



Global implementation of TB screening and Isoniazid preventive therapy among people living with HIV

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WHO

WHO recommended Collaborative TB/HIV activities

A. Establish the mechanism for collaboration

- A.1. TB/HIV coordinating bodies
- A.2. HIV surveillance among TB patient
- A.3. TB/HIV planning
- A.4. TB/HIV monitoring and evaluation

Jointly by NAP
and NTP

B. To decrease the burden of TB in PLWHA

B.1. Intensified TB case finding

B.2. Isoniazid preventive therapy

- B.3. TB infection control in health care and other settings

AIDS programme

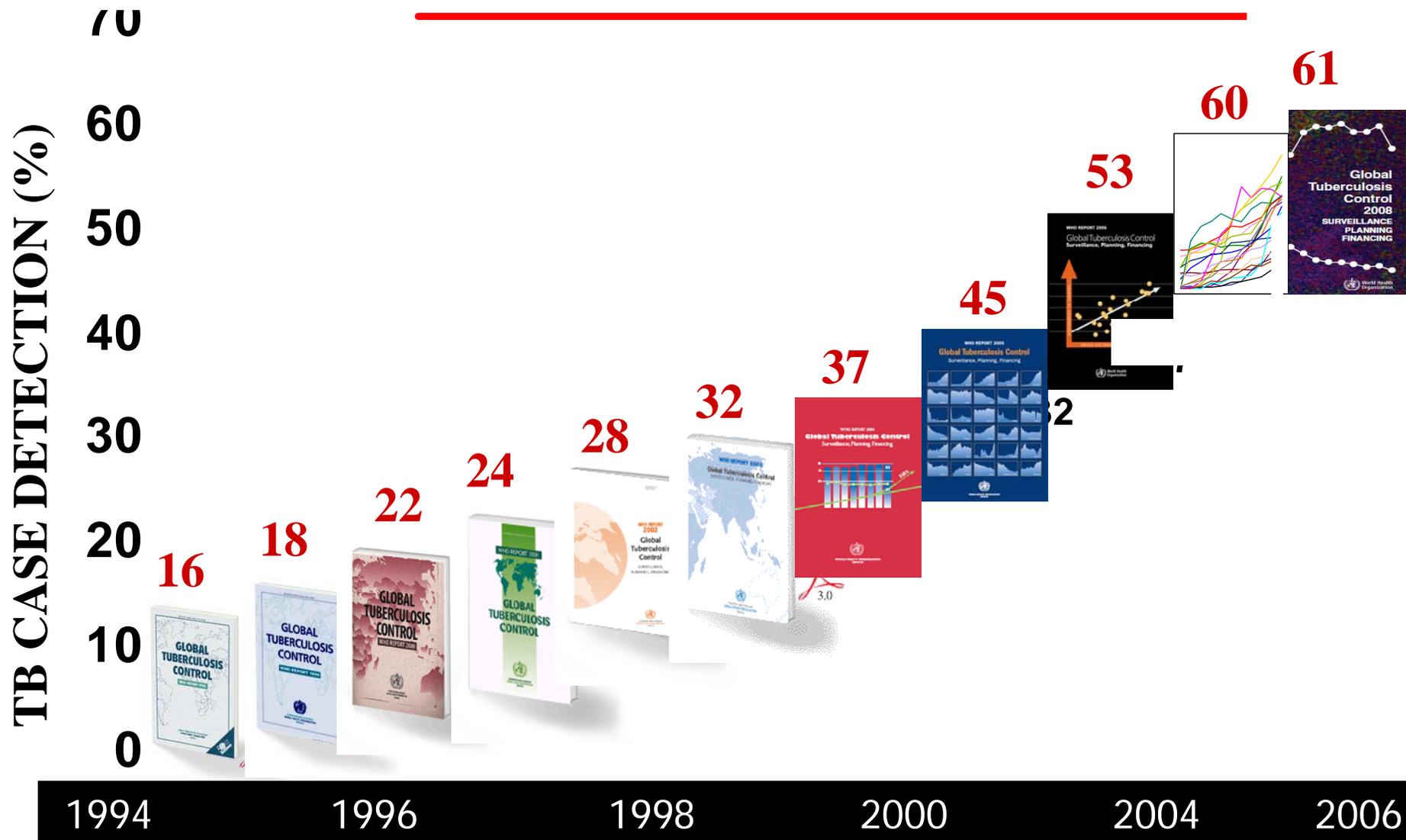
C. To decrease the burden of HIV in TB patients

