include available & soon to be available services namely VL & DST.

Specific Actions for intensified TB case finding:

Current situation:

- All TB patients are counselled for HIV, & around 80% are actually testing
- Not all HIV patients are properly screened for TB, & those screened are not properly reported to reflect upon
- Algorithms & screening checklist already in place within the draft guidelines but are not distributed yet for the clinics

Bottlenecks:

- No proper recording & reporting format at the care center level
- Each center reports on different information through a different form or method
- Culture/DST & CXR are not widely available or evenly distributed or properly trained on to improve case detection

Solutions & action points for scale-up:

- Policy already showed the importance of routine screening & testing , but this policy needs to be distributed to those who need it in-order to implement it

- CXR & DST have been requested from stakeholders already, but it needs follow up
- Algorithms & screening check-lists needs to be distributed as soon as possible to scale-up ICF
- Recording & reporting formats need to be uniform covering all required information & distributed to clinics which should be trained on how to use it
- Supervision needs to be joint, organized with check-lists, using standardized formats of reporting at all levels

Specific actions for INH Preventive Therapy:

Current situation:

- There is no IPT in Sudan although the magnitude of the problem is critical, but clinicians are reluctant to it
- There is ongoing drug-resistance surveillance (DRS) to establish INH-resistance among TB patients.

Bottlenecks:

- There is no IPT policy

Solutions & action points for scale-up:

- Political commitment will be advocated
- Draft IPT policy will be included in the draft TBHIV policy, guidelines, manuals & training
- Staff training on when, how & who should be given IPT will be included with the upcoming training to prepare for implementation later on
- Procurement system as to who should avail & distribute IPT of the 2 programs will be discussed in the next joint committee meeting
- Proper diagnostic procedures needs to be availed & scaled-up to be able to exclude active TB
- Pilot project in at least three different locations "where proper diagnostics are available" to be implemented maximum by the end of Q4 2009
- Avail reporting & recording formats as well as an IPT adherence-assurance system
- Include IPT related information in the registers (after being determined)
- Establish another DRS when IPT is made available

Specific actions for TB Infection Control:

Current situation:

- There is no infection control policy or actions in place

Bottlenecks:

- There is no infection control commitment & behaviour among our staff members

Solutions & action points for scale-up:

- Advocacy for infection control amongst health & non health policy makers need to be achieved
- Infection control measures will be included in the draft policy & guidelines as an integral part of TBHIV management
- Technical assistance to be requested from the WHO to help with the implementation of the policy
- Training on Infection control will be introduced to the regular ongoing training of TBHIV staff members namely the upcoming training Q4 2008
- Implementation of Infection control & supervision on that will start by Q4 2008 to scale-up the activity.

Specific Actions for M & E:

Current situation:

- The NTP registers have already included HIV-related information in their TB registers & are being reported upon regularly with relatively good data quality, collection, analysis & distribution
- The NAP registers does not yet include TB-related information, which are reported separately & intermittently. Collection, Analysis & distribution of TBHIV related data is not sufficient or useful
- However, in the draft M & E guidelines & guiding manuals are the suggested reporting & recording forms as well as data collection helper-sheets to assist in data collection across the country have been availed, and after agreement, TB-related information will be incorporated into the VCT & ART/Pre-ART registers.

Bottlenecks:

- Not all the WHO core indicators are covered with the current amount of TBHIV data collection available
- Registers are not including TBHIV information
- Data collection, analysis, & distribution is not proper
- Supervisors do not have a uniform check list as to what to collect
- No proper data base for M & E

Solutions & action points for scale-up:

- Update the NAP registers to include TBHIV data
- Improve both M&E & R&R formats & systems
- Collect & analyse data properly then interpret it & take the appropriate actions accordingly
- Request technical assistance from the WHO to assist with human resource training for both central & peripheral staff & supervisors
- Request assistance with a proper useful data base that is functional & informative form WHO

- Avail supervision at all levels to confirm proper data collection & use.

