CIVIL SOCIETY UNGASS TB/HIV COUNTRY REPORT

ZAMBIA

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TAG
Treatment Action Group

Commissioned By:
Treatment Action Group (TAG)
&
International Community of Women living with HIV/AIDS–East Africa (ICW-EA)

Conducted By:
Community Initiative for Tuberculosis, HIV/AIDS, and Malaria Plus Related Diseases (CITAM+)
&
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LIST OF ABBREVIATIONS

ART	antiretroviral therapy
ARVs	antiretroviral drugs
CPT	cotrimoxazole preventive therapy
DHMT	district health management team
ICF	intensified case finding
MOH	Ministry of Health, Zambia
NAC	National HIV,STI and TB Council, Zambia
NTP	National Tuberculosis Programme, Zambia
PLWHA	persons living with HIV/AIDS
PLWHA-TB	persons living with HIV and TB
PLWTB	persons living with TB
SSM	sputum smear microscopy (test for TB)
SSM+	sputum-smear-microscopy positive
UNGASS	United Nations General Assembly Special Session Declaration of Commitment on HIV/AIDS
UTH	University Teaching Hospital, Lusaka, Zambia
VCT	voluntary counseling and testing
WHO	World Health Organization

SECTION ONE: INTRODUCTION

Zambia had an estimated population of 12.2 million in 2007, and has had an annual population growth rate of 2.9 percent since 2000. It is estimated that the prevalence of HIV among those 15–49 years old is 15.6%, making Zambia one of the countries in sub-Saharan Africa worst affected by the HIV/AIDS pandemic. In 2007 the country had one of the highest donor dependency ratios in the world, with 90% of its budget provided by external donors versus 10% coming from the Zambian government. The economy of the country is characterized by high levels of unemployment and widespread poverty, presenting a serious social problem for the people of Zambia. These conditions present a significant challenge in combating HIV/AIDS, as they increase the number of people who turn to the sex industry for employment, lead to a rise in alcohol abuse, and increase the number of children who drop out of school because tuition cannot be paid—all of which are key drivers of HIV/AIDS[1].

The National Response to HIV and AIDS

A multisectoral response has been adopted in the implementation of the national HIV/AIDS program, with partnerships established both at the national and sub national levels. At the subnational level, partnerships are organized through the District AIDS Task Forces and the Community AIDS Task Forces. Approximately one million people in Zambia were living with HIV in March 2006, and an estimated 300,000 required antiretroviral therapy (ART), but only 65,000 people were accessing treatment[2]. In August 2006, the Ministry of Health (MOH) and the National HIV,STI and TB Council (NAC) announced the roll-out of free antiretroviral drugs (ARVs) to the private sector as part of the scale-up of access to treatment across the country. It is estimated that 400,000 people have now been put on ART but there are still a lot of people in need of treatment[3].

The National Response to Tuberculosis

The World Health Organization's Global Tuberculosis Controlreport for 2009 shows that the tuberculosis (TB) prevalence rate in Zambia is 387 cases per 100,000 persons[4]. Approximately 70 percent of detected TB cases are also those of people co infected with HIV.

The MOH, through the National Tuberculosis Control Programme (NTP), provides diagnostic and treatment services for TB- and TB/HIV-infected individuals at all levels of the health care delivery system in all 9 administrative provinces and 72 administrative districts in the country. The NTP has ensured the provision of free treatment for TB patients in all the public health facilities, and is promoting measures to decrease the burden of TB and HIV in populations affected by both diseases.

Data Gathering

Currently the country has 156 TB diagnostic health facilities. All the clinics that were selected for this monitoring claim to provide collaborative services as they all provide both ART and TB services. Our research was focused on nine health clinics in Lusaka that provide both HIV and TB services onsite. The clinics were selected on the basis of the high burden of TB/HIV and the willingness of contacts to provide information anonymously. This was a challenge because the country team of activists who carried out the monitoring exercise were not given the go-ahead by the MOH to gather information to assess the existence of policy and the availability of services addressing TB/HIV.

TB and HIV/AIDS

Mycobacterium tuberculosis continues to be one of the top ten causes of morbidity and mortality in Zambia. The HIV/AIDS pandemic has worsened the TB situation; approximately 70% of all detected TB cases of people who are also coinfected with HIV[5].

Case Detection

In 2008, the Zambia NTP documented 46,630 cases of TB (in all its forms), translating into a case notification rate of 413 per 100,000 people. This means a decrease of 7.5% compared to 2007. In total, 12,976 new sputum-smear-microscopy positive (SSM+) cases were notified in 2008, which is a decrease of 3% over 2007. The decrease in SSM+ notifications is a worrying trend. It may be the result of a shortage of laboratory staff, because decrease in HIV prevalence, widespread use of ART, and intensified case finding (ICF) interventions should actually contribute to an increase of the SSM+ rate versus all TB cases, which is not the case. The percentage of SSM+ versus all TB cases has remained between 26% and 29% for the years 2005–2008 (27.8% in 2008). At the same time, these factors probably contribute to an overall decrease in case notifications. A trend of decreasing retreatment notifications can be seen for the country as a whole, predominantly among SSM+ cases.

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1. Republic of Zambia 2008. Zambia Country Report: Multi-sectoral AIDS Response Monitoring and Evaluation Biennial Report 2006–2007; available online at http://www.unaidsrstesa.org/userfiles/file/Country%20Profiles/2008/zambia_2008_country_progress_report_en.pdf. Accessed March 12, 2010.
2. Draft 2009 National Tuberculosis Infection Control Guidelines for the prevention of the transmission of tuberculosis in health care facilities.
3. Republic of Zambia 2008, Zambia Country Report.
4. World Health Organization 2009. Global Tuberculosis Control: Epidemiology, Strategy, Financing. Available online at http://www.who.int/tb/publications/global_report/2009/pdf/full_report.pdf; accessed March 12, 2010.
5. Draft 2009 National Tuberculosis Infection Control Guidelines.*This is the WHO target which aimed at making ARVs accessible to three million people by 2005

SECTION TWO: OBJECTIVES AND METHODOLOGY

Objectives of the Monitoring Exercise

1. To assess the implementation of the TB/HIV indicators included in the United Nations General Assembly Special Session Declaration of Commitment on HIV/AIUNGASS)and the World Health Organization's 3 by 5* Initiative in Zambia.