- C.1. HIV testing and counselling
- C.2. HIV preventive methods
- C.3. Cotrimoxazole preventive therapy
- C.4. HIV/AIDS care and support
- C.5. Antiretroviral therapy to TB patients

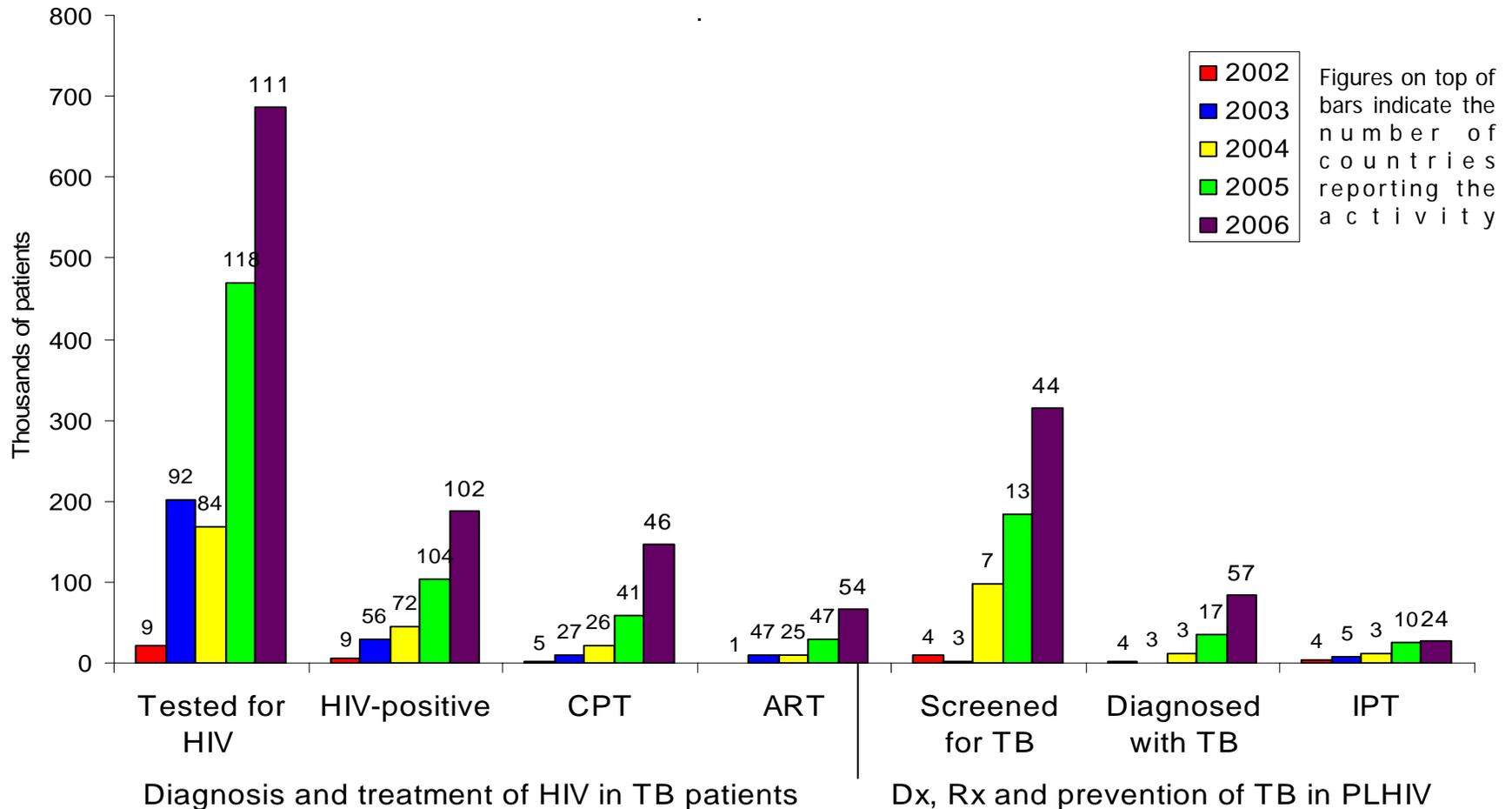
TB programme

Source of data: WHO global TB monitoring system

TB/HIV data collected from NAP and NTP 2002-06

