TB/HIV Integration
What it entails

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Outline of presentation

• Background
• TB/HIV activities in PHC settings
• Models of implementation and some country examples
• Challenges
• Conclusion
Background

• **What is the situation?**
  – TB and HIV/AIDS programmes are still implementing interventions independently;

• NTPs – Stop TB strategy (six components)

• ACPs – Comprehensive HIV/AIDS prevention, care and treatment package
• This leads to;
  – Sub-optimal coverage
  – Limited access
  – Missed opportunities
  – Inefficient use of resources
Collaborative TB/HIV activities

A. Establish mechanism for Collaboration (NTP+NAP)
   A.1. TB/HIV coordinating bodies
   A.2. HIV surveillance among TB
   A.3. Joint TB/HIV planning
   A.4. Monitoring and evaluation

B. Decrease burden of TB in PLWHIV (mainly NAP)
   B.1. Intensified TB case finding
   B.2. IPT
   B.3. TB infection control

C. Decrease burden of HIV in TB pts (mainly NTP)
   C.1. HIV testing
   C.2. HIV preventive methods
   C.3. CPT
   C.4. HIV/AIDS care and support
   C.5. Antiretroviral therapy

What are we talking about?

Two diseases, one patient
Community based services
Which model for Implementation?

**TB**

- **HIV**
  - Partial integration
    - Providing CTX, ART in TB clinics (TZ, Rwanda)
    - Providing DOT for TB in HIV/AIDS clinics (Zambia)
  - ‘One stop service’ for TB patients with HIV
- **TB/HIV**
  - Using mobile units to go to rural areas to treat TB and HIV (Nyanza province, Kenya)

**Referral**

Mozambique

Tanzania
Yes we can
Khayelitsha, South Africa

- 2000: HIV clinic started
- 2001: ART initiated
- 2002: VCT in TB clinic
- 2003: the two buildings merged-"one stop shop"
- Strong linkage with community services
- MSF and government partnership

*Trop Med Int Health. 2004; 9:A11-5*
PASADA, Tanzania

- FBO with comprehensive HIV/AIDS care including community based care (CBC)
- TB posed challenge in the care
- Collaboration with NTP for TB services integration
  - Laboratory improved and TB drug supplied by NTP
  - Staff training, recording and reporting harmonised
  - TB room dedicated and integrated into the CBC
- Services linked with strong social support system
- Effective partnership between NTP/NAP and NGO

What do we know?
More examples of services integration

- HIV testing to TB patients in the same room at the same time (Kenya)
- Swapping TB and HIV nurses in adjacent rooms (Ethiopia, Indonesia)
- IMAI TB and HIV co-management module and training (several countries)
Expand capacity by decentralization **AND** preparing TB and HIV staff to provide TB and HIV prevention, care, and treatment.

→ Co-management, Co-supervision, Co-sponsorship
Benefits of TB/HIV integrated services

• For patients (TB and HIV)
  – Improved access to prevention, diagnosis and treatment services
  – Improved adherence and outcome of treatment

• For health services
  – Decentralise services (to periphery and low cadre HCW)
  – Integrated and pooled staff training
  – Maximise synergy and partnership between stakeholders

What have we learned?
Challenges for TB/HIV integration

• TB infection control is difficult under current conditions

• MDR and XDR TB are lethal to PLHIV

• Health workers are at greater professional risk

• Separate programme management not always helpful (E.g. Who 'owns' these patients? And IPT?)

What have we learned?

Congested OPD, Kenya

Congested OPD, India
Challenges for TB/HIV integration

• How to do things differently

• Work load

• Documenting best practice and success

• Fragile health systems (HR, HIS, PSM, space)

What have we learned?
Conclusions

• No "one size fits all" approach, depend on local context and factors

• Communication, collaboration and coordination among stakeholders are essential

• Effective health delivery systems and primary health care are critical as a platform and should be everyone's responsibility

• Adequate numbers of qualified and motivated health workers are needed at all levels