Specific actions for integrated service delivery:

Current situation:

- The joint national policy already clearly states the collaboration between the 2 programs & its importance to be able to make it through with the intended plan of action
- The draft action plan clearly defines where each activity will be provided
- There are already 300 TBMU versus 124 VCT & 30 ART units, which clearly lead us to the importance of stating & start initiating the integrated approach of expanding VCT/ART services through the TBMU, which will safe human resources but requires space for such services as well as proper training & preparation of TB staff.
- Joint supervision already takes place to both HIV & TB units across the country at all levels

Bottlenecks:

- There is no joint check-list for the joint supervision done yet at the state level
- There is no documentation of joint activities & the supervision done, hence the data is recorded but not reported
- The delay of the arrival of condoms & HIV Kits sometimes delays the services at the TB units.
- CPT is not yet supplied to the TB units & there are now referral forms used yet for that purpose, although they have appeared already in the draft recording & reporting formats

Solutions & action points for scale-up:

- The programs need to discuss & clearly decide on who should procure & supply the CPT,IPT, Condoms, & HIV kits
- Both programs need to discuss together a uniform check-list for joint supervision with detailed description on who, when & how to collect such data, & who to report it to at all levels of both programs
- Supervise, record & report on how infection control is being achieved at each clinical setting under both programs.

Swaziland

ACCELERATION OF TB/HIV COLLABORATIVE ACTIVITIES					
ACTION	**ONGOING**	**INCREASE IMPLEMENTATION AND SCALE UP**	**BARRIERS**	**TA**	**Resources**
Mechanism of Collaboration	- National TB/HIV policy guideline (in place). - National Coordination Committee for TB/HIV collaborative activities - Regional TB/HIV committee (one region) - Regional TB coordinators (in place) - TB/HIV partnership -PPM (ongoing) - Workplace TB guidelines (ongoing) - TB/HIV communication strategy development (ongoing)	- Improving collaboration spirit e.g. meetings to be held quarterly - Strengthening joint planning,, implementation ,support supervision of TB/HIV activities - Resource mobilization (e.g. Application to Global fund) to continue in other activities - Multidisciplinary committee at facility level (planned) - Joint training of Medical officers and nurses on TB/HIV management and collaborative activities in HIV care settings needs strengthening - Mobilize support from policy makers , regional, local leadership and communities for TB/HIV collaborative activities - Capacity building for the two programmes staff on TB HIV collaboration activities	- Many activities occurring at the same time resulting in poor attendance. - Mechanism process is difficult resulting in programmes not accessing the funds - Medical officers not motivated to attend trainings resulting in lack of knowledge in TB/HIV management.	URC WHO	URC GFTAM WHO

Intensified Case finding	- Screening tool developed- Pilot study on the tool (ongoing) - Finalization of referral mechanism is ongoing and strengthening - NRL in place and 1st line DST done. -12 public health facilities and 3private facilities are TB/HIV diagnostic sites	- Roll out screening tool in all health facilities (Orientation of health workers on the tool) - Scaling TB screening tool in PMTCT department to identify cases of active TB - Provision of TB treatment to PLWH identified during screening - Ensuring regular supply of sputum containers and distributiori in all health facilities - Sputum transportation need to be scaled up and strengthened at clinic level - Training of health workers on TB,TB/HIV management (HIV care setting) - Pre and In-service training on the referral and screening tool - Scale up of 1st line DST at regional laboratory - Advocacy for availability of 2nd line DST in the country (Planned 2010) - Procurement Fluorescents microscopy - Human resource quantity and quality	- Inadequate health infrastructure - Diagnostic capacity is still low and long turn time for smears resulting in delay initiation - Transportation of sputum from clinic to - Strengthen culture capacity diagnostic facilities - Production of sputum by PLWH	WHO URC	GFTAM URC WHO

Isoniazid Preventive Therapy	- Provision of INH chemoprophylaxis for children (scale up and standardization to the other facilities)	- Guidelines for IPT provision (IPT implementation plan) - Strengthening standardized Recording and reporting of IPT (Develop tool) - Training of health workers on IPT (HIV care settings) - Provision of IPT to PLWH in HIV care settings **Community involvement** - Raising awareness on the importance of IPT and adherence	Diagnostic capacity for TB especial for PLHIV is still low which may result in under diagnosis	WHO URC	WHO
Infection Control	-**Infection control committee** **(Build in TB infection control to the existing structure)** TB Infection Control focal person at National level **- Infection control guidelines/framework (ongoing)** -Improving infrastructure within health facility to ensure infection control (started in one facility) - Distribution of N95 health facilities (Needs supervision to ensure their	Advocacy for Political commitment in Infection control - Develop and operationalize the Infection Control package at all levels **Community involvement in infection control** - Training of community leaders and RHMs to ensure cough etiquette, home isolation, increase awareness on infection control in congregate settings - Meaningful involvement for PLWH to raise awareness infection control	Limited stock of N95respirators	PATH URC WHO	URC GFTAM WHO