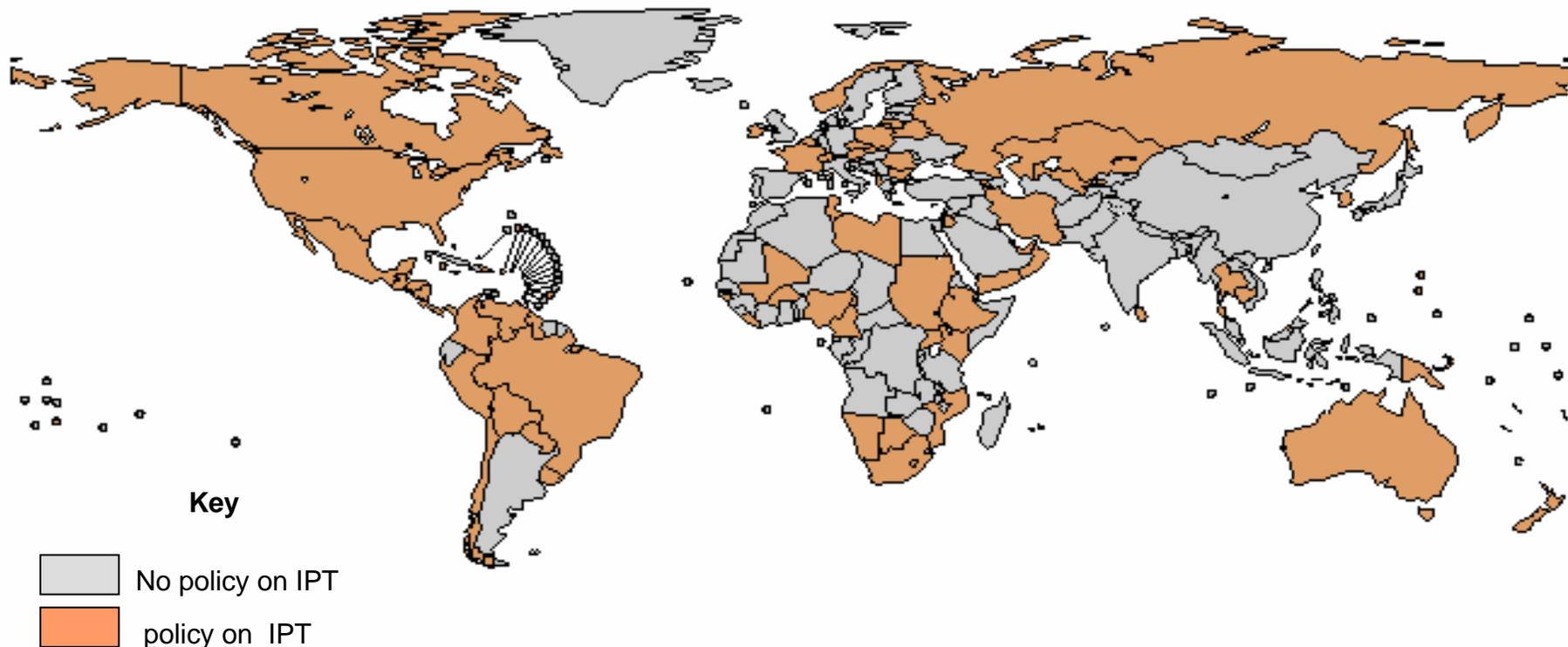


Global progress in implementation of key interventions (2002-2006)



Rapid progress in reducing HIV burden in TB patients and in the sub-Saharan Africa than others.

Countries with policy to provide IPT to PLHIV, 2006 (N=82)



Djibouti, India, Indonesia, Lesotho, Rwanda and Zambia exclude IPT as a national policy.



