CIVIL SOCIETY TB/HIV UNGASS MONITORING COUNTRY REPORT

UGANDA
JANUARY 2010

"...Even People Living With HIV/AIDS forget about TB and concentrate on demanding HIV services only"

Commissioned by: **Treatment Action Group/ International Community of Women Living with HIV/AIDS–East Africa**

Conducted by: **Health Rights Action Group and the Coalition for Health Promotion and Social Development–Uganda**

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List of Abbreviations

AIDS:	acquired immunodeficiency syndrome
ART:	antiretroviral therapy
ARVs:	antiretrovirals
CDC:	U.S. Centers for Disease Control and Prevention
CSOs:	civil society organizations
CDR:	case detection rate
GFATM:	Global Fund for AIDS, TB, and Malaria
HAG:	Health Rights Action Group, Uganda
HCs:	health centers
HEPS:	Coalition for Health Promotion and Social Development, Uganda
HIV:	human immunodeficiency virus
ICF:	intensified case finding
ICW:	International Community of Women Living with HIV/AIDS–East Africa
IPT:	isoniazid preventive therapy
JCRC:	Joint Clinical Research Centre, Uganda
MDGs:	United Nations Millennium Development Goals
MDR-TB:	multidrug-resistant tuberculosis
MJAP:	Mulago Joint AIDS Program, Uganda
MoH:	Ugandan Ministry of Health
NGOs:	nongovernmental organizations
NACP:	National AIDS Control Project, Uganda
NLTP:	National Tuberculosis and Leprosy Programme, Uganda
NTP:	National Tuberculosis Program, Uganda
PEAP:	Poverty Eradication Action Plan, Uganda
PEPFAR:	U.S. President's Emergency Plan for AIDS Relief
PLWHA:	people living with HIV/AID
PLWTB:	people living with tuberculosis
TAG:	Treatment Action Group
TB:	tuberculosis
STIs:	sexually transmitted infections
STBP:	Stop TB Partnership
UNAIDS:	Joint United Nations Programme on HIV and AIDS
UNGASS:	United Nations General Assembly Special Session Declaration of Commitment on HIV/AIDS
USAID:	United States Agency for International Development
WHO:	World Health Organization

SECTION ONE: INTRODUCTION

Uganda is a landlocked country located in East Africa that covers 241,551 square kilometers. With its population growing at the rate of 3.2% per annum, Uganda has one of the highest growth rates in the world—higher than the sub-Saharan Africa average of 2.4%. The population of Uganda as estimated in 2007 was 28.4 million people[1](State of Uganda's population report 2007).

In 2008, UNAIDS estimated that as of December 2007 there were 940,000 people (range 870,000–1,000,000) living with HIV in Uganda. An estimated total of 135,300 people were newly infected with HIV, and there were 76,400 deaths due to AIDS [2](UNAIDS 2008; WHO 2009).

Uganda is ranked 16 among the world's 22 high-TB-burden countries and experiences enormous challenges associated with TB and HIV/AIDS coinfection. The WHO's 2009 report *Global Tuberculosis Control: Epidemiology, Strategy, Financing* estimates that the prevalence rate of all forms of TB in Uganda was at 426 per 100,000 people, with an incidence rate of 136 per 100,000 people**.** The TB case detection rate was indicated at 51%, which is far below the WHO global target of 70%. In addition, the treatment completion rate was estimated at 70%, and only 29% of those treated were cured. The same report documents that Uganda's default rate was the highest among the 22 high-TB-burden countries, at 13%.[3]
Approximately 50–70% of TB patients are coinfected with HIV [4](MOH-NTLP, 2006) and TB is the leading cause of death, causing nearly 50% of deaths among people living with HIV/AIDS (PLWHAs); see MOH-NACP 2006). According to the WHO's 2009 *Global TB Control* report, 38% of TB patients in Uganda are tested for HIV although the target is 100%. In addition, only 2.3% of TB/HIV coinfected patients are on ARVs (WHO 2009, p. 155).

Uganda is among the countries that endorsed the June 2001 UNGASS and April 2001 Abuja Declarations of Commitment to scale up HIV/AIDS prevention, care, and treatment toward universal access by 2010 and provide 15% of the national budget for health. To meet these commitments the country has developed the National HIV and AIDS Strategic Plan (NSP) 2007–8 to 2011–12, which is aligned with the country's Poverty Eradication Action Plan (PEAP). Pillar 5 of the PEAP is a further translation of Goal 6 of the Millennium Development Goals, which aims to halt and reverse the spread of both HIV and TB.

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[1] State of Uganda's population Report 2007 available at http://www.popsec.org/documents/State of Uganda Population Report 2007.pdf Accessed on 23rd February 2010
[2] World Health organization / UNAIDS 09 AIDS Epidemic Update Report available at http://data.unaids.org/pub/report/2009/jc 1700 epi - update 2009 –en pdf accessed on Feb 23rd 2010
[3] World Health Organization Global Tuberculosis Control Report available at http://www.who.int/tb/publications/global- en report/2009/pdf/full report.pdf accessed on Feb 23rd 2010
[4] Ministry of Health -, National TB and Leprosy Program quarterly reports 2008 TB/HIV data on All TB cases

Since May 2007, the International Community of Women Living with HIV/AIDS–East Africa (ICW) partnered with Treatment Action Group (TAG) to implement the African activities of TAG's TB/HIV Advocacy Project. The project empowers, trains, and supports African TB/HIV community advocates, community-based HIV activist organizations, and networks of PLWHA to incorporate TB/HIV priorities into their advocacy work. The advocacy objective is to advance the goals as outlined in the Abuja and UNGASS declarations, as well as relevant targets set by the *Global Plan to Stop TB 2006–2015*.

The ICW and TAG have coordinated to produce this monitoring report to assess the scale-up of TB/HIV services against indicators developed by UNAIDS; the TB and HIV departments of the WHO; PEPFAR; and the Global Fund for AIDS, TB, and Malaria (GFATM). The TB/HIV components of the UNGASS commitments were monitored in Kenya, Uganda, and Zambia. The ICW and TAG supported a team of activists in each of the selected countries . These teams collected data using a monitoring tool developed by the ICW/TAG project team.

This shadow report will be used to provide input into the official country report to UNGASS for 2009. Results from the report will be disseminated globally, regionally, and nationally to advocate for the scale up of TB/HIV services in these countries.

SECTION TWO: METHODOLOGY

Overview

Various methods were employed to collect the data. These include:

a) in-depth structured interviews with key informants
b) focus group discussions.

Primary data were gathered from Ugandan Ministry of Health personnel—specifically, the National Tuberculosis Program (NTP) and the National AIDS Control Project (NACP)—as well as district health officials, support groups of PLWHAs, the staffs of health centers, and the heads of TB and HIV units in selected health centers.

The assessment was commissioned by the ICW and TAG and was carried out by Ugandan TB/HIV activists from the Health Rights Action Group (HAG) and Coalition for Health Promotion and Social Development – Uganda. The ICW and TAG have trained these activists in both TB and TB/HIV science.

Respondents were either approached on a one-on-one basis or in mixed focus groups of male and female respondents. Focus groups comprised four to eight members. Focus group members were both PLWHA and people with TB disease accessing medical services from the selected health centers. Focus group discussions had both urban and rural respondents.

The assessment was conducted in the Kampala, Mpigi, and Wakiso districts, which were selected based on current statistics compiled by the NTP, which reflect that they have a high TB/HIV burden. Mpigi and Wakiso are also rural resource-limited settings while Kampala is a cosmopolitan city that is relatively resource rich.

The respondents were specifically selected to ensure that they were able to provide data in the subject areas being assessed. Support group leaders and hospital administration committees mobilized the respondents, as they were more knowledgeable of the people and settings.

Scope

As noted above, the districts were chosen because of their high TB/HIV burdens but also because they have congregate settings (prisons, army barracks, etc). However, the team was not able to access the congregate sites due to bureaucratic obstacles.