	use by health workers) - Revitalize the existing structure. (Training of trainers at National level PPE, Admin, Environmental, engineering control measures, Assessment at facility level for ongoing interventions)	- Involvement of Environmentalists in TB/HIV infection control who are based at all levels i.e. clinics - **PI HTC for health workers to allow redeployment of health workers to less risk areas if HIV positive!!** - Training of Rural health motivators activities and other Community health workers on TB HIV collaborative activities			
Monitoring and Evaluation	**- National M& E framework is in place** **-** TB/HIV information inco-orperated in the national M & E framework - In -cooperate TB/HIV information in HTC,ART, TB, PMTCT registers - ART data clerks there is need for supervisors to guide and monitor and validate data before analysis - Recording and Reporting tools for TB/HIV in place.	- Strengthening of reporting and recording at clinic level i.e. documentation activities - Conducting joint supervision for TB/HIV activities - Ensuring quality and consistency data -Task shifting to allow nurses to focus on clinical duties - Research to facilitate evidenced based information and practical based on scientific rationale	Lay people may need supervision to ensure consistent and quality data	WHO URC	

Tanzania

Priority actions for accelerated implementation of interventions to reduce TB burden among PLHIV (Three Is for HIV/TB)

I. General actions for nationwide scale-up of TB/HIV activities

- **National targets**:
  - National target already set for various TB/HIV activities. Need to set annual meaningful target to achieve the goals.

- **Conducive policy environment**:
  - Debrief national TB and HIV program managers as well DPS to update on the meeting finding and develop action plan for implementation of the existing TB/HIV policy, especially Three Is. The policy ahs been printed and distributed to all the districts and the regions.
  - TB/HIV TWG currently oversees the TB/HIV activities. A formal Tb/HIV co-ordinating body will be formed.
  - HIV program will take responsibility of implementation of Three Is with technical support from Tb program.
  - Better planning and coordination for developing global fund proposals, national strategies.

- **Expanding HIV testing**:
  - HIV testing is currently being carried out by TB staff. TB/HIV policy mentions HIV testing for TB suspects but focus currently on TB patients. TB suspects will be covered under broader PITC roll-out.

- **Training & supervision:**
  - Need to harmonize HIV care & treatment training to include 3 Is.
  - Comprehensive TB/HIV training package already prepared and is being rolled out.
  - TB and HIV supervisory staff will be required to visit TB as well as HIV facilities during their supervisory visits. Joint supervisory visits will be piloted.

- **Implementing revised recording and reporting formats:**
  - TB registers already revised to include HIIV variables and rolled-out. All districts reporting using it. HIV R & R include some TB variables on patient card and pre-ART register but no reporting on regular basis.
  - TB variable will be incorporated in patient card, pre-ART and ART registers as well as reporting formats and progress monitored. Until the revisions are made a standard methodology will be developed and adopted to monitor progress with implementation of these activities.

- **Laboratory strengthening:**
  - National mapping of availability and need assessment of Diagnostic facilities already under discussion with USAID support and is part of national lab strategic plan.

II. Specific actions for intensified TB case finding

- Currently it is not mandatory to conduct TB screening as an eligibility assessment for ART. TB & HIV programs will discuss to include it in the TB/HIV SOP as well as HIV strategic plan.
- TB screening tool has already been developed. Algorithm for smear negative TB among HIV is being finalized. SOPs are in final stages of development. These will be dissemination widely. HIV care & treatment partners will be asked to mandatorily implement Intensified Tb screening at all the sites supported by them and progress monitored by NACP.
- To facilitate TB diagnostics at HIIV care and treatment centres, availability of smear microscopy is one of the criteria for selecting sites for CTC decentralization.
- HIV R & R tools will be revised as per new WHO M & E guidance to include TB variable in patient card. Registers as well as reporting formats, so that information is available at facility level and can be monitored at national level.
- Combined annual planning and review meeting by TB and HIV programs and stakeholders is not being done currently. Proposal to organize at least two joint review meetings in a year will be discussed with TB and HIV program managers.
- NACP training will be revised to include ICF, IPT, IC components, so that newly trained staff is comprehensively trained in TB/HIV. The CTC staff already trained on HIV care & treatment using the old training material will be trained with the HIV/TB training package.
- Develop national guidelines for improved referral systems.
    - Different models being used currently. TB/HIV referral form being used. Weekly meetings between HIV and TB staff to exchange information. Patient being personally walked to CTC/ TB clinics to ensure services. These different models will be documented and shared with the facilities so facilities can use the best approach for their situation. To improve ICF, TB suspect register will be piloted at few CTC with one of the track 1.0 partners to improve tracking of TB diagnosis and treatment.
- Currently discussions ongoing to include TB/HIV components in pre-service and in-service trainings.

