MINISTRY of Health

Shaping Fiji's Health

Fiji TBHIV

Collaborative Policy

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CPT	Co-trimoxazole Preventive Therapy
DOTS	The internationally recommended strategy for TB control
EPTB	Extra Pulmonary Tuberculosis
HIV	Human Immunodeficiency Virus
HIU	Health Information Unit
IPT	Isoniazid Preventive Therapy
MDR-TB	Multi-drug Resistant Tuberculosis
NTP	Tational Tuberculosis Programme
PLWHA	People Living with HIV/AIDS
STI	Sexually Transmitted Infections
TB	Tuberculosis
TB/HIV	The intersecting epidemics of TB and HIV

Definitions:

CD4 Count: The number of CD4 T-lymphocyte cells usually expressed as the number of cells per cubic millimeter. The CD4 count reflects the “health” of the immune system. A normal count in a healthy adult is variable and can range from 500-1400 cells/mm3.3

HIV testing and Counseling:

Prophylaxis: A measure taken for the prevention of a disease or condition.

Pre-Test Counseling: Is counseling done to an individual on HIV before the client receives a blood test

Post- Test Counseling: Is counseling the client receives after the blood test is done and the patient is receiving a counseling when receiving results for HIV. Post Test Counseling is done regardless of HIV Status.

TB/HIV co-infected: Is a state of the patient being both TB and HIV positive at the same time. Where in that instance the treatment care of the patient becomes a multidisciplinary with TB and HIV team, though the TB treatment is started prior to HIV Anti-Retroviral Therapy.

VALUES

The Ministry of Health strives to uphold customer focus, respect for human dignity, quality, equity, integrity, responsiveness and faithfulness as paramount values for the achievement of its mission and vision.

VISION STATEMENT

A population of Fiji that is free from TB and moving towards zero TB/HIV deaths.

MISSION STATEMENT

To ensure that all TB patients are screened for HIV and that all HIV patients are tested for TB thus if a co-infection is detected a multidisciplinary team is adequately trained and available for appropriate treatment and care for all TB/HIV patients.

Preamble

This policy document focuses on a collaborative move for the TB and HIV Units of Fiji to have activities that address the interface of the tuberculosis and the HIV and AIDS epidemics either it be from the preventative or the holistic care of patients who are co-infected.

Introduction

Human immunodeficiency virus (HIV) is the single greatest risk factor for the development of tuberculosis (TB) disease and TB is the commonest opportunistic infection in people living with HIV infection. The increasing prevalence of HIV infection in Fiji will present new and ongoing challenges to the national control of TB at all levels.

In 2012, there were 218 patients registered on TB treatment by the national TB programme. Fifty eight (58%) percent were tested for HIV infection and there were 5 (2.3%) TB/HIV co-infected cases.

There have been 482 confirmed positive cases of HIV infection in Fiji from 1989 to 2012. The Ministry of Health implemented a TB-HIV surveillance policy in 2006. The key elements of this policy are :

i) HIV testing for all TB cases aligned to the validated testing strategy in Fiji
ii) Surveillance of HIV prevalence rates among TB patients and
iii) The development of a core set of indicators and data collection tools for the monitoring and evaluation of TB-HIV activities.

Target Audience

This policy is intended for programme managers under the TB and HIV programme, the Divisional HIV and TB teams, private practitioners, and stakeholders who work in the area of TB or HIV prevention, treatment and care inclusive of the Positive network for HIV in Fiji which is known as the Fiji Network for Positive People.

Goal

To provide the Public and Private health sectors in Fiji to ensure that appropriate preventative, treatment and care of all TB/HIV patients has been delivered in an efficient manner.

Objectives

The three major objectives of TB-HIV collaborative activities are:

1. To establish mechanisms for collaboration at all levels in terms of program management and also implementation of the TB and HIV programme.
2. To increase detection of tuberculosis in people living with HIV infection and vice versa.
3. To optimise management and care for TB/HIV co-infection

Policy Statements

Establish and strengthen the mechanisms for delivering integrated TB and HIV Services:

The national Co-ordinating Committee for the collaborative TB/HIV programme needs to ensure that they cover these basic areas in their Terms of Reference:

i. Governance and coordination at national and sub-national levels.
ii. Resource Mobilisation
iii. Provision of General Policy and programme direction for the management of activities
iv. Capacity Building including training
v. Ensuring Coherence of communications about TB and HIV
vi. Ensuring the involvement of civil society, non-Governmental and community organizations, and individual.