NATIONAL POLICY GUIDELINES FOR TB/HIV COLLABORATIVE ACTIVITIES IN UGANDA.



Annex 1.

Eligibility criteria for an organization/institution to offer Isoniazid preventive therapy.

The following are the minimum requirements for an organization/institution to offer IPT

Human resource:

- Medical Officer
- Laboratory assistant
- Trained counselor
- Pharmacy technician
- Adherence supporters

Infrastructure:

- Functional Laboratory
- X-ray or access to x-ray services
- Counseling room/space
- Consultation room

Equipment and logistics:

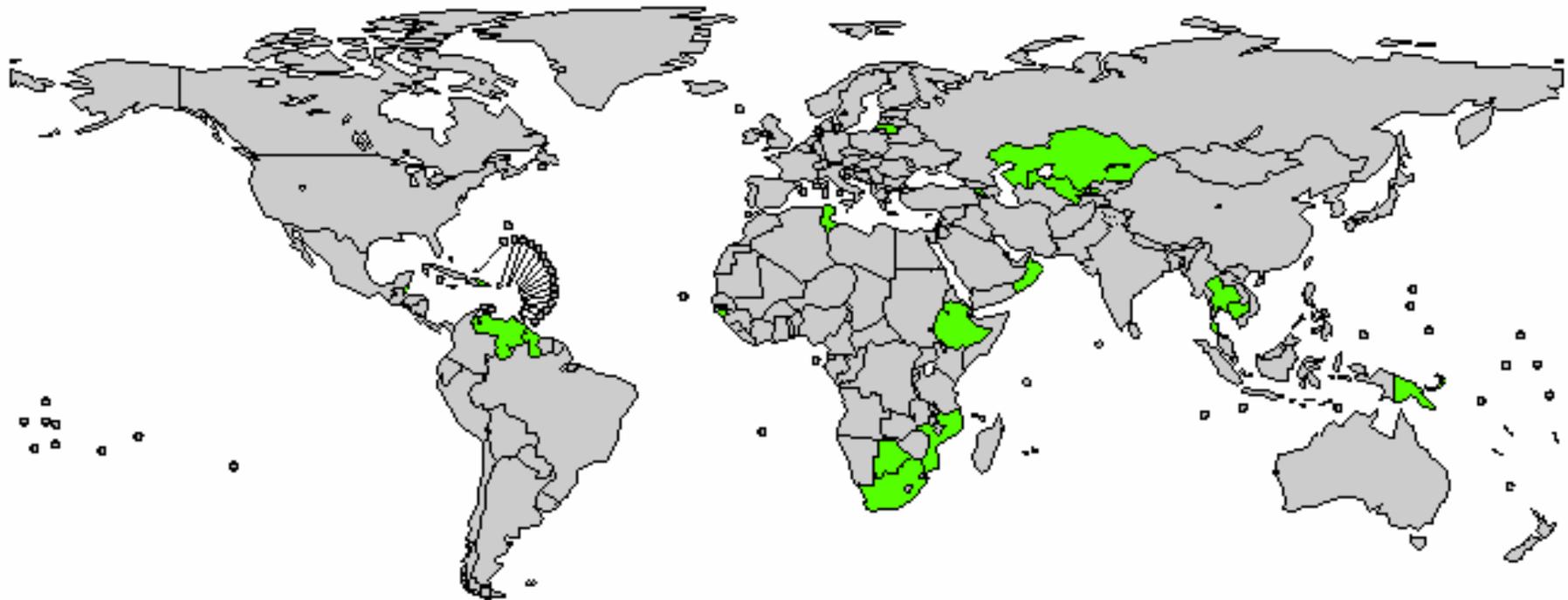
- Facilities for TB microscopy
- Facilities for skin testing (mantoux)
- Cold chain system
- Facilities for HIV testing
- Sustainable supply of anti-TB drugs including Isoniazid
- Sustainable supply of HIV test kits

Other key issues:

- If an organization has a TB default rate of greater than 5% it will not be eligible to provide IPT