In-Depth Interviews

In-depth interviews were held with MoH officials, including NTP personnel, the National TB/HIV and AIDS coordinator, and district officials who included a district planner who is also the HIV/AIDS focal person (a person instituted by the Central government and is responsible for the HIV/AIDS response at the district level). Uganda has level III and level IV heath centers (HCs). Level III HCs are those that only have a clinical officer, a midwife, and a laboratory. They do not provide ARVs, but carry out sputum-smear TB tests and give TB treatment. Level IV HCs have a resident doctor who is able to diagnose opportunistic infections and administer ARVs as well as TB treatment. At level IV HCs there are minitheaters in which minor surgery is performed. They are also supposed to have X-ray machines, but the majority of them do not. At the five health centers (levels III and IV), the team interviewed those in charge and the heads of the TB and HIV units.

The monitoring team used a questionnaire (see appendix II). Each category of respondents—HIV clinic officials, TB clinic officials, TB and HIV policy makers, and people infected/affected by HIV and/or TB—had its own set of questions. More than one person from each team recorded the proceedings to ensure accuracy and consistency.

Focus Group Discussions

Three focus group discussions were held in three health centers. Two of these were urban health centers, and one was in a rural setting. The number of respondents who participated in the group discussion at a given time ranged from four to eight people. The groups comprised both men and women, and people who were on treatment for TB, HIV, or both. The questionnaire that assessed the perspectives of PLWHA who were coinfected with TB on the availability of TB and HIV collaborative services was used to facilitate the group discussions.

Limitations

- The team could not access prison hospitals because of bureaucracy, and as such was not able to document the level of accessibility to TB/HIV services in these institutions that could potentially have a high burden of TB/HIV and a high risk of transmission for both diseases.

- The team realized that people mainly seek services from private and mission health facilities that are assumed to have better services and facilities. Nongovernmental organizations (NGOs) have facilitated peoples' access to TB/HIV treatment, and these are based in the private and mission health facilities. As a result, it was a challenge getting many respondents who receive TB/HIV services from public health clinics.

- Limited resources and time constraints prohibited the team from including wider geographic coverage in this report.

SECTION THREE: FINDINGS

I. Findings from HIV Health Facilities and Hospitals: Assessing the Availability of Services for Decreasing the Burden of TB among People Living with HIV

The team visited five health centers (HCs) and one national referral hospital (Mulago Hospital) in three districts: Kampala, Mpigi, and Wakiso. The team included only public health facilities that provide care for both HIV and TB.

District	Number of HCs
Kampala	3
Wakiso	1
Mpigi	1

Intensified Case Findings at Health Facilities

All four HIV clinics reported screening PLWHA for TB symptoms every time patients come for care and treatment. Most clinics have monthly appointments for clients and one clinic day a week. HIV counseling and testing is free of charge at all public health facilities.

At one health centre, the person in charge reported, "There is no written policy on how often a person should be screened, but the HIV patients have cards that have a question on access to TB screening every time a patient comes in to the clinic."

All five HCs visited had laboratories that carry out sputum-smear tests. Their biggest challenge was access to reagents, and personnel to perform the tests. One level III health center in the Mpigi district had its laboratory closed down due to lack of a technician. None of the centers other than Mulago hospital had X-ray services.

HIV-positive patients suspected to have TB but who have a negative sputum-smear result must travel long distances for X-rays to rule out TB disease, with the longest distance being in Mpigi, where the patients were referred to Gombe hospital 30 kilometers away. The average distance was at least 13 kilometers.

All the health workers interviewed reported no follow-up on referrals, as there was no mechanism put in place for follow-up on patients for further diagnosis.

The team attempted to assess the total number of adults and children enrolled for HIV/AIDS care in each clinic in the last quarter for which data were available (July 1–September, 30 2009 or April 1–June 30, 2009).

There were no uniform data available. However, 246 adults and children were enrolled for HIV/AIDS care at the level IV Mpigi HC in April–June 2009. In August 2009 at the level III Kiswa HC, 2,069 people were enrolled for HIV/AIDS care. In the level IV Wakiso HC, 1,200 adults and children were enrolled for HIV/AIDS care for the period June–September 2009.

The team attempted to document the number of adults and children enrolled for HIV/AIDS care that had their TB status assessed and recorded during the most recent quarter.

Uniform data were not available that covered the same period from all the health facilities visited; therefore it was not possible to calculate the general percentage of the number of PLWHA who had their TB status assessed. However, at the level IV Mpigi HC, out of the 246 cases of adults and children enrolled for HIV/AIDS care for the period April–June 2009 all had their TB status assessed, and 28 were suspected to have been infected with TB and were referred for diagnosis.

At the level IV Kawempe HC there were 463 adults and children whose TB status was assessed and recorded, with 82 having a smear-positive test result for the period June–August 2009.

One nursing officer at the level IV Wakiso HC's HIV clinic informed the team that each month the clinic provides services to an average of 250 HIV-positive patients, and there is 100% TB assessment.

The team assessed the success of working with other public NGOs in the high-TB/HIV-burden setting to conduct intensified TB case findings.

Two of the four HIV clinics assessed reported partnering with PEPFAR and CDC/USAID-funded projects like the Mulago Joint AIDS Program (MJAP), the Ugandan government's Infectious Disease Institute, its Joint Clinical Research Centre (JCRC), and the Baylor College of Medicine. None of the NGOs mentioned above carried out active case finding, however, and were only able to offer HIV/AIDS services to those that were already identified at the HCs.

None of the four HIV clinics visited reported working with other public/private/nongovernmental organizations in high-TB/HIV-burden congregate settings like prisons to conduct intensified case findings.

In the Mpigi district, it was reported that village health teams are used to provide education on TB infection control in the villages.

TB Treatment

It was not easy to obtain statistical data that would enable the team to calculate the percentages of PLWHA on TB treatment. Nevertheless, the table below contains the data that some clinics were able to provide.

Clinic	**Total no. of patients in HIV care**	**Patients on ART**	**Total number of patients on TB treatment or care**	**Percentage of PLWHA enrolled for TB treatment**
Mpigi	243	53 (50 adults and 3 children)	17 (14 Adults and 3 children)	6.9%
Kiswa	2,076	530	Data not provided	Data not provided
Kawempe	463	Data not provided	82 adults	17.7%
Mulago (TB clinic)	Data no provided	Data not provided	Data not provided	On Fridays, all HIV/TB patients are given TB treatment.
Wakiso	1,200	140	21	1.75%

All four HIV clinics that were assessed reported referring PLWHA with TB Disease to TB clinics within the same facility. The one exception was Level IV Wakiso HC where the TB clinic had been closed due to lack of personnel and the HIV positive clients who had also been diagnosed with TB had to access TB treatment from the HIV Clinic,

None of the four HIV clinics assessed provided treatment for drug-resistant TB other than the level IV Mpigi HC, which had offered multidrug-resistant TB (MDR-TB) treatment to two patients with support from the JCRC. One patient, a young girl, passed away before completion of treatment, while the other was reported to have recovered after successful treatment. However, the JCRC has scaled down its MDR-TB related activities and is no longer active at the center. The other three HIV centers visited referred drug-resistant TB patients to the national TB clinic at the Mulago hospital, which unfortunately does not provide MDR-TB treatment. All in all, it was acknowledged that MDR-TB treatment is quite inaccessible in Uganda.

Provision of Isoniazid Preventive Therapy

None of the four clinics assessed during this monitoring exercise provided isoniazid preventive therapy (IPT) as part of a package of care for PLWHAs.

The main obstacles mentioned by the HIV clinics for not providing IPT were:

- Isoniazid, a key first-line drug for TB, is not readily available for HIV clinics. Uganda is prone to medicine stockouts.
- The clinics noted that in July–August 2008 and December 2008–January 2009, they experienced stockouts for first-line TB drugs.
- There is a lack of diagnostic tools for effectively identifying all cases of active TB disease.
- Fear of creating resistance to isoniazid.
- Health workers lack information on IPT.

Infection Control Measures in HIV Health Care and Congregate Settings

The team assessed the number of HIV clinics with infection control plans.

All four HIV health clinics visited reported having infection control plans, though such plans did not exist in writing.

The HIV clinics surveyed implemented infection control strategies:

- Patient flow in the clinics was regulated by giving patients specific appointment days.
- Patients visiting the HIV treatment center who had TB symptoms were separated from those without symptoms. Those with symptoms were sent for TB screening.
- Two of the health care clinics, Wakiso level 111 and Mpigi level IV had waiting rooms set in open spaces or outside on the verandas of buildings however in the level III Kiswas HC and level IV Kawempe HC the waiting rooms were small rooms with inadequate ventilation
- Sputum collection rooms were well ventilated to reduce exposure to TB for people accessing other services at the clinics.