a) A TB-HIV co-ordinating committee should be established at National level and at Divisional Levels, they should at least meet on a bi-annual basis to develop TB-HIV collaborative activities. Areas of responsibility will include joint planning, coordination of capacity building, training of health care workers in TB-HIV activities, monitoring and evaluation and ensuring communication at all levels.
b) The TB-HIV co-ordinating committee should facilitate the implementation of the TB-HIV collaborative activities as per the national TB and HIV clinical guidelines. TB and STI/HIV officers from the divisional level should meet bi-annually to facilitate implementation of activities and review work progress. These activities should include updating and reviewing of records and registers, development and review of mechanisms for regular communication between the two programmes and formalizing information flow between the two services.
b) TB registers and treatment cards should be revised to capture information about whether TB patients have received HIV (testing)[1], cotrimoxazole preventative therapy (CPT) and if the patient is positive for HIV have they been initiated on antiretroviral therapy (ART). The patient monitoring and recordings system should also capture information on TB screening, isoniazid preventative therapy (IPT), TB treatment, CPT and ART.
c) The TB-HIV co-ordinating committee should develop a core set of indicators for both the National TB and HIV programmes that include:

i) Percentage of TB patients who have had an HIV test in the TB register.
ii) Percentage of people living with HIV advised and/or screened for TB at the most recent visit
iii) Percentage of adults and children newly enrolled in HIV care started on isoniazid preventative therapy
iv) Percentage of HIV infected TB patients that are receiving cotrimoxazole preventative therapy
v) Percentage of HIV infected TB patients that receive antiretroviral treatment

[1] To be done by HIV team

The Three I's to reduce the burden of TB disease among people living with HIV

There are three activities, known as the "*Three I's*," that those providing care to people with HIV should do to protect them from TB infection, help prevent active disease from developing, and to identify active TB disease early and improve the chances of cure:

- ICF: Intensified Case Finding for TB means regularly screening all people with or at high risk of HIV or in congregate settings (such as mines, prisons, military barracks) for the symptoms and signs of TB, followed promptly with diagnosis and treatment, and then doing the same for household contacts. Simple questionnaires to screen for TB can be performed when people first seek HIV services (e.g., care, voluntary counselling and testing, etc.) and/or by community based organizations supporting people with HIV. ICF serves as the important gatekeeper for the two other I's (infection control and isoniazid preventive therapy), facilitating rapid identification of TB suspects (allowing for triage and other steps to reduce TB transmission), and acting as the necessary first step for healthcare providers to confidently prescribe IPT to people living with HIV who do not have active TB.

- IPT: Isoniazid Preventive Therapy for TB can safely be given to people living with HIV without TB disease, reducing the risk of developing TB by 33–67% for up to 48 months. It is currently recommended for all people living with HIV in areas with a prevalence of latent TB infection >30%, and for all people living with HIV with documented latent TB infection or exposure to an infectious TB case, regardless of where they live. More recently, evidence has shown that the combined use of isoniazid preventive therapy and antiretroviral therapy among people living with HIV significantly reduces the incidence of TB; and the use of IPT in patients who have successfully completed a course of TB therapy has been shown to markedly reduce the risk of subsequent TB cases.

- IC: TB Infection Control measures are essential to prevent the spread of *M. tuberculosis* to vulnerable patients, health care workers, the community and those living in congregate settings. Fundamentally, TB infection control is about safety — people receiving or offering HIV care should not have to worry about being exposed to and infected with M. tuberculosis in the process. In light of the crisis of drug resistant TB in countries with a high burden of HIV, establishing facilities that are safe from TB has become an emergency situation for health services, prisons and other congregate settings, in general, but especially for HIV programmes.