"Considering that provision of IPT is labor intensive yet there is limited human resource and limited organizational capacity to offer it, feasibility of this therapy in Uganda is still a national challenge" 2006

Countries reported provision of IPT to PLHIV, 2006 (N=24)



Key

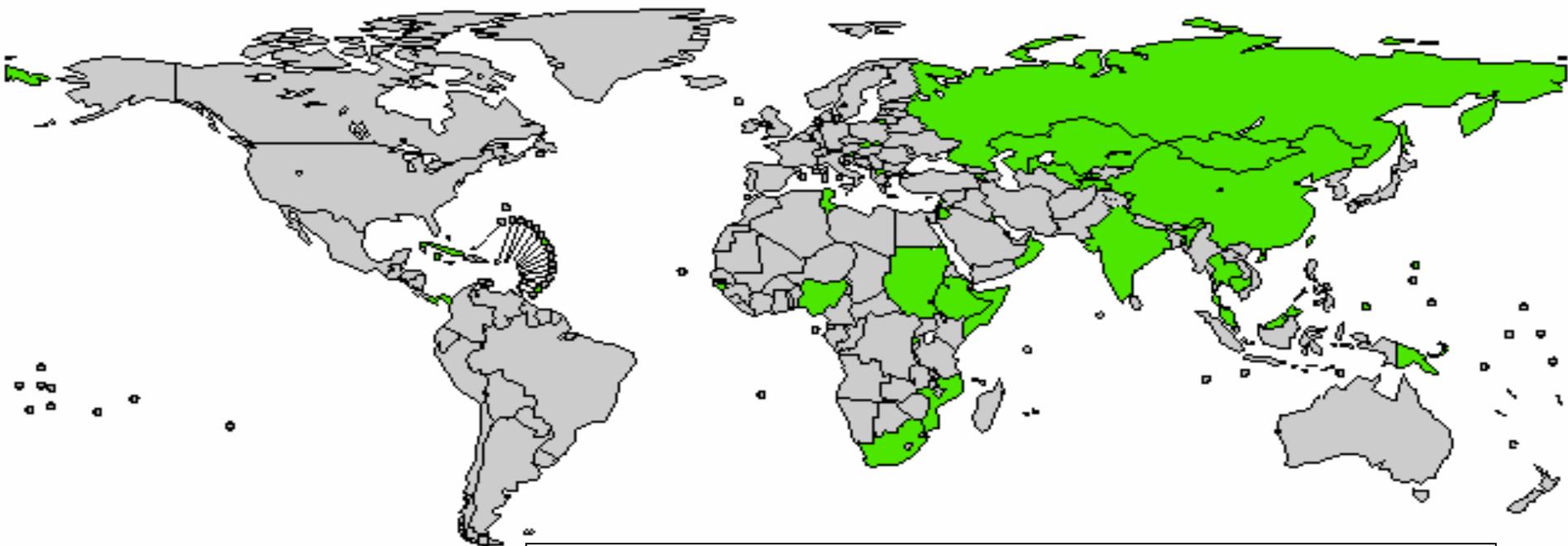
-  No reported activity
-  Countries reporting IPT

- Only 0.08% of PLHIV put on IPT globally
- Botswana report 70% of the global PLHIV on IPT

* Brazil provide IPT but did not report for 2006



Countries reported TB screening among PLHIV, 2006 (N= 44)