- Patients were educated on infection control measures on HIV clinic days at most centers.

HIV clinic staffs were not, however, frequently trained in infection control measures. Of the four HIV clinics assessed, only one (the level IV Wakiso HC) reported having sent one staff member to be trained

None of the four HIV clinics monitored reported to be working with other public/private/nongovernmental organizations based in high-TB/HIV-burden congregate settings to provide education on TB infection control

Support to Health Care Workers in High-TB/HIV-Burden Settings Who Provide Care to Patients

In all four HIV clinics visited, those in charge indicated that the environment did not enable or encourage health workers to share information about their own TB or HIV statuses. When the team raised this lack of a deliberate policy to protect health workers in high TB/HIV settings, one person in charge said, "You have opened my eyes, I need to do something about it."

Out of the 96 health care workers who were reported to provide care to PLWHA at the health facilities visited in the most recent quarter (July–September 2009), there were no reports of a case of TB disease. One of the major issues pointed out was the secrecy by the health workers about their health status. Noted a nursing officer at the level III Kiswa HC, "You cannot tell when a fellow staff [member] gets TB or is on TB treatment. We tend to hide our health problems from our fellow staff and seek treatment outside the place of work."

Of the four HIV clinics visited, three facilities reported having put in place the following measures to protect health care workers who work with PLWHA from TB infection:

- Ensuring patient flow and a waiting area outside the clinic to avoid overcrowding in the clinic.
- One clinic (the level IV Kawempe HC) reported providing TB treatment for staff with confirmed diagnosis of TB disease, but there were no reported workers with TB disease for the period July–October 2009.
- Providing regular and confidential screening for TB for health care workers in the HIV care centers, including nurses and counselors. "Every morning, I pray to God to protect me," one health officer from Wakiso reported when asked about a personal infection control strategy.

II. Findings from the TB Health Centers and Hospitals: Availability of Services for Decreasing the Burden of HIV among People with TB Disease

HIV Testing and Counseling for TB Patients

Two out of the five health facilities visited by the team (including the level III Kiwonga HC in the Mpigi district, which did not provide any data) did not have separate TB clinics. Lack of TB facilities was linked to a shortage of health care workers who could staff these clinics.

The Mulago TB clinic reported HIV counseling and testing of its TB patients. The other three clinics referred patients to a separate HIV clinic for testing, which is done at no cost. Though the HIV test facilities were located in the same health center, additional delays in getting HIV testing were identified as a barrier to access.

At the HCs that did have TB clinics, TB treatment and care was carried out in the HC and in a general outpatient clinic. Most referrals were within the same health facilities—from the TB clinic to HIV clinic, and vice versa.

Out of four TB clinics visited, two reported having TB registers that also capture the HIV status and HIV treatment regimen of the individual. "Most of the patients that come to the TB clinic have HIV results, but sometimes I do not record them on the TB register due to being overworked, I handle this clinic single-handedly" one health worker reported.

Provision of HIV Prevention Methods at TB Clinics

TB clinics reported providing the following HIV prevention strategies to TB patients who are at risk of HIV;

- referrals for TB patients to get condoms from HIV counselors
- programs that educate and promote safer sex practices
- information and referral for partner testing for HIV
- positive-living talks for those already living with HIV

Provision of Cotrimoxazole Preventive Therapy at TB Clinics for PLWHAS

In the three districts assessed, all the TB clinics referred HIV-positive patients with TB to the HIV clinic to access cotrimoxazole preventive therapy (CPT).

The main barriers to the provision of CPT to HIV-positive TB patients reported by the TB clinics are:

- Stockouts of cotrimoxazole. It was reported that at times patients are told to go and buy it.
- Having to refer patients to an HIV clinic that may not be open at that time of the day.

Provision of HIV Care and Support Services at TB Clinics for TB/HIV Coinfected Patients

The following care and support services are provided by the TB clinics to people coinfected with HIV and TB in the three districts visited:

- Educational talks promoting the importance of nutritional support and hygiene.
- TB/HIV care and treatment education for home-based care providers(reported in the level IV Mpigi HC, through the use of village health teams).
- Psychosocial support, such as counseling and sharing through encouragement of community support groups.
- Treatment adherence education for both TB and HIV treatment, and monitoring of adverse effects.

Provision of ART to HIV-positive TB patients

Out of the four TB clinics assessed, one—the Mulago TB clinic—reported that ART was available for HIV-positive TB patients. At the Mulago clinic ART was initiated at a CD4 count of 250/m^2l or below. However, for the other three TB clinics assessed (the Kiswa, Mpigi, and Kawempe HCs), ART was not available and clients had to be referred to the HIV clinic within the same facility. .

Since ART is not provided in most TB clinics, the health care workers interviewed were not aware of the numbers of TB patients initiated on ART in the most recent quarter (July–September 2009). "I cannot tell the numbers initiated on ART. I only refer patients to the HIV clinic and cannot follow up on what happens in the HIV clinic," said one nursing officer from the Kiswa TB clinic.

III. Questionnaire to Assess Establishment of TB/HIV Policy and Its Implementation: Questions Asked of Policy Makers

Does the Country Have a Policy or Guidelines on TB/HIV Collaborative Activities?

Two of the three policy makers questioned knew about the existence of a TB/HIV collaborative policy and its components in Uganda. One of the policy makers who did not know about the country policies was a district HIV/AIDS focal person; this clearly shows that there is an information gap between the national and district levels regarding awareness of TB/HIV policies. The district officials who are mandated to implement this policy have very limited to no knowledge about the existence of the policy.

Which Components Does the TB/HIV Policy Contain?

An officer working with the NTP could confirm that the policy existed and listed the following components:

- A joint coordinating board was established. It is comprised of civil society organizations (CSOs), the NTP, and the NACP and is coordinated by the Ugandan Stop TB Partnership—specifically its TB/HIV working group. This working group was mandated to create a joint plan, as well as to coordinate and budget for the collaborative TB and HIV activities.
- Both the NTP and the NACP are involved and consulted by the joint coordinating board.
- Periodic HIV prevalence studies are conducted among TB patients.
- The are efforts to ensure that advocacy, communication, and social mobilization for HIV includes TB information, and vice versa.
- Intensified case finding (ICF) for TB among PLWHAs, and vice versa, is performed. It was noted that although TB units actively screen for HIV, the HIV unit is not so vigilant in screening for TB. Some health care workers look at this as an addition to their already large workload. The official from the NACP that the team talked to said, "The Ministry of Health encourages recruiting and training PLWHA as expert clients or patients to help the medical personnel to do some of the work like health education, counseling, follow-up of patients and screening people at the health facilities for TB, among others."
- ART is provided to all HIV-positive TB patients in accordance with national protocol, including TB/HIV and ART policies.
- HIV-positive TB patients have a full continuum of HIV care and support services.
- CPT is provided to all HIV-positive TB patients.
- Access to diagnosis and treatment of TB is part of the basic package of care for PLWHAs.
- Routine counseling and testing for HIV is offered to all patients with confirmed TB disease.

The Government of Uganda is currently developing Infection Control (IC) guidelines. The issue of IPT is controversial in Uganda but is currently being piloted at the AIDS Information Center. Policy makers have fears that if IPT is implemented, PLWHA may develop resistance to isoniazid. Furthermore, the drug stockout problem that has persisted in the country would also make access to IPT difficult. Uganda does not currently have tools to diagnose latent TB infection; this is also barrier to the roll-out of IPT. Therefore, policy makers do not consider IPT easy to administer.

It was noted that CPT administration is also a big challenge due to constant stockouts of cotrimoxazole at health centers and hospitals.

What Mechanisms Have Been Put in Place to Ensure That Policy Is Being Implemented?