Reduce the burden of TB in people living with HIV and Initiate early Anti-retroviral Therapy (The Three I's for TB/HIV)

(1) All patients diagnosed with HIV infection should be screened for TB at initial assessment and at every follow-up visit within HIV care facilities. The algorithm developed for assessment of people with HIV infection for TB should be used as a tool to facilitate screening. (Intensifying TB Case finding)
(2) IPT should be provided to patients with latent tuberculosis infection once adequate screening has been completed to exclude active disease as outlined in the screening algorithm. IPT should be provided within HIV health care facilities.
(3) Case detection of smear-negative and EPTB should be increased and all patients who receive TB treatment should be recorded in the TB register. Culture and Gene-expert should be included in the algorithm for evaluating patients with negative smears.
(4) Drug susceptibility testing should be requested prior to the commencement of treatment for all known HIV infected TB patients. If a patient with HIV infection is identified with MDR-TB, provisions should be made for ART at the TB facility where appropriate infection control measures should be instituted. Sputum culture and GeneXpert testing must also be requested.
(5) A TB infection control policy that is aligned with the National Infection Control Manual, should be developed for all health care settings and referral of people living with HIV to TB clinic and wards for assessment should be minimised where possible. Key elements that should be

included in the TB infection control policy are:

- Development of a national TB infection control framework or guideline
- Training of health care workers on infection control policies
- Placement of written guidelines within all TB and HIV care facilities
- Ensuring good ventilation within all facilities in which TB suspects are present
- Ensuring all patients with a chronic cough visiting the Reproductive Health Facilities to notify the staff and be screened in a separate room
- "Cough etiquette" should be encouraged and patients should be provided with a barrier to use when coughing
- A system for monitoring and evaluation should be established

Increase the detection of HIV in TB patients

(1) HIV pre-test counseling should be offered to all diagnosed cases of TB for all health care settings. HIV testing is aligned to the validated testing strategy in Fiji.

(2) CPT should be provided to all HIV infected TB patients at the time of diagnosis and should be available at both TB and HIV care facilities.

(3) All TB patients with a confirmed positive HIV test following either the Divisional or Sub-Divisional HIV Testing Algorithm should be discussed with HIV care facilities in their respective divisions in an efficient and confidential manner for appropriate treatment.

(4) TB treatment should be observed daily for HIV infected TB patients either at DOTS centres or if this is not feasible by zone nurses in both the intensive and continuation phase of treatment.

(5) All TB/HIV co-infected patients should be discussed and seen by both the HIV and TB team prior to discharge.

(6) Contact tracing of the TB/HIV co-infected person should be done together by both teams though the patients HIV status doesn't need to be revealed to the family except to the identified partner by the patient[2].

Treatment for TB/HIV patients

1) All patients diagnosed with TB are immediately eligible for ART regardless of CD4 count. Thus the TB and HIV Team both need to ensure that under the right circumstances ART is initiated for the TB/HIV patient within the first 8 weeks of TB Treatment. The treatment should follow the Treatment Guidelines for Fiji 2013.

2) Since all TB cases detected by private clinicians is referred to and treated in the TB units in the country, if patient turns out to be HIV positive, HIV treatment can be provided by the HIV Team unless the patient chooses to be treated by his/her private practitioner. In the instance if the patient opts to be treated by a private practitioner for HIV, the private practitioner has to ensure that he/she is adequately trained with the HIV course in Fiji or Overseas though the management needs to be done in consultation with the HIV Team.

(3) The Drugs for HIV that is initiated by the private practitioner in this instance will be provided by the HIV Team at no cost. The private practitioner in this instance needs to ensure that a de-identified report has been sent to the HIV Team and an identified reporting to the HIV Manager who in this case will be the National Advisor for Family Health Unit under the Ministry of Health.

4) If for some unforseen reason the patient reacts to the ART the private practitioner will need to refer the patient immediately to the HIV Team in the Divisions to further manage the patient.

[2] This can be a defacto or a legal partner of the patient.

Over all the TB and HIV Programme should collaborate with other programmes to ensure access to integrated and quality assured services for all.

Leadership/Governance and Service Delivery

Under the TB and HIV National Strategy, with the guidance through of this Policy, it becomes the mandate of the various leadership in the Ministry of Health Fiji to ensure that the Policy is implemented in the appropriate manner and reviewed within the given time frame of this Policy.

It becomes the mandate of the Government and Ministry of Health to ensure that adequate preventative, treatment and care is given to all TB/HIV co-infected patients and that the appropriate service delivery standards are met in all areas of Fiji in accordance to the policy statements.

Human Resources

As it is essential to provide all TB patients with HIV counselling and testing and vice versa, the necessary programme managers need to ensure that the adequate training is made available and that adequate trained health care workers are available to provide the essential services with the TB and HIV programme.