2. To evaluate the extent to which Zambia is achieving universal access goals for TB/HIV treatment, care, and prevention by 2010 in line with the UN's Millennium Development Goals.

Methodology

A team of Zambian activists held in-depth interviews with the NTP manager, staff working in the TB and HIV clinics in nine health centers in Lusaka, and people living with HIV/AIDS who are accessing services from these nine health centers. A total of 180 recipients of care from different clinics attended focus-group discussions held at the different health centers during the monitoring exercise, and from these focus-group discussions data were collected using a monitoring tool that was developed by Treatment Action Group and the International Community of Women Living with HIV/AIDS–Eastern Africa project team.

Challenges and Limitations

It is very difficult to get information from clinics and hospitals. It is said to be classified, and one must declare what one wants to use the information for and get written consent from the permanent secretary at the MOH; such consent is not easily given. This is the biggest challenge, which makes it difficult for civil society organizations to access updated information.

The fact that only urban clinics were included in the present study is also a limitation, as there is thus no rural data. This was due to the limit in resources to work in other parts of the country, as Zambia has 9 provinces comprising 72 districts.

SECTION THREE: FINDINGS

3.1 Assessing the Availability of Services for Decreasing the Burden of TB among PWLHA

3.1a. Intensified TB Case Findings at HIV Health Facilities

3.1.a(i). Number of HIV Clinics That Screen PLWHA for TB Symptoms

Four out of the nine clinics assessed, or 44%, reported to be screening PLWHA for TB symptoms every three months. The remaining five clinics only screen for the disease if a client presents signs and symptoms suggestive of active TB.

3.1.a(ii). Referral of Those Suspected of Having TB to TB Clinics

If a client presents with signs and symptoms suggestive of active TB, he or she is referred to a TB clinic for confirmation. There is a TB clinic situated on or near the premises of each of the nine clinics visited—no more than 50 meters away. In exceptional cases where the laboratory is not functioning due to lack of reagents, clients are referred to other hospitals for testing, and the distance ranges from 1 to 5 kilometers. However, this only happened once in the urban areas studied.

3.1.a(iii). Number of Adults and Children Enrolled in HIV Care in the Last Quarter for Which Data Is Available

There was a challenge in accessing these statistics because of a district health management team (DHMT) policy that states that data can only be given out after approval of the permanent secretary of the MOH.

However, two clinics were able to provide us with some information. At one of the clinics we were told that in the last quarter, 23 children and 249 adults visiting the HIV clinic had had their TB status assessed and recorded; at another clinic we were informed that 3 children and 347 adults had had their TB status assessed and recorded. This represents a total of 9.23% of adults and children assessed for TB at the two clinics. The low number of children assessed was blamed on the nonavailability of culture diagnostics and drug sensitivity testing at the clinics; these cases are referred to the University Teaching Hospital (UTH) in Lusaka.

3.1.a(iv). Do Clinics Work with Other Public/Private/Nongovernmental Organizations in High-TB-Burden Settings to Conduct Intensified Case Findings in Congregate Settings?

The team found that only the UTH did some work in prison settings;

none of the clinics were working in any other congregate settings to address TB ICF.

3.1b. TB Treatment

3.1b(i). Number of Adults and Children Who Were Enrolled in Antiretroviral Therapy That Received TB Treatment

Data was unavailable because of the DHMT policy restricting the sharing of information without the approval of the MOH.

3.1b(ii). Number of the HIV Clinics Assessed That Provide TB Treatment for PLWHA Diagnosed with TB Disease

None of the nine HIV clinics assessed provided TB treatment for PLWHA diagnosed with TB disease; instead, clients are referred to TB clinics for treatment.

However, in each of the nine clinics visited, TB treatment is recorded in the ART register to facilitate the switching of anti-HIV drugs to avoid drug interaction when one has commenced TB treatment while taking ARVs.

3.1b(iii). Provision of Treatment for Drug-Resistant TB at HIV Clinics

None of the HIV clinics assessed during the monitoring exercise recorded the provision of treatment for drug-resistant TB, as all TB cases are referred to TB clinics.

3.1c. Isoniazid Preventive Therapy

3.1c(i). Proportion of HIV Clinics Visited Providing Isoniazid Preventive Therapy as Part of a Package of Care for PLWHA Latently Infected with TB and for Children under Five Years of Age

None of the ART clinics provide isoniazid preventive therapy (IPT) as part of a package of care for PLWHA who are latently infected with TB or for children under the age of five years of age who are in close contact with TB patients. There are currently four sites in Lusaka where IPT is being rolled out as part of a pilot research study, the ZAMSTAR project.

3.1c(ii). Obstacles to providing IPT

The main obstacle mentioned in providing IPT for PWLHA latently affected with TB and the eligible children in these HIV clinics is that IPT is not part of the MOH treatment guidelines and is only being implemented through the research project of the ZAMSTAR study.

3.1d. Infection Control in HIV Health Care and Congregate Settings

3.1d(i). Number of HIV Clinics Visited Implementing Infection Control Plans

All the HIV clinics visited are implementing infection control plans. The MOH recently finalized infection control guidelines.

Though all the clinics have infection control plans, none are complying with all of the standards that the World Health Organization (WHO) has recommended. For example, most of the clinics are still poorly ventilated, neither health care workers nor patients visiting the clinics wear protective masks, and the treatment rooms don't have built-in room air filtering systems.

3.1d(ii). Infection Control Measures

The common infection control measures being implemented in the HIV clinics that were assessed.

1. Patient flow in the clinic is regulated.2. TB suspects are evaluated in a separate space, with good ventilation and sunlight.
2. Waiting areas are set in open spaces or outdoor tents.
3. HIV clinic staff are trained in infection control, such as symptom screens and how to identify smear-negative TB in HIV-positive patients.

3.1d(iii). Do HIV Clinics Partner with Other Organizations and Congregate Settings to Provide Education on Infection Control?

All nine clinics visited work with other public/private/nongovernmental organizations (NGOs). Examples include a church wherein there is a very effective home-based care structure, and some NGOs who have trained treatment supporters to provide education on TB infection control and to conduct follow-up with patients.