According to the policy makers interviewed, the government of Uganda has established the following mechanisms:

- Quarterly joint coordination meetings.
- A communication strategy for the implementation of the policy.
- Joint planning is emphasized to ensure that NACP plans include TB and that TB plans include HIV components at the national level.
- There is joint resource mobilization for collaborative activities for TB and HIV.
- A plan is in place to involve affected communities in the implementation and monitoring of collaborative TB/HIV activities.
- Plans are developed for joint operational research in the TB/HIV collaborative activities.
- Joint monitoring and evaluation plans have been developed, and activities are carried out jointly. The indicators developed have implications for both TB and HIV. Capacity building is carried out for district health managers and PLWHA to ensure that there is effective delivery of services.

What Is the Total Number of HIV Centers in Uganda?

Currently, Uganda has 453 accredited centers for ART, but the officers the team talked to did not have accurate figures on how many provide TB treatment, screen for TB in HIV-positive adults and children, provide IPT, or have functional TB infection control policies especially in congregate settings.

Out of the Total Number of HIV Centers in Uganda, How Many do the Following?

1. Regularly screen for TB in HIV-positive adults and children?
The respondents did not know the answer.

2. Provide TB treatment for PLWHA diagnosed with TB disease?
The respondents did not know the answer.

3. Provide IPT to PLWHA who are latently infected with TB and to children under age five who are household contacts of someone with TB disease?
The respondent(s) did not know the answer.

4. Have implemented TB infection control policies in high-burden HIV congregate settings?
The respondents did not know the answer.

It was noted that development and implementation of an infection control plan is constrained by lack of funds and skills. The national TB/HIV coordinator expressed fear of lack of skills by health care workers to implement the policy once it is in place.

Has Uganda Developed a Strategy for Addressing TB and HIV among the Vulnerable Communities That Include PLWHAs, Children, and People in Congregate Settings?

It was noted that in Ugandan TB/HIV policy there is a component aimed at addressing TB and HIV among vulnerable communities like PLWHA and children. However, it was not clear if a deliberate strategy has been developed for people in congregate settings like prisons, schools, and brothels. It was, however, noted that there are specific vulnerable communities in different districts that are hard to reach. Such communities have been left out of the planning and resource-allocation processes. These include communities of pastoralists, fishing communities, people living on the islands in Lake Victoria, and people living around forest areas in the Mpigi district. None of the district officials interviewed knew whether special attention was being accorded to such high-risk settings. Children involved in bricklaying or those living near bricklaying areas in the Mpigi district are considered a high-risk group but have also been left out.

What Challenges Are There in Implementing a TB/HIV Collaborative Policy

The policy makers mentioned the following challenges:

- Respondents from both the TB and HIV groups mentioned that joint TB/HIV collaborative activities are very expensive to coordinate, implement, and monitor.
- There is a lack of collaboration and planning between health departments and local governments at the district level. It was noted that since health department priorities may differ from those of local governments, the latter might not allocate sufficient resources for TB and/or HIV.
- In terms of resource allocation by partners, there is unequal distribution of resources between TB and HIV, with a tendency to focus more on HIV than TB. One official mentioned that this has resulted in PLWHA themselves putting more emphasis on HIV and downplaying TB. He commented, “Even PLWHA themselves forget about TB and concentrate on demanding for HIV/AIDS services only.”
- Human resource constraints—that is, a limited number of medical workers. This is worse in remote rural areas where fewer incentives exist for health care workers.
- Stigma and discrimination are still rampant. This was seen specifically in the case of health care workers who were not willing or able to share their health information with their clinic authorities.
- TB has been handled as a medical issue and not a social issue. This has led to communities not being aware of what their roles and responsibilities are in preventing and managing the disease.
- Poor road infrastructure makes it difficult for both the TB and HIV programs to reach the most vulnerable communities.
- Food insecurity has greatly contributed to poor health among the people—especially in 2009, when many parts of the country were hit by famine. Policy

makers urge that medical services should not be looked at in isolation but should be seen in relation to the overall environment that has a direct implication on peoples' health. One official said, "Even with the best medical services and facilities, without good nutrition, one's health may not improve."

- Sub–county level planning is done without the knowledge or cooperation of the district council executive. It was noted that there is lack of cohesion among the various districts.
- Stockouts of drugs in the country and limited supplies for TB laboratory reagents. Sometimes NGOs provide the reagents, but they are also unable to fully resolve the issue of insufficient reagents.
- Limited inclusion of all stakeholders affects sustainability and continuity of programs. For instance, the lack of involvement of affected communities of PLWHA and people with TB disease may impede advocacy for increased resources for TB and/or HIV.
- CSOs have limited interaction with district health officials, and carry out their planning activities without involving the districts. District officials feel that they could advise CSOs on resource allocation and utilization, but note that they are never consulted.
- Poor resource allocation for the health budget at the district and national levels. For instance, from the NTP, the team learned that the 2008–9 fiscal budget had US$31.5 million allocated to HIV and approximately US$1.05 million allocated to TB. Even this latter allocation was not fully disbursed to the NTP.

What Specific Challenges Exist for the HIV Program in Implementing TB/HIV Collaborative Policies?

- There is limited funding for community-based organizations formed by PLWHAs, yet there is a lot they can do around social mobilization.
- Existing PLWHA networks lack technical information and support for resource mobilization to compete favorably for funds from donors and government.
- Limited involvement of PLWHA in implementation of HIV related activities.
- Limited information and capacity round TB/HIV issues for HIV program managers.
- District-based HIV focal persons and CSOs working on HIV/AIDS projects are not in communication with each other. As a result, the district is not aware of the CSO work in the district.
- Human resource constraints (which can be partly addressed by engaging expert clients).
- Top management accesses training opportunities, yet the lower-level staff that does most of the work need them as well.

What Specific Challenges Exist for the TB Program in Implementing TB/HIV Collaborative Policies?

- Most of the programs are biased toward HIV/AIDS and leave out TB.
- Consistent drug stockouts of first-line TB drugs.

- Lack of funding allocated to TB (US$1 million was allocated in 2008–9 but not disbursed).
- TB focal persons are not members of the district HIV/AIDS committees. This lack of involvement creates a gap in planning and resource allocation.
- There is no joint planning between TB and HIV focal persons at district levels. As one HIV focal officer at the district level commented,"Personally, I did not know the TB program manager until one year ago, when I met him."
- In schools, health awareness programs concentrate on HIV and never talk about TB.
- The police and prison systems have been centralized so that districts have been left out of their management. Even when districts are in a position to design programs, they are constrained because of the newly created administrative structures of these two institutions.
- Human resource constraints.

What are the overall achievements?

- Uganda has a TB/HIV collaborative policy.
- There is joint collaboration between HIV and TB programs at the national level.
- Capacity of health care workers in managing TB/HIV service delivery has been jointly built to some extent by the government and CSOs.
- Seven regional referral hospitals have been facilitated by the government to become one-stop centers for TB/HIV services.
- Involvement of CSOs has been enhanced through the joint coordination board and the Uganda AIDS Commission.
- Vibrant CSOs involved in HIV can be further strengthened to address TB/HIV resource advocacy for programs.

IV. Assessing the Perspective of Persons Living with HIV/AIDS and TB on the availability of TB/HIV Collaborative Services

Awareness of the Existence of TB/HIV Collaborative Policy

Apart from one interviewee, all the affected community members—PLWHA and people living with TB disease (PLWTBs)—had no knowledge about the existence of TB/HIV collaborative policy in the country. There were eleven affected community members interviewed in three districts.

There was a moderate degree of awareness of health centers where TB and HIV treatment was available. Five of the interviewed persons had knowledge about HIV treatment centers other than the one at which they were being given HIV care and treatment. These respondents were from the urban center—specifically, from the Mulago TB clinic. Other PLWHA and PLWTB interviewed could not name more than two centers that provided HIV and TB treatment in their district.

None of the PLWHA or PLWTB had any knowledge about the provision of IPT for latently infected PLWHA who are coinfected with TB or for children under five years of age who are in close contact with someone with TB.

In addition, the PLWHA and PLWTB interviewed didn't know whether Uganda has a strategy for addressing TB/HIV among vulnerable persons such as children, PLWHAs, and people living in congregate settings like prisons and schools. In Kawempe, members of the Mama's Club support group had never seen the health workers organize an outreach to any nearby schools.