Key

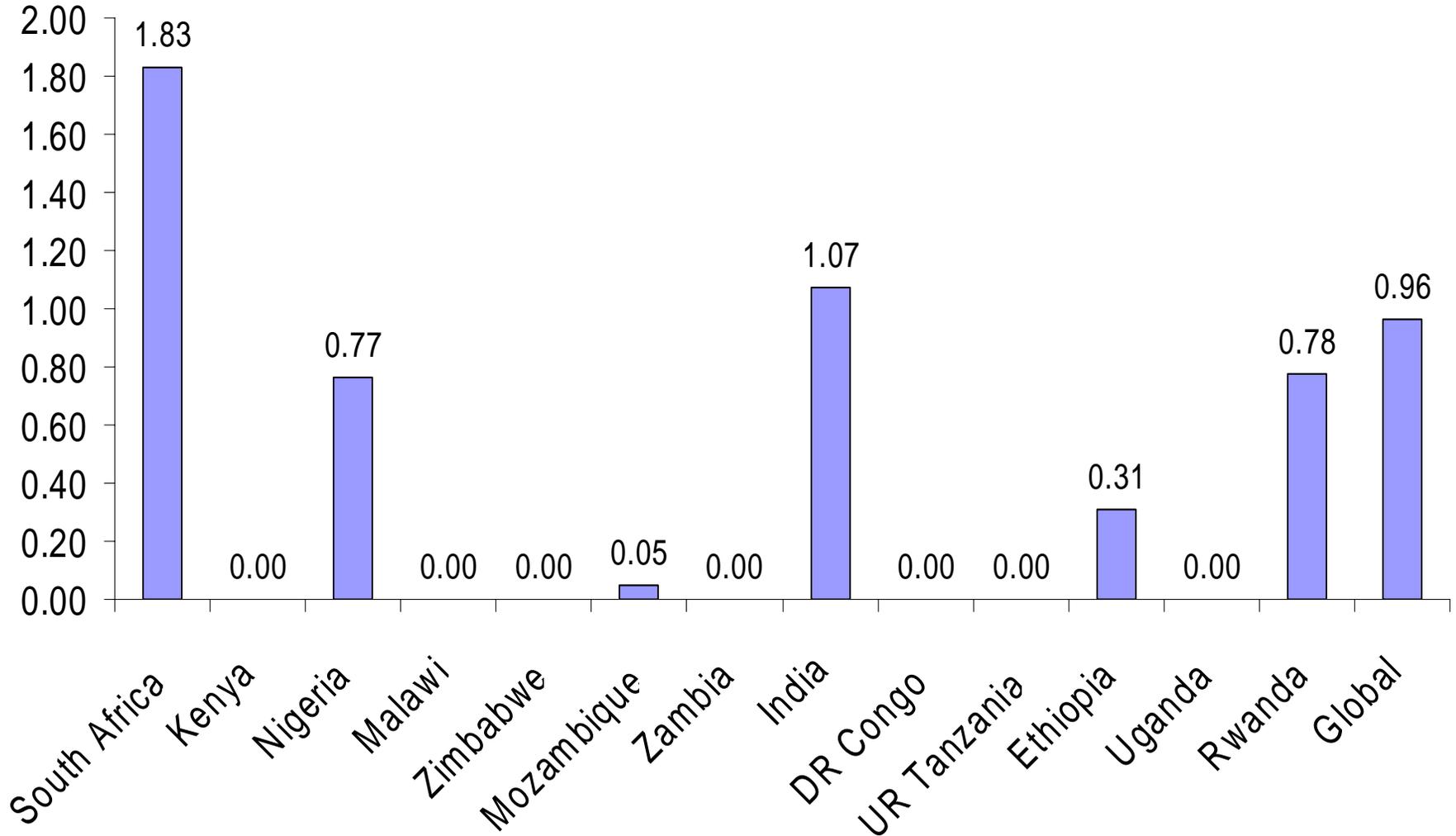
-  No reported activity
-  Countries reporting ICF

- 0.96% of PLHIV are screened for TB globally
- South Africa and Russia report 68% of the screened PLHIV

* Brazil did not report for 2006



Percentage of PLHIV screened for TB in countries with 80% of the global burden, 2006.