III. Specific actions for Isoniazid preventive therapy

- NTLP and NACP have already agreed to implement IPT in HIV care and treatment services. Operational manual for IPT has been developed. It will be done at five sites as a demonstration early next year and scaled up at all HIV care & treatment sites based on operational aspects learnt at the demonstration sites.

IV. Specific actions for TB infection control

- NACP and NTLP are jointly developing national TB IC guidelines with assistance from ICAP. Draft document has been circulated for comments and is being finalized. Includes a facility assessment tool which forms the basis for developing infection control plan at the facility level. Infection control posters also developed which will be printed and disseminated to the facilities. SOPs to developed to assist facilities develop their own infection control plans. Plan includes forming an infection control committee at facility level.
- Finalization of these guidelines will be expedited and once finalized these will be

implemented at all HIV care and treatment facilities with the assistance from HIV care and treatment partners. Basic interventions not needing much resource will be prioritized and implemented nation-wide on priority.
- These guidelines will be coordinated with existing generic infection control guidelines.

V. Specific actions for monitoring and evaluation

- As a part regular supervision, staff will be mentored to use data generated at the facility level (currently not being done).
- Develop a system of providing regular feedback to health facilities that collect the data and use it for improvement of performance at local level. This will be done through the HIV care & treatment partners.
- Revised TB R & Rtools were rolled out in a phased manner. Now all districts use revised tool and report using revised formats. An evaluation is being planned in June 2009 and will include data quality assessment and validation of data both at TB and HIV sites.
- National targets already set, but no system for ongoing tracking of progress and adjusting targets annually in a realistic way. Targets will be set for the next year depending on current achievements and with final targets in mind.
- TB variable will be incorporated in patient card, pre-ART and ART registers as well as reporting formats and progress monitored. Until the revisions are made a standard methodology will be developed and adopted to monitor progress with implementation of these activities.

VI. Specific actions for integrated service delivery

- TB clinic staff is trained in HIV C & T and at least 4- TB clinics in each district are performing HIV testing in TB clinic. Efforts will be done ensure that all TB clinics are performing/ referring all TB patients for HVI testing.
- CPT is procured by TB program for HIV-infected TB clinics and provided at the TB clinic during the period of TB treatment.
- Temeke TB clinic has piloted provision of ART in TB clinic since July 2006. This model is being evaluated and based on report the model will be replicated in additional TB clinics. Renovations are already under way at 10 selected sites to prepare them in provision of ART in TB clinic. More clinics will be involved under global fund support.
- IPT operational manual is being finalized and IPT will be delivered as a part of HIV care program. INH will be procured and distributed by NTLP.

Uganda

I. Specific actions for intensified TB case finding

- Revise counselling policy to emphasize TB Screening at post test counselling
- Develop and ensure availability of simplified algorithms and job aids for TB screening and diagnosis in all HIV care facilities.
- Catalyse development of ICF IEC materials for PHA net work works
- Ensure that **all PLHIV in care** are screened for TB in assessing for ART eligibility and assessed for TB during each follow up visit
- Complete national mapping of diagnostic capacity for TB and HIV (Microscopy and HCT) and earmark resources to improve and establish diagnostic facilities depending on the assessment and need.
- Provide HCT and smear microscopy, for those with suspected TB
- Emphasize ICF to Basic care package
- Conduct integrated training to roll out ICF.
- Involve communities through VHTS to screen patients

II. Specific actions for Isoniazid preventive therapy

- Consultations to develop IPT policy

III. Specific actions for TB infection control

- Review policy on infection control with the view of incorporating TB infection control and PEP for HIV
- Develop infection control implementation guidelines
- Strengthen infection control committee to include HR bodies, bring environmental health on board