There needs to be staff trained and available in:

- Voluntary Counselling and Testing
- TB Treatment and Care
- HIV Treatment and Care
- Infection Control and care

The programme managers need to ensure that staff whose capacity has been built in the area of TB and HIV Care remain in the area of TB and HIV unless the health care worker decides to choose a different career path of choice or seeks tranfers for personal reasons.

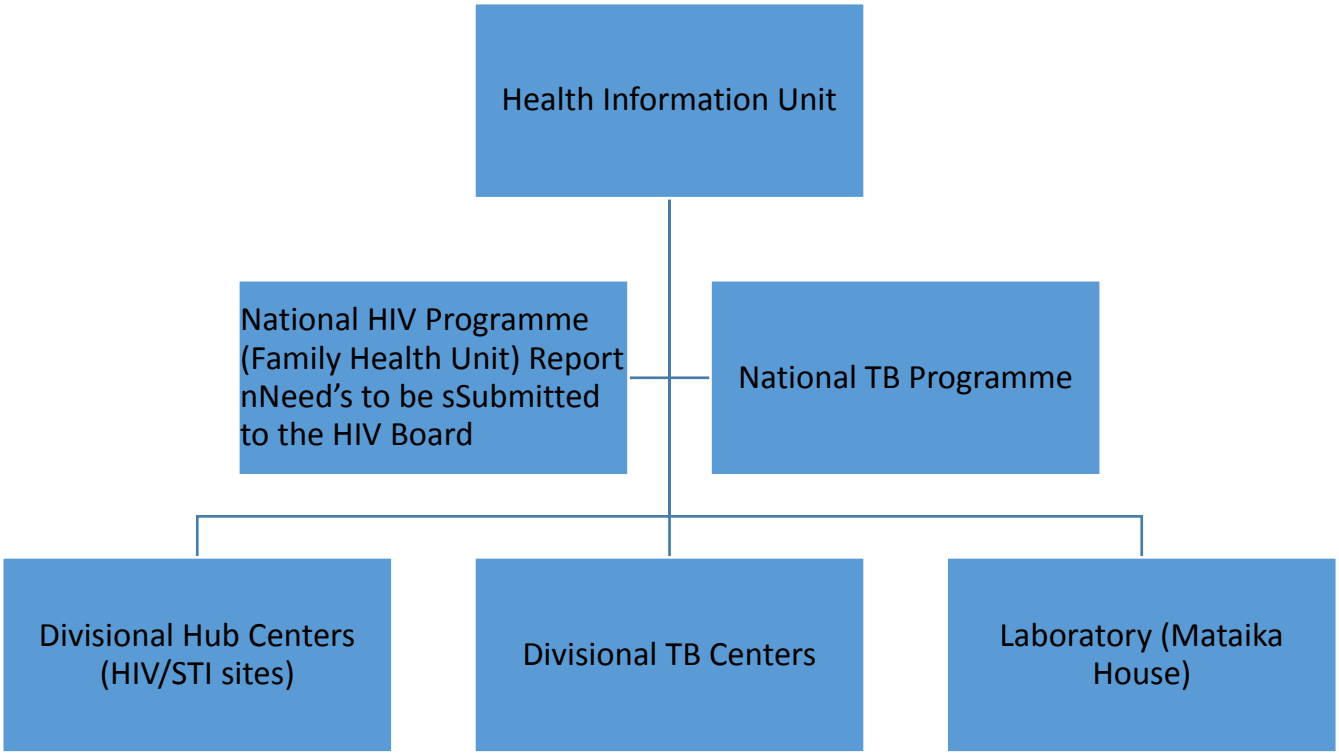
Communications and Commodities

There needs to be collaboration in the communications strategy for TB and HIV, which will ensure cost effective measures and strengthen messages to society. These Behaviour Change messages need to be made available at all health care facilities in Fiji and not just the TB and HIV clinic sites in the three divisions.

Information Systems/Reporting

All necessary data collected under the TB and HIV programme needs to be in line with the Information Systems in the Ministry of Health, Health Information Unit (HIU). Reports need to be submitted to the Health Information Unit while the systems are being developed for reporting purposes for both the TB and HIV programme.

The Reporting in country needs to be in line with the International Reporting Requirements to which the Ministry of Health is obliged to report under the Millenium Development Goals.