TB/HIV Universal Access in HIV Care Settings

Intensified Case Findings in HIV Treatment Clinics

The HIV clinic providers and affected community members differed in their assessment of the availability of proactive screening for TB among persons living with HIV. Though HIV clinic staff stated they routinely screened for TB at all clinic visits, most of the affected members stated that they were only screened for TB when they brought up the fact that they had a cough. One member of the Mama's Club support group stated, "It's only when you raise the issue that you are coughing that they screen you for TB."

Respondents were asked whether the HIV clinic they attend most have a policy on screening PLWHA for TB symptoms.

It seems that all HIV clinics have a policy of referral for TB diagnoses. Most of the affected community members could not tell the proportion of PLWHA referred from the HIV clinic for TB diagnosis.

However, all people interviewed agreed that the HIV clinic refers people with TB symptoms for confirmation of TB diagnosis either to the laboratory within the center or refers the patient for chest X-rays to the nearest public health facility or to a private clinic.

Some participants of a focus group discussion in Kawempe estimated that only 25% of the people that are referred follow through to get TB diagnosis. When asked how they knew this, the response was that during clinic days they discuss and share information about such topics among themselves.

TB Treatment

Regarding accessibility of TB treatment in HIV clinics, the PLWHA interviewed reported that the HIV clinics they go to most frequently provide first-line TB treatment for PLWHA diagnosed with TB when the drugs are available. Most HCs have two separate clinics for TB and HIV, and the HIV clinic will refer the patients to the TB clinic to collect their medicines.

The PLWHA interviewed were not in full agreement about whether TB treatment was recorded on either the ART/pre-ART registers or their ART treatment cards. Some patients were not aware of whether it is done, while other respondents mentioned that it was recorded.

All PLWHA interviewed did not know of any HIV clinic within the three districts that provides treatment for drug-resistant TB.

All of the PLWHA interviewed said that none of the clinics provided information on IPT or offered it as a package of care to PLWHA who are latently infected with TB.

Those interviewed were not aware of whether most HIV clinics have infection control plans or not. However, they named a number of common infection control measures that they had observed:

- Patient education on infection control measures (such as coughing etiquette) is done on clinic days.
- Patient flow in clinics is regulated.
- Waiting areas in open space or outdoors to allow air circulation/
- Using masks/handkerchiefs to cover the mouth and nose.

However, IC is not practiced consistently in all TB clinics. As one of the focus group discussion participants at Kawempe HC commented, "The TB room is very small and squeezed, with no window; there are no infection control measures."

The people interviewed were not aware of whether the TB clinics partner with NGOs to provide education on TB infection in congregate settings.

TB/HIV Universal Access in TB Care Settings

HIV Testing and Counseling for TB Patients
Some respondents who had TB disease reported that their TB clinics refer them for voluntary HIV counseling and testing which is carried out at the HIV clinic within the same health facility. The monitoring team also learned that there was no follow-up to ensure that those referred had gone to the HIV clinic.

Provision of HIV Prevention Methods at the TB Clinic
PLWTB mentioned that there were no HIV prevention methods at the TB clinics. However, the affected members were referred to HIV clinics where they received the following:

- provision of condoms (at times)
- education on positive living for those with HIV
- promotion of partner testing for HIV infected patients
- education programs promoting safer sex practices

Provision of CPT

All the PLWTB interviewed said that that their TB clinics do not provide CPT for their HIV-positive TB patients, and that they got their CPT from the HIV clinic.

The HIV prevention and care services that were reported by PLWTB at clinics included:

- promotion of nutrition support and hygiene
- psychosocial support
- treatment adherence information for both TB and HIV treatment

The TB clinics referred people with TB and HIV to the HIV clinics for the following services:

- TB/HIV care and treatment education for home-based care providers
- follow-up on opportunistic infections and palliative care

SECTION FOUR: KEY OBSERVATIONS, A BEST PRACTICE, AND RECOMMENDATIONS

Key Observations about the Availability of TB/HIV Services

1. Uganda has in place a TB/HIV collaborative policy but information about it has not been disseminated. To a large extent, both health care workers and the public interviewed were not aware of the policy.
2. Though HIV and TB clinics are often located close to each other and refer patients to each other, no patient information is shared between them and health care workers in each of the clinics continue to operate without all the relevant information needed to provide appropriate care. Systems of information sharing need to be implemented that also address the confidentiality concerns of the patients.
3. TB treatment and care is still medicalized, while HIV care and treatment has moved out of the health care setting into the community. This has led to more people being aware of HIV than TB.
4. Joint planning by HIV and TB departments is evident at the national level, but not at the district and lower levels. This disjointed relationship had led to districts having less information about national TB/HIV policies.
5. The MoH and the government of Uganda need to scale up lab capacity so that health centers providing sputum-smear tests for TB can also do chest X-rays to minimize the loss of patients as a result of referral to other clinics that are not close by.
6. The availability of TB/HIV services is hampered by drug stockouts—primarily of TB drugs and cotrimoxazole.
7. TB programs lack adequate funding and need more political will to prioritize them and ensure adequate funding for staff and infrastructure. Most health care workers shun working in TB clinics and prefer HIV clinic work.
8. Intensified TB case finding among people with HIV needs to be done regularly and proactively. Though health care workers stated they were undertaking such case finding, people with HIV and TB said that they were only screened reactively after they self-reported TB symptoms. Similarly, infection control was also not consistently implemented. Isoniazid preventive therapy was not offered at all.
9. There is no follow-up mechanism to trace TB patients who are defaulting on TB medications, including those who are also on ART.
10. There is a lack of health personnel in health centers—for example, the level III Kiwonga HC, where the laboratory was closed due to lack of personnel.
11. Capacity-building opportunities go to top management staff in HCs or hospitals and these opportunities also need to be shared with the lower-level level staff that implement these programs.
12. TB has not received as much media attention as HIV, and as a result the public has put not enough emphasis on it.

A Best Practice

The TB clinic within Mulago Hospital, which is the national referral hospital, runs a TB/HIV clinic once a week. It offers both TB and HIV services other than CPT to TB/HIV patients so that they do not have to move from one clinic to another. The MoH's TB and HIV programs in all health facilities should replicate this best practice.

Recommendations

1. There is a need to consolidate planning for TB and HIV from the national to the district health center levels: government should ensure that this is done.
2. Greater collaboration in patient follow-up is needed between HIV clinics and TB clinics within HCs.
3. Provision of IPT is needed, especially to health workers working in high-TB/HIV-burden settings and for PLWHAs.
4. There is an urgent need to address medicine stockouts via review—on the part of the MoH and the National Medical Stores—of the current drug supply and distribution chain.
5. There is need to scale up proactive TB screening at HIV clinics.
6. The MoH needs to devise a plan to increase the numbers of health care workers within the clinics, including lab technicians, so that these units are able to effectively respond to growing numbers of clients and their needs.
7. The MoH and its NTP program needs to address the growing MDR-TB problem in Uganda by providing diagnostics and treatment.
8. Though the government is to be commended for taking up the fight against corruption by dealing with those health care workers who have been implicated in drug theft, this needs to be scaled up to ensure that limited drugs available reach those who most need them.
9. There is a need to provide support such as training for program implementers, to ensure their ability to scale up TB/HIV collaborative activities.
10. The HIV and TB clinics need to put in place support mechanisms and an enabling environment in which all health care workers who are infected with TB and/or HIV may access services within their clinics without fear of stigma.
11. Dissemination of the TB/HIV collaborative policy to all involved in care provision and management, including the affected communities, is crucial.

Conclusion

This report has highlighted the key TB/HIV issues and gaps in service delivery that all private, public, and civil society organizations in Uganda have reported in the fight against HIV and TB. The Ugandan government and its Ministry of Health need to urgently address these issues. There needs to be a scale-up of TB/HIV service delivery in order to reduce morbidity and mortality due to TB infection among PLWHAs. There is also need to enhance partnerships among TB/HIV policy implementers, health clinic staff, civil society, and policy makers in order to effectively address the issues that have been identified if TB is to be eradicated from Uganda.

