TB HIV Co-infection poses a critical challenge for the health-sector and for people living with HIV and TB. People living with HIV who are also infected with TB are much more likely to develop TB disease than those who are HIV-negative. Starting in the 1980s, the HIV epidemic led to a major upsurge in TB cases and TB mortality in many countries.

In 2012, 1.1 million (13%) of the 8.6 million people who developed TB worldwide were HIV-positive. The African Region accounted for 75% of the estimated number of HIV-positive incident TB cases. The number of people dying from HIV-associated TB has been falling since 2003. However, there were still 320 000 deaths from HIV-associated TB in 2012 and further efforts are needed to reduce this burden.

Globally, the percentage of notified TB patients with a documented HIV test result was 46% in 2012, up from 40% in 2011 and 15 times higher than the 2004 level. WHO recommendations on the interventions needed to prevent, diagnose and treat TB in people living with HIV have been available since 2004 and are collectively known as collaborative TB/HIV activities. They include establishing and strengthening coordination mechanisms for delivering integrated TB and HIV services, testing TB patients for HIV, providing ART and CPT to TB patients living with HIV, providing HIV prevention services for TB patients, intensifying TB case-finding among people living with HIV, offering IPT to people living with HIV who do not have active TB, and controlling the spread of TB infection in health care and congregate settings (the latter three activities are referred to as the Three ‘Is’ for HIV/TB). Since December 2010, the rapid molecular test Xpert MTB/RIF has been recommended as the primary diagnostic test for TB among people living with HIV who have TB signs and symptoms.

There was an encouraging increase in ART coverage among HIV-positive TB patients between 2011 and 2012, from 49% worldwide in 2011 to 57% in 2012. Nonetheless, given the WHO recommendation that all HIV-positive TB patients are eligible for ART, the coverage of ART for HIV-positive TB patients still needs to be greatly improved.
In 2012, 80% of HIV-positive TB patients were provided with co-trimoxazole preventive therapy (CPT), a level similar to recent years and 4.1 million people enrolled in HIV care were reported to have been screened for TB, up from 3.5 million in 2011. Of the reported 1.6 million people newly enrolled in HIV care in 2012, almost 520 000 were provided with isoniazid preventive therapy (IPT). Coverage needs to be increased, since about 50% of those newly enrolled in HIV care and screened for TB are likely to be eligible for IPT.

ART is a critical intervention for reducing the risk of TB morbidity and mortality among people living with HIV. It reduces the individual risk of TB disease by 65%, irrespective of CD4 cell count and when combined with IPT it can have a significant impact on TB prevention. In the latest WHO guidelines released in July 2013 the threshold CD4 count at which starting ART is recommended has been raised from a CD4 count of ≤350 to ≤500 CD4/mm. Implementation of these guidelines on a large scale should substantially reduce morbidity and mortality resulting from HIV-associated TB. As in previous guidelines, ART is recommended for all TB patients living with HIV, irrespective of their CD4 cell count. CPT also helps to reduce mortality among HIV-positive TB patients.

The number of HIV-positive TB patients on ART has grown from a very low level in 2004 to reach 0.3 million in 2012. Among TB patients notified in 2012 and who had a documented HIV-positive test result, 57% were on ART globally this is a considerable improvement from 49% in 2011.

Globally, 0.4 million TB patients living with HIV were enrolled on CPT in 2012, up from a negligible number in 2004. The absolute number fell between 2011 and 2012, which is at least partly explained by the decrease in the number of HIV-positive TB cases reported between 2011 and 2012. The coverage of CPT among TB patients with a documented HIV-positive test result was 80% in 2012, similar to the level of 2010 and 2011.

Joint activities between national TB and HIV/AIDS programmes are crucial to prevent, diagnose and treat TB among people living with HIV and HIV among people with TB. These include establishing mechanisms for collaboration, such as coordinating bodies, joint planning, surveillance and monitoring and evaluation; decreasing the burden of HIV among people with TB (with HIV testing and counseling for individuals and couples, co-trimoxazole preventive therapy, antiretroviral therapy and HIV prevention, care and support); and decreasing the burden of TB among people living with HIV (with the three I’s for HIV and TB: intensified case-finding; TB prevention with isoniazid preventive therapy and early access to antiretroviral therapy; and infection control for TB). Integrating HIV and TB services, when feasible, may be an important approach to improve access to services for people living with HIV, their families and the community.
In 2012, a total 8,506,63 TB patients with known HIV status was tested in which 44,334 (5.21%) tested TB patients are HIV-positive among them 92.16% and 59.4 % are started CPT and ART in the SAARC region.

In the SAARC region, India accounts for highest TB patients with known HIV status followed by Nepal and Pakistan. Around 92% of HIV-positive TB patients started CPT and 59% started ART in India at the end of 2012. However Nepal, Afghanistan and Bangladesh has 100 % HIV-positive TB patients started on CPT and ART. Only in Afghanistan and Sri-Lanka HIV-positive people provided with IPT and they are 25 and 08 respectively.