3.1e. Support to Health Care Workers in High-TB/HIV-Burden Settings Who Provide care to HIV Patients

3.1e(i). Number of Health Care Workers Providing Care for PLWHA Who Developed TB in the Last Quarter

None of the health care workers in the HIV clinics developed TB disease in the last quarter for which data were available (either July 1 – September 30, 2009 or April 1–June 30, 2009).

3.1e(ii). TB Prevention Measures Taken by HIV Clinics for Health Care Workers

TB prevention measures were put in place in all of the HIV clinics to "protect health care workers from TB infection, and likely contributed to the fact that no health care provider working with PLWHA developed TB in the last quarter for which data were available. These measures included:

1. Training for health workers on TB infection control.
2. Locating the waiting room in open space or an outdoor tent.
3. Training HIV clinic staff on infection control measures, such as the use of symptom screens and how to identify smear-negative TB in HIV-positive patients.
4. Providing TB treatment for staff with confirmed diagnosis of TB disease.
5. Regulation of patient flow in the clinic.
6. Making sure that sputum collection rooms were well ventilated and located away from the waiting area to reduce exposure of other people to TB.

3.2. Assessing the Availability of Services for Decreasing the Burden of HIV among PLWHA with TB Disease

3.2a. HIV Testing and Counseling for TB patients

3.2a(i). Number of TB Clinics Offering HIV Testing to TB Patients

None of the nine TB clinics offers HIV testing to TB patients. Patients are referred for voluntary counseling and testing (VCT) for HIV, and then to the ART clinic if found to be HIV-positive.

3.2a(ii). Number of TB Clinics Referring Adults and Children Diagnosed with TB for HIV VCT

All of the TB clinics assessed refer adults and children diagnosed with TB for HIV VCT.

3.2a(iii). Average Distance between TB Clinic and VCT Center

The average distance between a TB clinic and the nearest VCT centre is usually about 50 meters, as all TB and HIV services are provided within the larger health center premises.

3.2a(iv). Number of TB Clinics Capturing HIV Status and Treatment Regimen Information in Their TB Registers

All of the clinics capture HIV status and treatment regimen information in their TB registers.

3.2b. Provision of HIV Prevention Services at TB Clinics

3.2b(i). HIV Prevention Strategies That TB Clinics Provide to Their Patients

The following HIV prevention strategies have been put in place by TB clinics for their patients who are at risk for HIV:

1. Educational discussions on HIV prevention and safer sex practices.
2. HIV testing information.
3. Provision of free condoms (both male and female).

3.2c. Provision of Cotrimoxazole Preventive Therapy

3.2c(i). Number of TB Clinics Providing Cotrimoxazole Preventive Therapy to HIV-Positive TB Patients

None of the TB clinics assessed provide cotrimoxazole preventive therapy (CPT) for their HIV-positive patients. However, CPT is given to HIV-positive patients once they are referred to ART clinics.

3.2c(ii). Barriers to Providing CPT to HIV-Positive TB Patients

CPT is not provided to HIV-positive TB patients at TB clinics because these clinic only stock and dispense anti-TB drugs. CPT is only dispensed at ART clinics to HIV-positive people with eligible CD4 counts and to those with complications from opportunistic infections.

3.2d. HIV Care and Support Services Being Provided by the TB Clinic to PLWHA-TB. Psychosocial support.

1. TB care and treatment education for home-based caregivers who support the implementation of directly observed treatment short course therapy; this contributes to the roughly 85% TB treatment adherence rate.
2. The promotion of nutrition support, hygiene, and follow-up care for those with opportunistic infections.

3.2e. Provision of ART to HIV-Positive TB Patients

3.2e(i). Number of Assessed Clinics Providing ART to HIV-Positive TB Patients Eligible Enough to Start

None of the nine TB clinics provide ART to eligible HIV-positive TB

patients. Those who are eligible to start are referred to ART clinics.

3.2e(ii). Average Number of TB/HIV Patients Who Were Initiated on ART in the Last Quarter (July 1–September 30, 2009 or April 1 – June 30, 2009) in the Clinics Visited

Data was unavailable because of the DHMT policy restricting the sharing of information without the direct approval of the MOH.

3.2e(iii). CD4 Cell Count at Which PLWHA-TB Are Eligible for ART.

People living with HIV who have a confirmed diagnosis of active TB disease are eligible for ART regardless of their CD4 count.

3.2e(iv). Mechanisms Put in Place between the HIV and TB Programs to Provide ART to Eligible HIV-Positive TB Patients as Reported by the TB Clinics Assessed.

There is a very effective referral system in place between the TB and ART clinics in all health centers assessed. PLWHA noted their satisfaction because they don't have to travel long distances in order to access either service.

3.3. Assessing Planning and Coordination between the TB and HIV Programs

3.3a. Existence of a TB/HIV Collaborative Policy

3.3a(i). Existence of National TB/HIV Collaborative Policy/Guidelines and Knowledge of Them on the Part of TB and HIV Policy Makers Interviewed

Zambia has TB/HIV collaborative guidelines and all three of the policy makers interviewed were aware of them. They were also aware that infection control guidelines had recently been finalized.

3.3a(ii). Mechanisms Put in Place by HIV and TB Policy Makers to Ensure That Collaborative Guidelines/Policies Are Implemented

The TB/HIV collaborative guidelines were distributed to all the health centers in each district. The overall sister in charge of the health center, the sister in charge of the ART clinic, and the sister in charge of the TB clinic were all familiar with the document before it was rolled out. Implementation included the development and implementation of infection control plans and of intensified TB case finding both in the community and during screening of patients in HIV clinics. A joint coordinating board has also been set up by the MOH in each of the nine provinces with representation from government and civil society;

the board meets quarterly to share implementation successes and challenges.

3.3a(iii). The Number of HIV Clinics in the District

There are 22 HIV clinics in the Lusaka district, but of these only 9 were monitored.

3.3a(iv). Actions Taken Toward Collaborative Policy

According to the policy makers who were interviewed, a number of HIV centers in the district were taken a number of actions toward collaborative HIV/TB policy.

1. **Regular Screening for TB in HIV-Positive Adults and Children**
   The NTP policy maker reported that HIV-positive adults and children were being regularly screened for TB but he was not sure of the number of clinics. Data collected through this monitoring exercise indicates that implementation is variable. Four out of the nine clinics visited regularly screen for TB. Children are mostly referred to UTH, where they are able to access culture and drug susceptibility testing.