Proportion of PLHIV screened and diagnosed with TB in selected countries, 2006

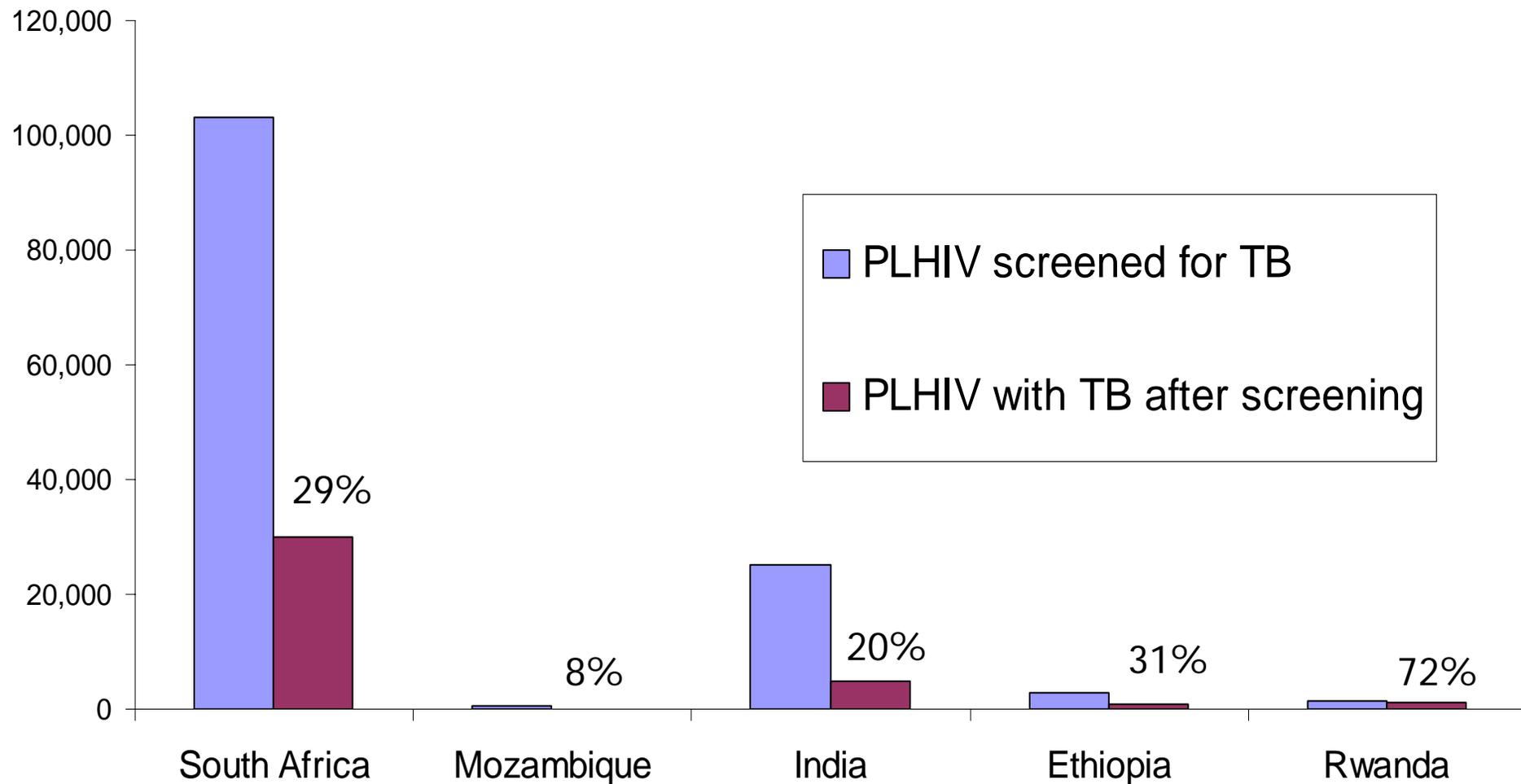
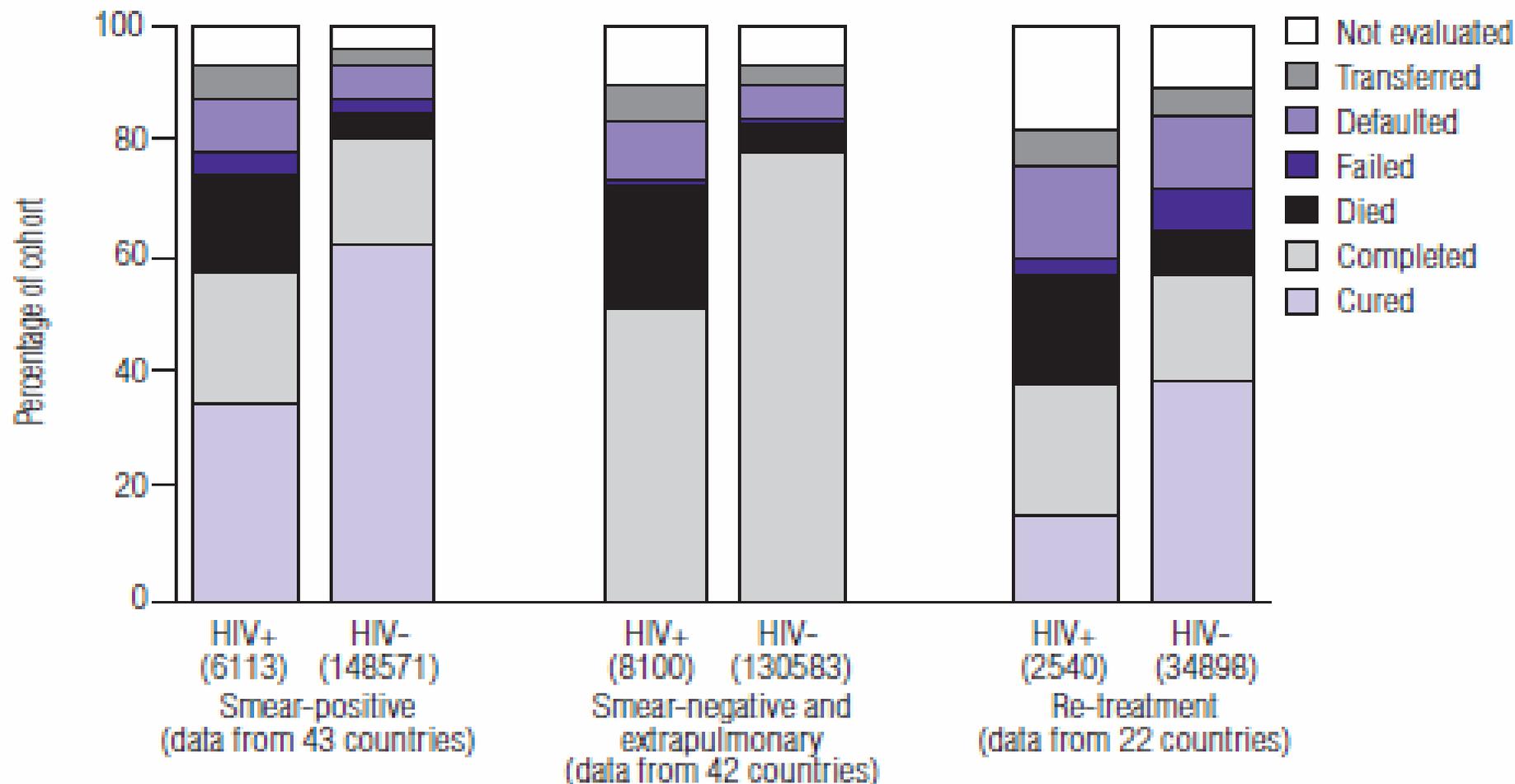


FIGURE 1.17

Treatment outcomes for HIV-positive and HIV-negative TB patients, 2005 cohort. The numbers under the bars are the numbers of patients included in the cohort.



Challenges: IPT

- Excluding active TB and role of CXR (*Mosimaneotsile et al Lancet 2003; 362: 1551–52, Samandari et al CROI 2007 Abstract*)
- Sub clinical TB in PLHIV (*Mtei et al CID 2005; 40:1500–7, Corbett et al PLoS Med 2007 1(4): Wood et al. AJRCCM 2007*)
- Fear of "drug resistance" by TB programme managers and control over Isoniazid
- Existing policies are restrictive and labor intensive
 - IPT dropped as a national policy: Kenya
 - Tuberculin skin test difficulties
 - Burundi reprogrammed Global Fund funding for IPT

Challenges: TB screening

- Lack of rapid, simple and accurate TB diagnostic tool
- No internationally recommended standardised TB screening tool
- Low uptake of TB interventions by HIV stakeholders including policy makers and service providers

Conclusions

- The global implementation of interventions to reduce TB burden among PLHIV is unacceptably very low.
- There is disconnect between policy and implementation in many countries.
- There are urgent basic and operational research needs.