The reporting of the TB and HIV Programme which will include the TB/HIV coinfection prevention, treatment and care will be in co-operated into the reports which will be received. The reports need to be submitted on a:

- Quarterly (2nd Week Friday of the Following Month of the Quarter)
- Half Yearly Report
- Annual Report (Annual Report should be received by the 3rd week of the first month of the year)

Regulations

The TB/HIV Policy needs to be in line with the Public Health Act and the HIV Decree 2011 which was gazetted on the 4th of February. This policy should also follow the HIV and STI Testing and Counselling Policy 2013 for the purposes of Counselling and Testing of patients who are diagnosed to be TB positive and for all HIV patients, the TB guidelines should be followed for the purposes of appropriate investigation, referral and treatment needed.

Responsibility

This policy will fall under the TB and HIV programme managers, thus it becomes the responsibility of the two units to ensure that this policy is implemented appropriately with the support of the Project officers in each unit and the Divisional Teams under the two units.

Research

Research in the area of TB/HIV coinfection is important and is definitely encouraged, though the researcher will need to undergo the right processes in place under the (FNRERC and NHRC) Fiji National Research Ethics Committee and the National Health Research Committee.

Support by the two units after approval is sought is important and strongly suggested. Though in the researches for TB/HIV which deals with patients directly, there needs to be involvement of a TB and HIV Health Care worker for the purposes of confidentiality.

Monitoring and Evaluation

Monitoring and Evaluation provides the means to assess the quality, effectiveness, coverage, and delivery of collaborative TB/HIV activities. It promotes a learning culture within and across the programmes and ensures continuous improvement of individual and joint programme performance.

Monitoring and Evaluation will involve the collaboration between the programmes and the general health system, the development of referral linkages between different services and organizations, and joint supervision. Ensuring that there is a harmonized indicator set that should be captured by each programme are essential to avoid duplication of the combined efforts and the national reporting and recording formats should be standardized.

Using the three interlinked patient monitoring systems for HIV Care/ART, MCH/PPTCT, and TB/HIV will facilitate the cross checking and reconciliation of data between HIV programmes and TB control programmes at local and country levels and will strengthen ownership of data. [3]

The Global Targets for TB/HIV is to reduce TB deaths in people living with HIV by 50% by 2015.

The important indicators to ensure that the scale up of the TB/HIV collaborative programme is happening would be:

i. Proportion of TB patients Counselled and Tested for HIV in the reporting period
ii. Percentage of TB/HIV patients counselled and initiated on Anti-Retroviral Therapy within the first 8 weeks of admission
iii. Proportion of newly HIV positive patients (adults and children) tested and recorded for TB in the reporting period
iv. Percentage of adults and children newly enrolled in HIV care starting isoniazid preventative therapy
v. Percentage of health care facilities providing ART services for people living with HIV which demonstrate infection control practices that include TB control.
vi. Percentage of HIV positive incident TB cases that received treatment for both TB and HIV.

[3] Reference: WHO Policy on Collaborative TB/HIV activities, Guidelines for national programmes and other stakeholders 2012.