2. **TB treatment for PLWHA diagnosed with TB disease**
   The NTP policy maker was not sure of the number of clinics where TB treatment was being provided to PLWHA, but based on our monitoring we found that all TB/HIV coinfected patients are referred to TB clinics for TB treatment.

3. **Provision of IPT to PLWHA Who Are Latently Infected with TB Disease**
   IPT is still in the research project stage in Zambia and hence is not offered to patients unless they are part of the ongoing ZAMSTAR study.

4. **Implementation of TB Infection Control Policies in High HIV-Burden Congregate Settings**
   Some TB infection control measures are being implemented in high-HIV-burden congregate settings such as health centers. These include the construction of new TB clinics that have bigger windows and allow more sunlight. What is lacking is the presence of information, education, and communication materials to educate people on simple infection control measures that they can implement to help prevent TB infection.

3.3a(v). Has Zambia Developed a Strategy for Addressing TB and HIV among Its Vulnerable Communities?

Zambia has developed a strategy for addressing TB and HIV among vulnerable communities by implementing infection control measures and intensified case activities in health care facilities and the community. IPT is not yet being given to PLWHA as prophylaxis but is in the research stages via the ZAMSTAR study. The prison system now has a seat on the national TB/HIV joint body, and prisons have started isolating inmates who have TB from those who do not.

3.3a(vi). What Are the Biggest Challenges to Implementing TB/HIV Collaborative Policy?

The three biggest challenges in implementing the TB/HIV collaborative policy are:

1. TB and ART programs are run in parallel as there is very little information shared on a daily basis between the ART and TB clinics.
2. The shortage of personnel in both programs makes it difficult for them to work in collaboration, as each concentrates on what it is supposed to be doing.
3. There is a lack of daily information sharing between ART and TB clinics.

3.3a(vii). Challenges Expressed by HIV Policy Makers to Implementing TB/HIV Collaborative Policy

The three major challenges expressed by HIV policy makers to implementing TB/HIV collaborative policy are:

1. TB/HIV collaborative policy guidelines have not been seen by all staff members working in ART clinics, making implementation difficult at times.
2. Tracking of patients referred from TB clinics to ART clinics is difficult, as some patients are not psychologically prepared to start ART because of some of the myths they have heard—particularly about the interaction of ART with TB drugs.
3. There is inadequate human resource capacity to meet the demands of service.

3.3a(viii). Challenges Expressed by TB Policy Makers to Implementing TB/HIV Collaborative Policy

The two major challenges expressed by TB policy makers to implementing TB/HIV collaborative policy are:

1. There has been inadequate participation from HIV/AIDS programs in joint TB/HIV collaborative activities.
2. There are inadequate financial and human resources.

3.4. Assessing the Perspectives of PLWHA-TB on the Availability of TB/HIV Collaborative Services

3.4a. Number of PLWHA and PLWTB Aware of the Existence of TB/HIV Collaborative Policy

All 180 PLWHA-TB interviewed were from support groups at the health centers where they access their ART. None had any knowledge of the existence of TB/HIV collaborative policy. This lack of information about such policy is due to the fact that it is assumed that the documentation is meant solely for health care workers. Therefore the input of PLWHA is often not requested unless activists demand to be part of the process when developing such documentation. Furthermore, interviewees noted that policy documents are only accessed by people who know about them and are interested in them while most PLWHA-TB are only interested in accessing treatment.

Some PLWHA-TB that work in the Community Initiative for Tuberculosis, HIV/AIDS and Malaria Plus Related Diseases, the Zambia Association for the Prevention of HIV and Tuberculosis, the Treatment Advocacy and Literacy Campaign, and the Network of the Zambian People Living with HIV/AIDS who are involved in policy analysis now know about the existence of TB/HIV policy documents and how their input into the development of these documents can change certain policies that are not favorable to PLWHA coinfected with TB.

3.4a(i). Components of TB/HIV Collaborative Policy Commonly Known to the TB- and HIV-Affected Communities

As mentioned above, PLWHA are not aware of the existence of such documents and hence are not aware of any components.

3.4a(ii). Perspectives of the Affected Communities on Mechanisms Put in Place to Ensure That the Collaborative Policies Are Being Implemented

The affected communities are not enlightened on the existence of the collaborative services. There is need to educate them so that they understand these collaborative services and their importance

3.4b. ICF in HIV Treatment Centers

3.4b(i). TB Screening in HIV Treatment Centers

The monitoring team was unable to access TB screening tools, as we

did not have the MOH's permission to conduct the monitoring exercise. We were only able to access the screening tool that is being used by the ZAMSTAR study to rule out active TB disease before the initiation of IPT.

3.4b(ii). Number of HIV Treatment Centers Providing Specific Services, as Reported by the PLWHA Interviewed

1. **Regular Screening for TB in HIV-Positive Adults and Children.**
   None of the patients interviewed were aware they were being screened for TB as the questions asked during adherence counseling are for general screening and are not TB specific.

2. **Provision of TB Treatment for PWLHA Diagnosed with TB Disease.**
   All of the PLWHA interviewed were aware of this service.

3. **Provision of IPT to PLWHA Who Are Latently Infected with TB and to Children Under Age Five Whose Household Had Come into Contact with Someone with TB**
   All of the PLWHA interviewed were aware of the provision of IPT

4. **Implementation of TB infection control policies in high HIV-burden congregate settings**
   Patients are unaware of why infection control measures such as regulated patient flow into the clinic, outreach to patients with HIV and TB in their homes, and patient education are being implemented.

3.4b(iii). Strategies for Addressing TB and HIV among Vulnerable Communities, including PLWHA, Children, and People in Congregate Settings

The interviewees feel that the situation in prisons still remains a bad one because of the high number of inmates and the conditions increase the risk of TB transmission. In schools, children are taught that windows must be opened, yet brothels are always closed spaces because they are illegal and thus places where people may be at increased risk for TB infection.

3.4b(iv). Number of PLWHA Interviewed Who Are Screened for TB Symptoms at HIV Clinics, and How Often

Eighteen of the 180 PLWHAs interviewed, or 10%, said they had been screened for TB symptoms at HIV clinics. They noted that after thorough screening and one is found with suspected active TB disease, he or she is referred to a TB clinic for confirmation and initiation of TB treatment.