Appendix I: List of Interviewees

Ministry of Health Officials

1. Dr. Eric Ikona – National TB/HIV Coordinator
2. Dr. Frank Mugabe – National TB Program staff

District Level

1. Mr. Paul Kirabira – District Planner and HIV/AIDS Focal Person (Mpigi)

APPENDIX II: TB/HIV UNGASS Monitoring Tool

TB/HIV UNGASS Monitoring Tool
Introduction
International Community of Women living with HIV/AIDS (ICW) Eastern Africa has partnered with Treatment Action Group (TAG) since May 2007 to implement the African activities of TAG's TB/HIV Advocacy Project. The objectives of the project are to empower, train, and support African TB/HIV community advocates, community-based HIV activist organizations, and networks of people living with HIV/AIDS (PLWHA) to incorporate TB/HIV priorities into their advocacy work. These objectives are intended to advance the goals related to scale-up of HIV/AIDS prevention, care and treatment toward universal access by 2010 as outlined in the 2006 Abuja, G8, and UNGASS declarations, as well as relevant targets set by The Global Plan to Stop TB 2006-2015.

ICW and TAG are coordinating a report aimed at assessing the implementation of the TB/HIV indicators included in the UNGASS and the 3 X 5 commitments in Kenya, Uganda and Zambia. This civil society shadow report will reflect the extent to which these countries are achieving the Universal Access goals for TB/HIV treatment, care, and prevention by 2010. ICW and TAG will be working with a team of activists in each of the selected countries who will form country teams to carry out the data collection using a monitoring tool that has been developed by the ICW/TAG project team. This shadow report will be used to provide input into the official country report to UNGASS as well as disseminated globally, regionally and nationally and used as an advocacy tool to scale up access to the TB/HIV services in countries.

I. QUESTIONNAIRE TO ASSESS TB/HIV UNIVERSAL ACCESS IN HIV CARE SETTINGS

GOAL: Assessing the availability of services to decrease the burden of TB among people living with HIV

Name of facility and address:

……

…….....

.....

Name of the interviewer:

……

Name of interviewee:

……

I. A. Intensified TB case finding in HIV treatment clinic

1. Does this HIV clinic have a policy on screening PLWHA for TB symptoms?

Yes ☐ No ☐

i. If yes how often are PLWHA screened for TB symptoms in this healthcare facility?

a. Every 3 months,
b. Every six months
c. Whenever they come for their care and treatment
d. Other, please specify: _____

ii. If yes to (1) does this HIV clinic refer TB suspects for confirmation of TB diagnosis?

Yes ☐ No ☐

iii. If yes, how many kilometers is the nearest TB diagnostic clinic from this HIV clinic.

Distance to nearest TB Diagnostic Clinic: _____

iv. What portion of the patients you referred followed up on the referral? How do you know this? (if the respondent does not know, mark that)

……
……
……
……
……
…….

2. What is the total number of adults and children enrolled for HIV care in the last quarter for which data is available (July 1st – 30th September, 2009 or April1st- June 30, 2009) in this clinic?

……
……

3. What is the total number of adults and children whose TB status has been assessed and recorded in the last quarter for which data is available (July 1st – 30th September, 2009 or April 1st- June 30, 2009) in this clinic?

……
……

4. Does this clinic work with other public/private/non governmental organizations working in high TB/HIV burden congregate settings to conduct intensified TB case finding in these settings?

Yes ☐ No ☐ Don't Know ☐

i. If yes, what types of congregate settings do this clinic work in to address TB intensified case detection? (Mark X to all that apply)
   a. Prisons
   b. Brothels
   c. HIV support groups
   d. Police and Army Barracks
   e. Any other setting?

   ……
   ……

I. B. TB Treatment

1. What is the total number of HIV-positive adults and children enrolled for ART treatment in the last quarter for which data is available (July 1st – 30th September, 2009 or April 1st- June 30, 2009)?

……
……

2. Does this HIV clinic provide first line TB treatment for PLWHA diagnosed with TB disease? Yes ☐ No ☐
I don't Know ☐

i. If yes, what is the estimated number of HIV-positive adults and children who have been started on TB treatment at this HIV clinic in the last quarter for which data is available (July 1st – 30th September, 2009 or April 1st- June 30, 2009)?
   a. Number of HIV-positive children started on TB treatment
      ……

b. Number of HIV-positive adults started on TB treatment ……

c. I don't know

ii. Is TB treatment recorded on the pre ART/ ART registers?

Yes ☐ No ☐

iii. Does this HIV clinic also provide treatment for drug-resistant TB?

Yes ☐ No ☐

I. C. Provision of Isoniazid Preventive Therapy (IPT)

1. Does this HIV clinic provide PLWHA information about isonaizid preventive therapy (IPT?)

Yes ☐ No ☐

2. Does this HIV clinic offer PLWHA who are latently infected with TB access to IPT as part of their package of care?

Yes ☐ No ☐

i. If yes, what are the number of PLHIV adults and children that were on IPT in the last quarter for which data is available (July 1st – 30th September, 2009 or April 1st- June 30, 2009)?

a. No of adults…….

b. No of children……

ii. If no to both C.1 and C.2 what are the obstacles to making IPT available for:

a. PLWHA

……
……
……
……
……
……

b. Children under 5 who are close contacts of TB patients

……
……
……
……
……
……

I.D. Infection control measures in HIV health care and congregate settings

1. Does this HIV Clinic have an infection control plan?

Yes ☐ No ☐

2. Which of the following infection control measures are being implemented in this HIV clinic? (Mark an X besides all that apply)

a. Waiting room set in an open space or tent outside/ is a large room with large open windows
b. Separating patients visiting the HIV treatment center with any TB symptoms like cough, from those without any TB symptoms.
c. Patient-flow in the clinic is regulated
d. Patient education on infection control measures to be taken.
e. Infection control education posters (eg. cough hygiene) displayed in HIV settings.
f. Presence of mechanical tools to reduce TB infection (eg, fan, UV lamps).
g. Training of HIV clinic staff on infection control measures, use of symptom screens and how to identify smear negative TB in HIV-positive patients
h. TB suspects are evaluated in a separate space with good infection control measures such as sunlight and ventilation.
i. Sputum collection space or room is well ventilated and located away from waiting area to reduce exposure of other people to airborne infectious germs.
j. Conducting outreach to homes of patients with HIV and TB to improve infection control at home.

3. Does this clinic partner with other public/private/non governmental organizations working in high TB/HIV burden congregate settings to provide education on TB infection control in these settings?

Yes ☐ No ☐ Don't Know ☐

i. If yes, what type of congregate settings does this clinic work in to address TB infection control?

a. Prisons
b. Brothels
a. HIV support groups
b. Police and Army Barracks
c. Any other setting?

……
……

I.E. Support to health care workers in high TB/HIV setting who provide care to patients

1. What is the total number of health workers who provided care for PLWHA in your health care facility in the last quarter for which data is available (July 1st – 30th September, 2009 or April 1st- June 30, 2009)??

……
……

2. For the above quarter, what is the total number of health workers who developed TB disease who provide care for PLWHAs?

.....
.....

3. What are the TB prevention measures/policies that are in place to protect health care workers who work with PLWHA? (Mark all that apply)

i. Provide regular and confidential screening for TB for health workers working in the HIV care centers including the nurses, counselors, etc.
ii. Provide IPT to staff who are latently infected with TB.
iii. Provide TB treatment for staff with confirmed diagnosis of TB disease.
iv. Training for health workers on TB infection control
v. Other: …….

II. QUESTIONNAIRE TO ASSESS TB/HIV UNIVERSAL ACCESS IN TB CARE SETTINGS

GOAL: Assessing availability of services to decrease the burden of HIV among people with TB disease

Name of facility and address:

……

…….....

.....

Name of the interviewer:

……

Name of interviewee:

……

II.A. HIV testing and counseling for TB patients

1. Is HIV testing and counseling offered to TB patients at this TB clinic?

Yes ☐ No ☐

i. If yes, is the HIV testing service offered at a fee or is it free of charge?

……
……

ii. If no, does this TB clinic refer all adults and children diagnosed with TB to the HIV VCT and treatment centre?

Yes ☐ No ☐

iii. If yes how many kilometers is the nearest HIV diagnostic clinic from this TB treatment clinic?

Distance to the nearest HIV Clinic……..

iv. What portion of the patients you referred followed up on the referral? How do you know this? (if the respondent does not know, mark that)

……
……
……
…….