IV. Specific actions for monitoring and evaluation

- Establish national targets for the proportions of patients whose TB status is assessed in different settings.
- Conduct joint support supervision and biannual external review missions
  - *Encourage maximal use of 'one-stop' services depending on local situation and with due emphasis for TB infection control*
- Conduct combined annual planning and review meeting by TB and HIV programs and stakeholders at national level.
- Field test revised M& E tools
- Collect, Validate, Analyse and share data at National and district level
- **Need to link HIV and TB Data bases to be accessible for both programs**

V. Specific actions for integrated service delivery

- Develop a clear national directive where to provide ART for HIV infected eligible TB patients (either in ART or TB service, or in both delivery points). Also develop clear national directive where to start TB treatment when a patient on chronic HIV care is diagnosed of TB. Develop clear national directive to define which service will be

provided where? HIV testing and counseling, CPT, IPT,

- Advocate for adequate infrastructure and space for HIV counseling and testing at TB clinics and other point of care facilities
- Strengthen and conduct supportive supervision and clinical mentoring to ensure quality of care.
- Ensure that TB infection control is part of good clinical practice, and facility staff routinely adhere to such practices.
- If feasible, HIV testing should be done at point of care. When HIV testing is not available on-site at the TB clinic, the patient or the specimen should be referred to an HIV test site. While sending patients for test to HIV test sites strict infection control measures should be applied.
- Document best practices and lessons learnt on different modalities integrated service delivery
- Ensure uninterrupted supply of key TB/HIV commodities and supplies e.g. HIV test kits, INH, cotrimoxazole, etc at all service sites Define mechanisms for procurement and supply, and funding.

UGANDA PLAN TO ACCELARATE TB/HIV COLLABORATIVE ACTIVITIES WITH THE FOCUS ON THE 3IS

S/N	Activity		Quarterly Implementation 2008/09			
		Responsible person	Qtr 1	Qtr2	Qtr3	Qtr4
1	**Intesified Case Finding**					
1.1	Revise counselling policy to emphasize TB Screening at post test counseling		X	X		
1.2	Adapt and disseminate ICF tool		X			
1.3	Catalyse development of ICF IEC materials for PHA net work works				X	X
1.4	Involve communities through VHTS to screen patients			X	X	X
1.5	Emphasize ICF to Basic care package				X	X
2	**Isoniazid Preventive Therapy**					
2.1	Consultations to develop IPT policy			X	X	X
3	**TB infection Control**					
3.1	Review policy oon infection control with the view pof incorporating TB infection controlk and PEP for HIV		X	X		
3.2	Develop infection control implementation guidelines				X	X
3.3	Strengthen infection control committee to include HR bodies,bring enviromental health on board				X	X
4	**Monitoring and Evaluation**					
4.1	Set targets and agree on indicators for TB/HIV		X			
4.2	Field test revised M& E tools		X	X		
4.3	Analyse and share data at National and doistrict level		X	X	X	X
4.4	Internal and External TB and HIV program reviews					
4.5	Need to link HIV and TB Data bases to be accessible for both programs					
5	**Specific actions for integrated service delivery**					

5.1	Develop a clear national directive where to provide ART for HIV infected eligible TB patients. Also develop clear national directive where to start TB treatment when a patient on chronic HIV care is diagnosed of TB. Develop clear national directive to define which service will be provided where? HIV testing and counseling, CPT, IPT,		**X**	**X**		
5.2	Advocate for adequate infrastructure and space for HIV counseling and testing at TB clinics and other point of care facilities		**X**	**x**	**x**	**x**
5.3	Strengthen and conduct supportive supervision and clinical mentoring to ensure quality of care.		**X**	**X**	**X**	**X**
5.4	Ensure that TB infection control is part of good clinical practice, and facility staff routinely adhere to such practices.		**X**	**X**	**X**	**X**
5.5	If feasible, HIV testing should be done at point of care. When HIV testing is not available on-site at the TB clinic, the patient or the specimen should be referred to an HIV test site . While sending patients for test to HIV test sites strict infection control measures should be applied.		**x**	**x**	**x**	**x**
5.6	Document best practices and lessons learnt on different modalities integrated service delivery		**x**	**x**	**x**	**x**
5.7	Ensure uninterrupted supply of key TB/HIV commodities and supplies e.g. HIV test kits, INH, cotrimoxazole, etc at all service sites Define mechanisms for procurement and supply, and funding.		**x**	**x**	**x**	**x**