Even when screening was done, patients were not aware that they were

being screened for TB because of the general questions asked relating to coughing, night sweats, and the like. The PLWHA who were aware of being screened for TB disease reported being screened quarterly.

3.4b(v). Follow-up for PLWHA Referred from HIV Clinics

Of the PLWHA interviewed, the average percentage of those who were referred for and given follow-up on TB diagnostics was 80%. This is attributed to the fact that there is a very low number of full time treatment supporters employed under the Lusaka DHMT to carry out follow-ups. These tasks are generally taken up by volunteers who are paid by NGOs. This was confirmed by the interviewees who reported being given follow-up by treatment support members from NGOs.

3.4c TB Treatment

3.4c(i). Provision of First-Line TB Treatment for PLWHA Diagnosed with TB Disease by HIV Clinics

All of the PLWHA interviewed reported that none of the HIV clinics provide TB treatment for PLWHA diagnosed with TB disease but instead refer them to TB clinics to access treatment.

3.4c(ii). TB Treatment Information Recorded on the ART Register

In each of the nine clinics visited the TB treatment information is recorded in the ART register.

3.4c(iii). Number of HIV Clinics Reported by PLWHA-TB to Be Providing Treatment for Drug-Resistant TB

All of the PLWHA interviewed reported that none of the HIV clinics provide treatment for drug-resistant TB.

3.4c(iv). Percent of the Total Number of PLWHA Interviewed Who Reported to Have Received Information about IPT

All of the PLWHA interviewed noted that none of the HIV clinics provide information on IPT and as such they as patients were not aware of IPT. This means that IPT is not provided as a package of care to PLWHA who are latently infected with TB.

3.4d. Infection Control in HIV Care and Congregate Settings

3.4d(i). The Number of Clinics That Are Implementing Infection Control Strategies

All nine clinics visited implement infection control strategies.

Four Common Infection Control Measures That the PLWHA Interviewed Claimed Were Implemented at Their HIV Clinics:

1. Regulation of patient flow in the clinic.
2. Education of client on coughing etiquette.
3. Those suspected of having TB are screened in a separate space with good infection control measures such as sunlight and ventilation.
4. Waiting room (for those awaiting screening) is set in an open space or in an outdoor tent.

3.4e HIV Testing and Counseling for TB Patients

34d(i). Number of PLWTB Interviewed Who Expressed That HIV Testing and Counseling Services for TB Patients Are Performed at TB Clinics

All the PLWTB interviewed confirmed that they had been referred for HIV tests and counseling services as part of TB diagnostic counseling and testing.

34d(ii). Referral of Adults and Children Diagnosed with TB to HIV Voluntary Counseling and Testing, and Average Distance to the Nearest Clinic Where Such Services Are Available

All of the PLWTB interviewed confirmed that they had been referred for HIV testing and counseling services as part of VCT and the average distance was 50 meters, as all testing facilities are on clinic premises. However, these referrals are time-consuming, as referred PLWTB have to spend time waiting in long queues at the VCT centers.

34d(iii). Referral of TB Patients from the TB Clinic for HIV Testing and Follow-up

TB patients are referred to the VCT sections of clinics and then, if found to be HIV-positive, referred to ART clinics for treatment. It is difficult for health care workers to follow up on referrals made due to a shortage in staffing. However, 75% of PLWTB interviewed felt that most of the PLWTB referred to the ART clinics do follow up on their referrals. The remaining 25% felt that some don't follow up because of being in denial and/or because of the stigma attached to visiting an ART clinic.

34d(iv). HIV Prevention Methods Offered to Clients at TB Clinics, as Reported by PLWTB

The following HIV prevention methods were noted by PLWTB:

1. Education on HIV prevention and safer sex practices.
2. Information about HIV that is intended to lead to informed decisions about testing on an opt-out basis.
3. Provision of free condoms (both male and female).

34d(v). Provision of CPT to PLWTB.

The respondents reported that CPT is not provided to PLWTB at TB clinics but can be accessed upon referral to an ART clinic.

34d(vi). The Main Reason Given by the PLWTB Interviewed on Why Clinics Are Not Able to Provide CPT

The respondents reported that CPT is not provided to HIV-positive patients, as TB clinics only stock and dispense anti-TB drugs, whereas CPT can only be found at the central pharmacy and at ART clinics.

34d(vii). Provision of HIV Care and Support Services in TB Care Settings

HIV care and support services being provided for people diagnosed with TB and HIV in the clinics include:

1. Nutrition and hygiene support, by supplying the clients with food supplements from the United Nations World Food Programme.
2. TB/HIV care and treatment education by home-based care providers.
3. Psychosocial support.
4. Treatment adherence planning for both TB and HIV treatment and monitoring of adverse effects.
5. Follow-up care for opportunistic infections.

34d(viii). Provision of ART to Eligible HIV-Positive TB Patients at TB Clinics

None of the TB clinics provide ART to eligible HIV-positive TB patients, but there is a referral system in place so that HIV-positive patients with TB disease are referred to ART clinics for treatment.

SECTION FOUR: OBSERVATIONS, A BEST PRACTICE, AND RECOMMENDATIONS

Observations

The Availability of TB/HIV Services and Their Utilization by PLWHA-TB

TBand HIV services are utilized by PLWHA-TB but information on IPT and its availability is not available, thereby compromising the reduction of the burden of TB among PLWHA-TB.

Patient information is not being shared between the ART and HIV clinics. This needs to be addressed, as there is a benefit for TB and HIV care providers to be aware of both TB and HIV statuses and treatments to ensure optimal care.

Clinicians reported that ICF was done regularly, while PLWHA did not know whether they were screened for TB. However, this is due to clinicians having less time to explain signs and symptoms of TB to the clients as they are so few in the health facilities and they attend to overwhelming numbers of patients.

There is very limited access to culture and drug susceptibility testing to diagnose TB among PLWHA and in pediatric cases. This is due to the fact that some diagnostic services are only available in specimen referral facilities with trained staff.

IPT is only accessible through research pilot sites being conducted as part of the ZAMSTAR project.

Policy and Coordination of TB and HIV Programs

The lack of involvement of ART policy makers in the implementation of TB/HIV collaborative activities that are supposed to strengthen coordination of the management of the two diseases is notable. This further isolates these programs, highlighting the fact that the two are run as parallel programs. The NTP was of the view that it was true, that there are system barriers(e.g. understaffing, shortage of drugs for opportunistic infections) in the health facilities that require immediate action.