2. Does the TB patient register also capture information about the HIV status of the individual?

Yes ☐ No ☐

3. What percentage of TB patients from your clinic have had their HIV test results recorded in the TB register in the last quarter for which data is available (July 1st – 30th September, 2009 or April 1st- June 30, 2009)?

……
……
……
……

4. Does the TB treatment register also capture the HIV treatment regimen?

Yes ☐ No ☐

II.B. Provision of HIV prevention methods at the TB clinic

1. Does this TB control clinic have a strategy to provide HIV prevention for TB patients?

Yes ☐ No ☐

.

a. If yes, how does the strategy address people at risk for HIV? (Mark X besides all that apply)

i) Provision of free condoms
ii) Education programs promoting safer sex practices
iii) Early diagnosis and treatment of other sexually transmitted infections
iv) Information on prevention of mother to child transmission of HIV
v) Promotion of positive living among those already living with HIV
vi) Partner testing for HIV infected patients
vii) Others, please describe:

……
……
……
…….

II.C. Provision of Cotrimoxazole Preventive Therapy (CPT)

1. Does this TB Clinic provide CPT for HIV-positive TB patients?

Yes ☐ No ☐

If not, why?

……
……
……
……
……
……
……..

II.D. Provision of HIV Care and Support services at the TB care setting.

1. What HIV care and support services are being provided for people diagnosed with TB and HIV in this TB clinic? (Mark X besides all that apply)

a. Promotion of nutrition support and hygiene
b. TB/HIV care and treatment education for home-based care providers,
c. Psycho-social support
d. Treatment adherence for both TB and HIV treatment and monitoring of adverse events
e. Palliative care
f. Follow-up care for opportunist infections
g. Others please specify:
……
……
……
……...

II.E. Provision of ART for TB patients who are HIV positive

1. Is ART available for HIV-positive TB patients at this TB clinic?
   Yes. ☐ No ☐

a. If yes, how many HIV-positive TB patients who were eligible were initiated on ART in the last quarter for which data is available (July 1st – 30th September, 2009 or April 1st- June 30, 2009)?
……
……..

b. If yes, at what level of CD4 cell count are HIV-positive people with TB disease eligible to start ART?
……
……

c. If no, has a mechanism been created between the HIV and TB program to provide ART to eligible HIV-positive TB patients?
   Yes. ☐ No ☐

If yes, what does it look like?
……
……
……
……
……
……
……..

III. QUESTIONNAIRE TO ASSESS ESTABLISHMENT OF TB/HIV POLICY AND ITS IMPLEMENTATION

GOAL: Assessing the planning and coordination between TB and HIV programs

Name of policy Institution and address:

……
…….....
.....

Name of the interviewer:

……

Name of policy maker:

……

III.A. Existence of a TB/HIV Collaborative Policy

1. Does the country have a policy or guidelines on TB/HIV collaborative activities?

Yes: ☐ No: ☐

a. Does the TB/ HIV policy contain any of the following components? (Mark X besides all that apply)

i. Establishment a joint TB and HIV coordinating body, TB/HIV technical advisory committee or task force to help with communication, joint planning, coordination, and budgeting of collaborative HIV and TB activities.
ii. Inclusion of representatives from the NTP in the planning process of the NACP and vice versa
iii. Surveillance of HIV prevalence among TB patients
iv. Advocacy, communication and social mobilization strategy for HIV to include appropriate information about TB, and vice versa.
v. Intensified TB case finding for all people living with HIV/AIDS at each clinic visit/ in accordance with a national ICF policy.
vi. ART access provided for all eligible HIV-positive TB patients in accordance with the national protocols
vii. HIV-positive TB patient to have full access to continuum of HIV care and support services.
viii. Cotrimoxazole Preventive Therapy (CPT) for all HIV-positive TB patients and all people living with HIV in accordance with the international guidelines.
ix. Access to diagnosis and treatment of TB to be part of a basic package of care for people living with HIV.
x. IPT offered to all PLWHA latently infected with TB.

xi. HIV testing and counseling routinely offered to all patients with confirmed TB diagnosis.
xii. Infection control policy is in place and monitored to ensure its effective implementation.

b. What mechanisms have been put in place to ensure that the policy is being implemented? (Mark X besides all that apply)
   i. Joint coordinating board/committee/task force has been set up and meets regularly (If yes, ask how often :……)
   ii. A dissemination/communication strategy for the policy has been implemented.
   iii. Joint planning to ensure that AIDS control plans include TB and TB control plans include HIV components.
   iv. Joint resource mobilization for collaborative TB/HIV activities
   v. Joint communication and advocacy strategy for TB and HIV control programs (HIV programs include TB and vice versa)
   vi. Joint plan for and involving affected communities in implementation of collaborative TB/HIV activities
   vii. Joint plan for operational research in collaborative TB/HIV activities
   viii. Joint approach to monitoring and evaluating collaborative activities.

2a. What is the total number of HIV centers in your country/ district?
……
……
……
……

b. Out of the total number of HIV centers in your country/ district, how many do the following?
   i. Regularly screen for TB in HIV-positive adult and children
   Number of Clinics: …… Don't Know ☐
   ii. Provide TB treatment for PLWHA diagnosed with TB disease
   Number of Clinics: …… Don't Know ☐
   iii. Provide IPT to PLWHA who are latently infected with TB and to children under 5 who are household contacts of someone with TB disease
   Number of Clinics: …… Don't Know ☐
   iv. Have implemented TB infection control policies in high-HIV burden congregate settings
   Number of Clinics: …… Don't Know ☐

c. Has your country developed a strategy for addressing TB and HIV among the vulnerable communities that include (mark X besides all that apply):

i. PLWHA
ii. Children
iii. People in congregate settings (e.g. prisons, schools, brothels)

d. What are the three biggest challenges in implementing the TB/HIV collaborative policy?

1……

2…….

3……

e. Are there any specific challenges for the HIV program in particular?

……
……
……
……
……
……

f. Are there any specific challenges for the TB program in particular?

……
……
……
……
……
……...

IV. QUESTIONNAIRE TO ASSESS PLWHA-TB PERSPECTIVE ON AVAILABILITY OF TB AND HIV COLLABORATIVE SERVICES

Name of the interviewer:
……
Name of interviewee:
……

If Interviewee is an individual, please note whether PLWHA:____, PWTB: _____, PLWTB and HIV: ____
If data is being collected in a support group setting, please ask a show of hands to show number of people who have HIV:___, Have/have had TB disease: ____, Have both TB and HIV:_____

Name of city/ district in which they access services facility and address:
……
…….....
.....

Names and addresses of HIV and TB clinics at which the interviewee accesses services most often/ and names of clinics that they are speaking about that exist in that region:
……
…….....
.....

IV.1. TB/HIV Collaborative Policy

IV.1.A. Existence of a TB/HIV Collaborative Policy

1. Does the country have a policy or guidelines on TB/HIV collaborative activities?

Yes ☐ No ☐ Don't Know ☐

a. Does the TB/ HIV policy contain any of the following components? (Mark X besides all that apply)

i. Establishment a joint TB and HIV coordinating body, TB/HIV technical advisory committee or task force to help with communication, joint planning, coordination, and budgeting of collaborative HIV and TB activities.
ii. Inclusion of representatives from the NTP in the planning process of the NACP and vice versa
iii. Surveillance of HIV prevalence among TB patients
iv. Advocacy, communication and social mobilization strategy for HIV to include appropriate information about TB, and vice versa.
v. Intensified TB case finding for all people living with HIV/AIDS at each clinic visit/ in accordance with a national ICF policy.
vi. ART access provided for all eligible HIV-positive TB patients in accordance with the national protocols

vii. HIV-positive TB patient to have full access to continuum of HIV care and support services.
viii. Cotrimoxazole Preventive Therapy (CPT) for all HIV-positive TB patients and all people living with HIV in accordance with the international guidelines.
ix. Access to diagnosis and treatment of TB to be part of a basic package of care for people living with HIV.
x. IPT offered to all PLWHA latently infected with TB.
xi. HIV testing and counseling routinely offered to all patients with confirmed TB diagnosis.
xii. Infection control policy is in place and monitored to ensure its effective implementation.

b. What mechanisms have been put in place to ensure that the policy is being implemented? (Mark X besides all that apply)

i. Joint coordinating board/committee/task force has been set up and meets regularly (If yes, ask how often :……)
ii. A dissemination/communication strategy for the policy has been implemented.
iii. Joint planning to ensure that AIDS control plans include TB and TB control plans include HIV components.
iv. Joint resource mobilization for collaborative TB/HIV activities
v. Joint communication and advocacy strategy for TB and HIV control programs (HIV programs include TB and vice versa)
vi. Joint plan for and involving affected communities in implementation of collaborative TB/HIV activities
vi. Joint plan for operational research in collaborative TB/HIV activities
vii. Joint approach to monitoring and evaluating collaborative activities.