Zambia

Present: N. Kapata, M. Bweupe, A. Mwinga, A. Reid, Y. Kebede

1. **ICF**

Current situation:

- Guidelines developed at national level supporting ICF
- No much attention on screening so far so it is a strategy to be focused
- Plan to implement ICF in VCT, PMTCT, STI, ART services. 352 ART sites, 678 PMTCT sites.
- As part of Pre ART OI screening Tb screening is included. No clear record on TB screening activities.
- At PMTCT sites – screening guideline available but no recording and reporting
- STI – no specific clinic and integrated with general services (OPD 1400 sites), so should be seen how this could be integrated.
- VCT
  - Currently no systematic screening taking place, although passively done. Reflex CD4 count testing done.
  - There is no screening tool as part of the VCT register.

- Phased delivery for TB screening

Action point:

- Develop a Zambia TB screening tool; make use of existing tools (eg. ZAMSTAR)
- Protocol how the screening should be implemented in the specific setting. With emphasis to reduce drop out rate in PMTCT and VCT centers.
- Implement screening tool in PMTCT as a pilot in a couple of sites and consider scaling up. The challenge would be the referral process for TB diagnosis
- ART and VCT programs to include screening as mandatory with routine recording and reporting.
- As an action point targets need to be set based on the performance of the different services (PMTCT, VCT, ART).
- Ensure that the HIV/TB focal person (officer) a district level coordinate recording and monitoring including ICF activities in ART, PMTCT and VCT centers. Look at the existing HR structure and devise best way to ensure R&M.
- Find ways to integrate ICF at the community level through community activities eg. ZAMSTAR.
- Laboratory capacity strengthening, x-ray, culture need to be further considered.
  - Discuss and coordinate with existing lab strengthening activities. Look at possible funding with GF, PEPFAR. Round 8 GF applications has lab strengthening and approved make use the resources.
- Hold further discussion with different training institutions if the curriculum has been revised and look at the content and adapt on ICF.
- Community engagement: dialog with ZNAN (Zambian National AIDS Networks) so that the TB advocacy tools and protocols are in line with the national protocol

2. **M&E**

Current situation:

- Currently a Pre ART and Post ART register available. Not clear what elements are included on TB patient data.
- PMTCT registers capture TB patient data.
- SMART care system is currently used
- Dedicated HIV data entry clerks are available with ART partners. This has proved useful.

Action plan:

- Review the M&E system according to the revised WHO M&E system
- Integrate TB data collection with the SMART care system
- Explore possibilities to expand use data entry clerks.
- Review the supervisory system to ensure integrated supervision.
- Build capacity at the local level to expand the M&E capacity to include the 3Is within HIV/AIDS care.

- Expand the quarterly review meeting to include the 3Is

3. **IC**

Current situation:

- TBCAP supported IC training (TOT) in Botswana (4 participants). The action plan developed is being revised.
- TB/HIV subcommittee consultative group working on development of TB IC guidelines and implementation plan.
- There is a general IC service within the MOH that would be used to integrate TB IC planned activities.

Action Plan:

- Discuss with management at national level to include TB IC within the general IC plan.
- Link TB IC with general respiratory IC (Avian flue). Share experience and resources.
- Organize IC national consultative meeting which includes TB IC with all major stakeholders. Invitation to come from a higher level. Include MDR-TB and XDR-TB issues to form a basis for the consultative meeting.
- Focus on prioritizing the IC strategy according to the specific context. Start with basic and appropriate infection control plan.
- Put IC in the agenda of the HIV/AIDS program. The focus on PLWH on prevention of TB transmission in health care settings
- In parallel continue to develop the IC plan with the TB/HIV consultative group.
- Engage in discussion on occupational health and staff protection policy. Put this in the overall IC agenda especially of staff who are PLWH without stigmatizing them.
- Consider IC in other settings than HC facilities where TB transmission is happening in congregate settings like prisons etc.

4. IPT

Current Situation:

- Currently being implemented in ZAMSTAR sites.
- Plan to review the experiences and develop a national plan

Action point:

- Implement the experiences from ZAMSTAR to other non ZAMSTAR pilot sites.
- Review national guidelines on IPT for national rollout
- Plan a rollout of IPT nationally.

5. Specific actions for integrated service delivery.

Action plan:

- Work on proper documentation of the best practices and lessons learnt.