Best Practice in the Availability of Services and TB/HIV Program Policy and Coordination

The best practice recorded is the availability of both TB and ART services at health facility levels that have led to:

1. The promotion of measures to decrease the burden of TB and HIV in populations affected by both diseases in Zambia.
2. The treatment of opportunistic infections in order to reduce the disease burden

on the infected individuals.

Recommendations Drawn from These Observations

- To record the positive strides in the fight against TB and HIV and achieve the universal access goals for TB/HIV treatment, care, and prevention by 2010. TB and HIV services must be offered collaboratively to ensure easy and coordinated access to both. These collaborative activities can improve TB/HIV service delivery and save the lives of manyPLWHA-TB.

- Prevention and treatment of TB in people living with HIV is an urgent priority for both HIV/AIDS and TB programs. The WHO's recommended "Three I's"—intensified case finding (ICF), TB infection control (IC), and isoniazid preventive therapy (IPT)—are key health strategies to decrease the impact of TB on people living with HIV. Out of these three, IPT is lacking outside of research settings, and needs to be scaled up immediately in Zambia.

- IPT provision, and information about it, should be made available for all who are eligible, including children under five years of age and PLWHA. The NTP should seriously consider scaling up IPT provision from pilot projects into the national program.

- IPT should be included in the national strategic framework; this will facilitate the roll-out of IPT on an opt-out basis to PLWHA nationwide.

- There should be a deliberate effort on the part of HIV and TB programs and health care units to scale up the integration of HIV and TB testing services in TB and HIV clinics, respectively. Despite the close physical proximity of the two clinics, clients are still forced to suffer the long queues at testing sites.

- The MOH should build the capacity of all TB and HIV health care providers to implement the TB/HIV collaborative policy that is currently limited to only a few health care workers.

- The TB and HIV national programs, working together with civil society, should put in place a mechanism for disseminating TB/HIV collaborative policy information to the affected communities and include education on the "Three I's" so that the communities are able to effectively deand and utilize these services.

- For diagnosing TB in pediatric cases and in PLWHA, a system should be created whereby there will be a decentralized diagnostic system for case finding, confirmation, and treatment commencement under one roof. This will reduce delays in treatment initiation due to loss of results and unplanned transportation costs, which are a burden to an infected person.

- Health care workers should educate the recipients of care on the services that

are provided—particularly on infection control, intensified case finding, and isoniazid preventive therapy.

- There should be collaboration of activities and sharing of information between the NTP and the national ART program in order to integrate services between the two units at health center levels.

- All PLWHA with active TB should be able to access CPT in accordance with the WHO recommendations, which clearly state that CPT must be given to all TB patients, regardless of CD4 counts, at both TB and HIV clinics.

- Pediatric TB diagnostics need to be made available in all health centers that will make diagnostic processes easier and fast enough to facilitate early treatment, as well as to ensure that clinics have staff that are able to diagnose and treat children with HIV and TB.

Appendix 1: Table of Facilities Visited

Name of Facility	Description of services offered	Location	Population served
Kabwata Clinic	This is an urban clinic that offers primary health care, TB treatment, and ART. It caters to the densely populated areas of Kabwata, Burma, Libala, and Chalala.	Urban area	50,000
Bauleni Clinic	This is an urban clinic that offers primary health care, TB treatment, and ART. It caters to the densely populated Bauleni area and surrounding farming areas.	Urban area	55,326
Kalingalinga Clinic	This is an urban clinic that offers primary health care, TB treatment, and ART. It caters to the densely populated Kalingalinga area and the low-density areas of Kabulonga and Long acres.	Urban area	80,000 to 100,000
Chelston Clinic	This is an urban clinic that offers primary health care, TB treatment, and ART. It caters to the densely populated areas of Chelston, Avondale, Kamanga, and the Chamba Valley, and to surrounding farming areas.	Urban area	60,000
Chipata Clinic	This is an urban clinic that offers primary health care, TB treatment, and ART. It caters to the Fumbelo, Chipata Compound, Mandevu, and Matyela areas.	Urban area	55,000
University Teaching Hospital (UTH)	This is the biggest hospital in Zambia, and offers all services related to primary health care, TB, and ART. It caters to many different communities, as complicated cases are referred to this institution for examination, testing, and treatment.	General hospital, urban area	1,000,000
George Clinic	This is an urban clinic that offers primary health care, TB treatment, and ART.	Urban area	20,000

University of Zambia Clinic	This is an urban clinic that offers primary health care, TB treatment, and ART services to students, lecturers, university workers, and their families.	Urban area	3,000
Chilenje Clinic	This is an urban clinic that offers primary health care, TB treatment and ART inclusive. It caters to the Chilenje, Libala, Chalala, Woodlands, Twin Palms, and Nyumba Yanga communities.	Urban area	55,000

Appendix 2: Questions to Guide Country Teams in Report Writing

A. ICF

1. Out of the number of HIV clinics assessed in this region / district how many have reported to be screening PLWHA for TB symptoms and how often on the average are PLWHA screened for TB?
2. What proportion of the HIV clinics accessed in the region/district refer the HIV positive TB suspects for TB confirmatory test and what is the average distance from the HIV clinic to the nearest TB clinic. (Divide the total distance by the number of clinics)
3. Out of all the adults and children that were accessing HIV care in the clinic, what is the average percentage of them who had their TB status assessed and recorded during the last quarter (July 1st – 30th September, 2009 or April 1st – June 30th,2009) as compared to the all adults and children enrolled in HIV care and seen for care in the same reporting period

B. TB Treatment

1. What percentage of (a). Adults and (b). Children were started on TB treatment during the last quarter (July 1st – 30th September, 2009 or April 1st – June 30th, 2009) out of the all adults and children enrolled for ART in the same reporting period in this region/district?
2. Out of the HIV clinics assessed, what proportion provide TB treatment for PLWHA diagnosed with TB disease in this regions/ district?
3. What percentage of the HIV clinics assessed provides TB treatment for drug resistant TB?

C. Isoniazid Preventive Therapy (IPT)

1. What proportion of the HIV clinics visited provide IPT as a package of care for:

    a. PLWHA who are latently infected with TB:_____, and
    b. Children under 5 year who are close contacts of TB patients in this regions/ district: _____

D. What are three main obstacles mentioned by the HIV clinics for not providing IPT for PWHA latently affected with TB and the eligible children, in this regions/ district?