2a. What is the total number of HIV centers in your country/ district?

……
……
……
…….

b. Out of the total number of HIV centers in your country/ district, how many do the following?

i. Regularly screen for TB in HIV-positive adult and children
Number of Clinics: …… Don't Know ☐

ii. Provide TB treatment for PLWHA diagnosed with TB disease
Number of Clinics: …… Don't Know ☐

iii. Provide IPT to PLWHA who are latently infected with TB and to children under 5 who are household contacts of someone with TB disease
Number of Clinics: …… Don't Know ☐

iv. Have implemented TB infection control policies in high-HIV burden congregate settings
Number of Clinics: …… Don't Know ☐

c. Has your country developed a strategy for addressing TB and HIV among the vulnerable communities that include (mark X besides all that apply):

i. PLWHA
ii. Children
iii. People in congregate settings (e.g. prisons, schools, brothels)

IV.2. TB/HIV UNIVERSAL ACCESS IN HIV CARE SETTINGS

IV.2.A. Intensified TB case finding in HIV treatment clinic

1. Does the HIV clinic you attend most have a policy on screening PLWHA for TB symptoms?

Yes ☐ No ☐

i. If yes how often are PLWHA screened for TB symptoms in this healthcare facility?

a. Every 3 months,
b. Every six months
c. Whenever they come for their care and treatment
d. Other, please specify: _____

ii. If yes to (1) does your HIV clinic refer TB suspects for confirmation of TB diagnosis?

Yes ☐ No ☐

iii. If yes, how many kilometers is the nearest TB diagnostic clinic from this HIV clinic.

Distance to nearest TB Diagnostic Clinic: _____

iv. What proportion of people that are referred followed up on the referral?

a. Less than 25%:___, b. Between 26-50%: ____, c. Between 51-75%: ____ d. Greater than 75%: ____

b. How do you know this? (if the respondent does not know, mark that)

……
……
……
……
……
…….

2. Does your clinic work with other public/private/non governmental organizations working in high TB/HIV burden congregate settings to conduct intensified TB case finding in these settings?

Yes ☐ No ☐ Don't Know ☐

i. If yes, what types of congregate settings does this clinic work in to address TB intensified case detection? (Mark X to all that apply)

a. Prisons
b. Brothels
c. HIV support groups
d. Police and Army Barracks
e. Any other setting?

……
……

IV.2.B. TB Treatment

1. Does the HIV clinic you go to most frequently provide first line TB treatment for PLWHA diagnosed with TB disease?

Yes ☐ No ☐ I don't Know ☐

2. Is TB treatment recorded on the pre ART/ ART register?

Yes ☐ No ☐

3. Does your HIV clinic also provide treatment for drug-resistant TB?

Yes ☐ No ☐

IV.2.C. Provision of Isoniazid Preventive Therapy (IPT)

1. Does the HIV Clinic you go to most often provide PLWHA information about isonaizid preventive therapy (IPT?)

Yes ☐ No ☐

2. Does your HIV clinic offer PLWHA who are latently infected with TB access to IPT as part of their package of care?

Yes ☐ No ☐

IV.2.D. Infection control measures in HIV health care and congregate settings

1. Does your HIV Clinic have an infection control plan?

Yes ☐ No ☐

2. Which of the following infection control measures are being implemented in your HIV clinic? (Mark an X besides all that apply)

a. Waiting room set in an open space or tent outside/ is a large room with large open windows
b. Separating patients visiting the HIV treatment center with any TB symptoms like cough, from those without any TB symptoms.
c. Patient-flow in the clinic is regulated
d. Patient education on infection control measures to be taken.
e. Infection control education posters (eg. cough hygiene) displayed in HIV settings.

f. Presence of mechanical tools to reduce TB infection (eg, fan, UV lamps).
g. Training of HIV clinic staff on infection control measures, use of symptom screens and how to identify smear negative TB in HIV-positive patients
h. TB suspects are evaluated in a separate space with good infection control measures such as sunlight and ventilation.
i. Sputum collection space or room is well ventilated and located away from waiting area to reduce exposure of other people to airborne infectious germs.
j. Conducting outreach to homes of patients with HIV and TB to improve infection control at home.

3. Does your HIV clinic partner with other public/private/non governmental organizations working in high TB/HIV burden congregate settings to provide education on TB infection control in these settings?

Yes ☐ No ☐ Don't Know ☐

i. If yes, what type of congregate settings does the clinic work in to address TB infection control?

c. Prisons
d. Brothels
d. HIV support groups
e. Police and Army Barracks
f. Any other setting?

……
……

IV.3. QUESTIONNAIRE TO ASSESS TB/HIV UNIVERSAL ACCESS IN TB CARE SETTINGS

Name of the interviewer:
……
Name of interviewee:
……
Name of city/ district in which they access services facility and address:
……
…….....
.....
Names and addresses of HIV and TB clinics at which the interviewee accesses services most often/ and names of clinics that they are speaking about that exist in that region:
……
…….....
.....

IV.3.A. HIV testing and counseling for TB patients

1. Is HIV testing and counseling offered to TB patients at your TB clinic?

Yes ☐ No ☐

i. If yes, is the HIV testing service offered at a fee or is it free of charge?

……
……

ii. If no, does your TB clinic refer all adults and children diagnosed with TB to the HIV VCT and treatment centre?

Yes ☐ No ☐

iii. If yes how many kilometers is the nearest HIV diagnostic clinic from your TB treatment clinic

Distance to the nearest HIV Clinic……..

iv. What proportion of people that are referred followed up on the referral?

a. Less than 25%:___, b. Between 26-50%: ____, c. Between 51-75%: ____ d. Greater than 75%: ____

b. How do you know this? (if the respondent does not know, mark that)

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……
……

2. Does the TB patient register also capture information about the HIV status of the individual?

Yes ☐ No ☐

IV.3.B. Provision of HIV prevention methods at the TB clinic

1. Does your TB control clinic have a strategy to provide HIV prevention for TB patients?

Yes ☐ No ☐

.

d. If yes, how does the strategy address people at risk for HIV? (Mark X besides all that apply)

i) Provision of free condoms
ii) Education programs promoting safer sex practices
iii) Early diagnosis and treatment of other sexually transmitted infections
iv) Information on prevention of mother to child transmission of HIV

v) Promotion of positive living among those already living with HIV
vi) Partner testing for HIV infected patients
vii) Others, please describe:

……
……
……
…….

IV.3.C. Provision of Cotrimoxazole Preventive Therapy (CPT)

1. Does your TB Clinic provide CPT for HIV-positive TB patients?

Yes ☐ No ☐

If not, why?

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……..

IV.3.D. Provision of HIV Care and Support services at the TB care setting.

1. What HIV care and support services are being provided for people diagnosed with TB and HIV in your TB clinic? (Mark X besides all that apply)

a. Promotion of nutrition support and hygiene
b. TB/HIV care and treatment education for home-based care providers,
c. Psycho-social support
d. Treatment adherence for both TB and HIV treatment and monitoring of adverse events
e. Palliative care
f. Follow-up care for opportunist infections
g. Others please specify:

……
……
……
……...

IV.3.E. Provision of ART for TB patients who are HIV positive

1. Is ART available for HIV-positive TB patients at your TB clinic?

Yes. ☐ No ☐

a. If yes, at what level of CD4 cell count are HIV-positive people with TB disease eligible to start ART?

……
……

b. If no, has a mechanism been created between the HIV and TB program to provide ART to eligible HIV-positive TB patients?
Yes. ☐ No ☐

If yes, what does it look like?
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……
……..