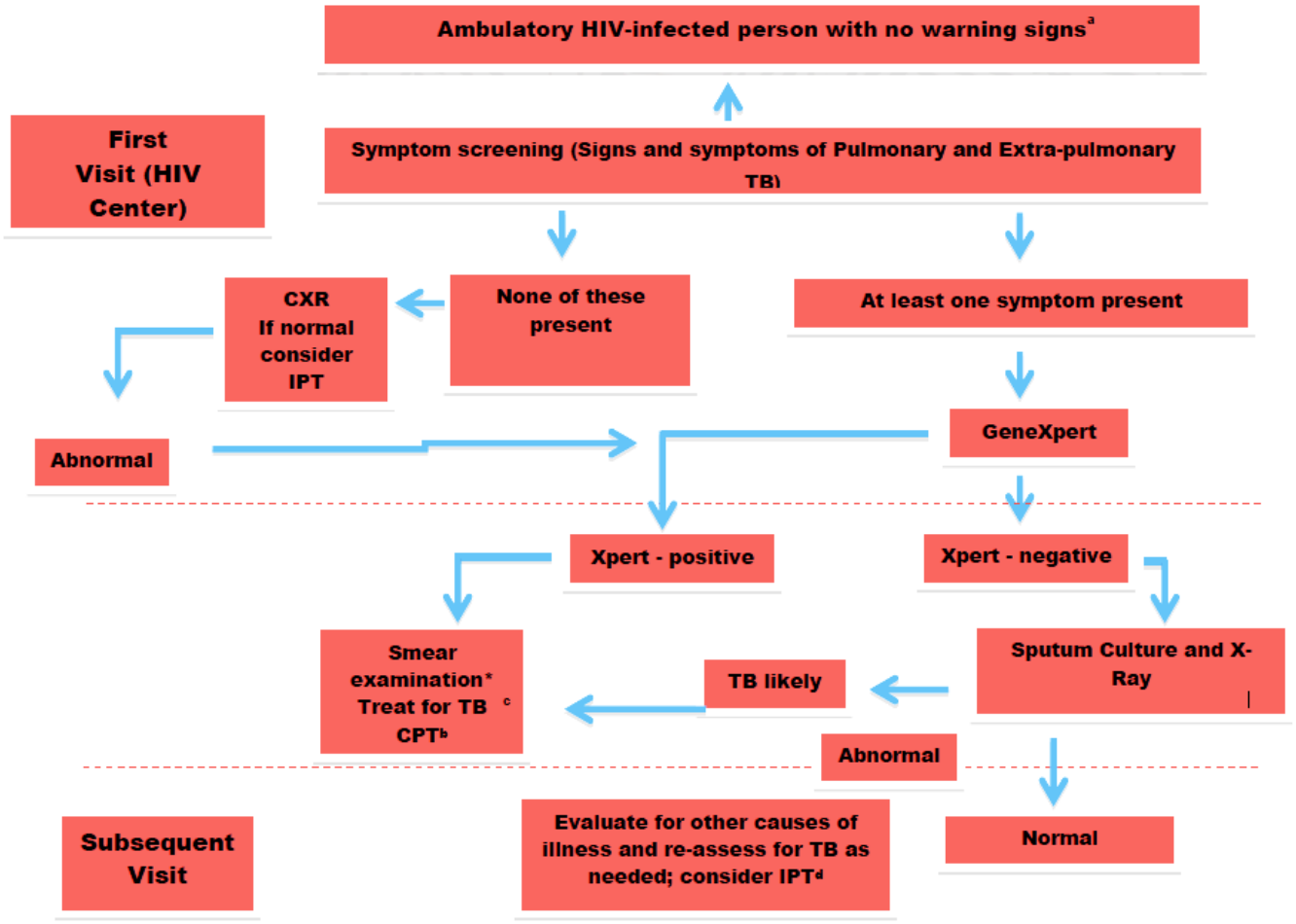
References

- WHO policy on Collaborative TB/HIV activities, Guidelines for national programmes and other stakeholders 2012
- Fiji Mid Term Review for the 10 Targets under HIV Programme
- HIV/STI Testing and Counselling Policy, Ministry of Health, Fiji Islands 2013
- Global AIDS Response Progress Reporting 2013 , Construction of Core Indicators for Monitoring the 2011 UN Political Declaration on HIV/AIDS
- National HIV Report for 2012
- National TB Programme Technical Guidelines 2011
- National TB Programme Annual Report 2012
- Fiji Strategic Plan to Stop TB 2011-2015
- Republic of Fiji National Strategic Plan on HIV and STI's, 2012-2015

Review

The TB/HIV Collaborative Policy will need to be reviewed in the next 3 years unless suggested to be done earlier due to the rapid advancements in the area of HIV and TB. The next review period would be in the year of 2016.

Algorithm for TB Screening for Ambulatory People Living with HIV (PLHIV)



a. Warning signs include any one of: respiratory rate > 30/minute, fever >39 C, pulse rate > 120/min and unable to walk.
b. CPT – cotrimoxazole preventive therapy
c. HIV care and ART includes WHO clinical staging, CD4 testing and antiretroviral therapy (ART).
d. The investigations within the box should be done at the same whenever possible to decrease the number of visits and speed up diagnosis.
If culture is not available, then the decision should be made based on chest X-ray and clinical assessment.

*sputum to be collected before taking first dose of TB drugs for smear examination

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Source: World Health Organization. *A revised framework to address TB-HIV co-infection in the Western Pacific Region*. Geneva: World Health Organization, 2006.