E. Infection control measures in the HIV health care and congregate settings

1. What percentage of HIV clinics visited in this region/ district are implementing an infection control plan?
2. What are the 5 most common infection control measures that being implemented in the HIV clinics that you have assessed in this region/district?

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

1. What is the percentage of health care workers employed in HIV health care facilities in the province/region provide care for people living with HIV; developed TB in the last quarter (July 1st – 30th September 2009 or April 1st – June 30th, 2009)
2. What TB prevention measures/ policies have been put in place by the HIV clinics in the region/district to protect health care workers who work with PLWHA and what percentage of the clinics assessed have these measures in place?

Availability of services to decrease the burden of HIV among people living with TB disease.

A. HIV testing and Counseling for TB patients

1. What percentage of the TB clinics assessed offer HIV testing to TB patients in this region/ district?
2. What percentage of the TB clinics assessed refer the adults and children diagnosed with TB for HIV voluntary counseling and testing, and what is the average distance to the nearest HIV clinic in this region/ district?
3. What percentage of the TB clinics assessed in the region/ districts also capture the HIV status and HIV treatment regimen of their TB patients in their TB register?

B. Provision of HIV prevention methods/ CPT and HIV care and support services at the TB clinic

1. What HIV prevention strategies do the TB clinics in this region/district provide to TB patients who are at risk for HIV?
2. What percentage of the TB clinics assessed in the district / regions provide CPT for HIV positive TB patients?
3. What are the 3 main barriers for not providing CPT to HIV positive TB patients that have been reported by the TB clinics assessed
4. What HIV care and support services are being provided by the TB clinic to people living with TB and HIV in the region/district and what percentage of the TB clinics assessed provide these services?

C. Provision of ART to HIV positive TB patients

1. Out of the number of TB clinics assessed in the region/district, what percentage of these provide ART to HIV positive TB patients who are eligible to start?
2. Out of the total number of TB patients who access TB services in the

clinics visited what is the average percentage of TB/HIV patients who were initiated on ART in the last quarter (July 1st – 30th September, 2009 or April 1st – 30th, 2009) in the clinics visited?

3. What mechanisms have been put in place between the HIV and TB program to provide ART to eligible HIV positive TB patients in the region/district as reported by the TB clinics assessed?

Assessing the planning and coordination between the TB and HIV programs

A. Existence of the policy

1. Does the country have the TB/HIV collaborative policy/guidelines? How many TB and HIV policy makers interviewed have knowledge about the existence of the policy/ guidelines in the country?
2. What mechanisms have been put in place by the HIV and the TB policy makers to ensure that the TB/HIV guidelines/policy are implemented in the selected region/ district?
3. According to the policy makers interviewed, what percentage of all the HIV centers in the country/district/region do the following:

   i) Regular screening for TB in HIV- positive adults and children
   ii) Provide TB treatment for PLWHA diagnosed with TB disease
   iii) Provide IPT to PLWHA who are latently infected with TB disease
   iv) Have implemented TB infection control policies in high burden congregate settings

4. What are the 3 major challenges expressed by the HIV policy makers in implementing the TB/HIV collaborative policy?
5. What are the 3 major challenges expressed by the TB policy makers in implementing the TB/HIV collaborative policy

Assessing the perspective of PLWHA- TB on the availability of TB and HIV Collaborative services

1. What percentage of PLWHA interviewed has knowledge about the existence of the TB/HIV collaborative policy in the country/ district?

2. What percentage of PLWTB interviewed have knowledge about the existence of the TB/HIV collaborative policies

3. What are the 5 components of TB/HIV collaborative policy/ guidelines that are commonly known to the TB and HIV affected communities in this region/ district?

4. What mechanism do the affected communities feel have been put in place to ensure that the collaborative policies are being implemented in this region/ district?

5. What percentage of HIV treatment centers visited are providing the following services in the region / district? as reported by the PLWHA interviewed?

    i) Regular screening for TB in HIV positive adults and children
    ii) Provide TB treatment for PWHA diagnosed with TB disease
    iii) Provide IPT to PLWHA who are latently infected with TB and to children under 5 whose household contacts of someone with
    iv) Have implemented TB infection control policies in HIV burden congregate settings

6. Does the TB and HIV affected communities feel their country/ region/ district has developed a strategy for addressing TB and HIV among the vulnerable communities that include, PLWHA, children, and people in congregate settings (e.g. Prisons, schools, brothels)

7. What percentage of the total number of PLWHAs interviewed, expressed that they are screened for TB symptoms at the HIV clinics they visit in the district / region and how often on average are PWHA screened for TB?

8. What is the average proportion of the PLWHA referred from the HIV clinics that the PLWHIV interviewed feel that are able to follow up on the referral for TB diagnostics?

9. What percentage of the total number of PLWHA interviewed reported that the HIV clinics that they go to also provide first line TB treatment for PLWHA diagnosed with TB disease and that this treatment is recorded on their ART treatment cards?

10. What percentages of the HIV clinics are reported by the PLWHIV and PLWTB to be providing treatment for drug resistant TB in this region/ district?

11. What percentage of the total number of PLWHA interviewed reported to have received information about IPT and in addition report that their HIV clinics also provide IPT as a package of care to PLWHA who are latently infected with TB?

12. What are the 4 common infection control measures that the PLWHIV interviewed in this region/ district report to be implemented by their HIV clinics?

13. What percentage of the total number of PLWTB interviewed expressed that their TB clinics have also offered HIV testing and counseling services to TB patients?

14. What percentage of the total number of PLWTB interviewed reported that their TB clinics also refer all the adults and children diagnosed with TB to the HIV voluntary counseling and testing and what was the average distance to the nearest clinic?

15. What is the average proportion of the TB patients referred from the TB clinics for HIV testing that the PLWTB interviewed feel are able to follow up on the referrals in this region/district?

16. What HIV prevention methods are accessed by the PLWTB at the TB clinics as reported by the PLWTB interviewed?

17. What percentage of the total number of PLWTB interviewed report that their clinics provide CPT for HIV positive TB patients in this region/district.

18. If it is not being provided, what are the 3 main reasons given by the PLWTB interviewed for their clinics not being able to provide the CPT.

19. What are the HIV prevention and care services that are being accessed by the PLWTB at their TB clinics?

20. What percentage of the total number of PLWTB interviewed have reported that their TB clinics also provide ART to eligible HIV positive TB patients and what mechanism has been created between the HIV and the TB programs to provide ART to eligible HIV positive TB patients.

What key observations have you noted from the survey in relation to the availability of TB/HIV services and their utilization by the TB and HIV patients and the policy and coordination of TB programs and HIV programs?

1. Did the policy makers, clinic leaders, and PWH/TB have the same assessment of the availability of TB/HIV collaborative services?
2. If not then what were the differences in perspective

What are the key best practices in the region/district noted in to availability of services, and TB/HIV program policy and coordination?

What recommendations do you draw from these observations?

APPENDIX III: TB/HIV UNGASS Monitoring Tool

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 April 1st - 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 lamp.)
- ☐ 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
c. HIV support groups
d. Police and Army Barracks
e. 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 ☐

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

- ☐ a. Provision of free condoms
- ☐ b. Education programs promoting safer sex practices
- ☐ c. Early diagnosis and treatment of other sexually transmitted infections
- ☐ d. Information on prevention of mother to child transmission of HIV
- ☐ e. Promotion of positive living among those already living with HIV
- ☐ f. Partner testing for HIV infected patients
- ☐ g. 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 ☐

i. 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 ☐

   i. 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)?

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

   iii. 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?

IV. 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 ☐

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

☐ a. 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.
☐ b. Inclusion of representatives from the NTP in the planning process of the NACP and vice versa
☐ c. Surveillance of HIV prevalence among TB patients
☐ d. Advocacy, communication and social mobilization strategy for HIV to include appropriate information about TB, and vice versa.
☐ e. Intensified TB case finding for all people living with HIV/AIDS at each clinic visit/ in accordance with a national ICF policy.
☐ f. ART access provided for all eligible HIV-positive TB patients in accordance with the national protocols
☐ g. HIV-positive TB patient to have full access to continuum of HIV care and support services.
☐ h. Cotrimoxazole Preventive Therapy (CPT) for all HIV-positive TB patients and all people living with HIV in accordance with the international guidelines.
☐ i. Access to diagnosis and treatment of TB to be part of a basic package of care for people living with HIV.
☐ j. IPT offered to all PLWHA latently infected with TB.
☐ k. HIV testing and counseling routinely offered to all patients with confirmed TB diagnosis.
☐ l. Infection control policy is in place and monitored to ensure its effective implementation.

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

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

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

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

a. Regularly screen for TB in HIV-positive adult and children

Number of Clinics:___ Don't Know ☐

b. Provide TB treatment for PLWHA diagnosed with TB disease

Number of Clinics: ___ Don't Know ☐

c. 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 ☐

d. Have implemented TB infection control policies in high-HIV burden congregate settings

Number of Clinics: ___ Don't Know ☐

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

- ☐ a. PLWHA
- ☐ b. Children
- ☐ c. People in congregate settings (e.g. prisons, schools, brothels)

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

1.

2.

3.

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

6. 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 & 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.A. TB/HIV Collaborative Policy

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

Yes ☐ No ☐ Don't Know ☐

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

- ☐ a. 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.
- ☐ b. Inclusion of representatives from the NTP in the planning process of the NACP and vice versa
- ☐ c. Surveillance of HIV prevalence among TB patients
- ☐ d. Advocacy, communication and social mobilization strategy for HIV to include appropriate information about TB, and vice versa.
- ☐ e. Intensified TB case finding for all people living with HIV/AIDS at each clinic visit/ in accordance with a national ICF policy.
- ☐ f. ART access provided for all eligible HIV-positive TB patients in accordance with the national protocols
- ☐ g. HIV-positive TB patient to have full access to continuum of HIV care and support services.

- ☐ h. Cotrimoxazole Preventive Therapy (CPT) for all HIV-positive TB patients and all people living with HIV in accordance with the international guidelines.
- ☐ i. Access to diagnosis and treatment of TB to be part of a basic package of care for people living with HIV.
- ☐ j. IPT offered to all PLWHA latently infected with TB.
- ☐ k. HIV testing and counseling routinely offered to all patients with confirmed TB diagnosis.
- ☐ l. Infection control policy is in place and monitored to ensure its effective implementation.

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

- ☐ a. Joint coordinating board/committee/task force has been set up and meets regularly (If yes, ask how often :.....)
- ☐ b. A dissemination/communication strategy for the policy has been implemented.
- ☐ c. Joint planning to ensure that AIDS control plans include TB and TB control plans include HIV components.
- ☐ d. Joint resource mobilization for collaborative TB/HIV activities
- ☐ e. Joint communication and advocacy strategy for TB and HIV control programs (HIV programs include TB and vice versa)
- ☐ f. Joint plan for and involving affected communities in implementation of collaborative TB/HIV activities
- ☐ g. Joint plan for operational research in collaborative TB/HIV activities
- ☐ h. Joint approach to monitoring and evaluating collaborative activities.

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

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

a. Regularly screen for TB in HIV-positive adult and children

Number of Clinics:___ Don't Know ☐

b. Provide TB treatment for PLWHA diagnosed with TB disease

Number of Clinics:___ Don't Know ☐

c. 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 ☐

d. Have implemented TB infection control policies in high-HIV burden congregate settings

Number of Clinics:___ Don't Know ☐

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

- ☐ a. PLWHA
- ☐ b. Children
- ☐ c. People in congregate settings (e.g. prisons, schools, brothels)

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

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%

v. **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.C. 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.D. 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.E. 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?

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

V. 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:

V.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?

Yes ☐ No ☐

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%

v. 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 ☐

V.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 ☐

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

- ☐ a. Provision of free condoms
- ☐ b. Education programs promoting safer sex practices
- ☐ c. Early diagnosis and treatment of other sexually transmitted infections
- ☐ d. Information on prevention of mother to child transmission of HIV
- ☐ e. Promotion of positive living among those already living with HIV
- ☐ f. Partner testing for HIV infected patients
- ☐ g. Others, please describe:

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

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

Yes ☐ No ☐

If not, why?

V.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:

V.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 ☐

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

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

   Yes ☐ No ☐

   iii. If yes, what does it look like?