TB/HIV overview in the African Region

The case of ESA and related countries

Presented by Wilfred & Brain

TB & HIV/AIDS Units

WHO AFRO IST ESA
Outline of presentation

• Global trends of TB burden by region
• Trend of TB burden in the African Region
• Progress in achieving Regional HIV/AIDS targets
• Global, Regional and selected country specific status of TB/HIV interventions indicators
• Remaining challenges
• Discussion on way forward
Trends in new HIV infections (2001-2011)

- Globally 51 countries have recorded reductions of at least 25% in HIV incidence
- Overall SSA had 25% decline in new infections
  - 23 SSA with declines 25% or more
  - 11 ESA countries with declines of 25% or more
    - 4/19 ESA countries with 25-49% decline
    - 7/19 ESA countries with ≥50% decline
- 24% decline in number children acquiring HIV infection in SSA between 2009 and 2011
Global ART Scale-up, number of AIDS deaths and new HIV infections in LMIC*, 2001–2011

*LMIC = Low- and middle-income countries
Progress in achieving Regional HIV/AIDS Targets

• Progress in the provision of ART
  – ART coverage 56% in SSA (54% globally)
    • Coverage is > 80% in 5 countries, all ESA (Botswana, Namibia, Rwanda, Swaziland and Zambia)
    • Coverage between 60% and 79% in 5 SSA countries (4 ESA - Kenya, Malawi, South Africa and Zimbabwe; 1 WCA - Benin)

• Progress in PMTCT
  – Coverage of pregnant women living with HIV who received ART for PMTCT 59%
  – Between 75% and 100% in 6 SSA countries
    • 5 ESA - Botswana, Namibia, South Africa, Swaziland and Zambia
    • 1 WCA – Ghana)
Status of core TB-HIV indicators and TB deaths

- % on CPT
- Known HIV status
- % on ART
- % HIV Pos

TB deaths new cases
Retreated cases
TB deaths new cases
Some illustrative country examples
Namibia: HCT Coverage and HIV prevalence among TB Patients; Namibia 2005-2012
Review of TB Status

Start TB treatment unless already on ART—these clients need to be referred to MO.

See subsection 8.4, Comprehensive HIV Care with ART guidelines, C31 for how and when to refer TB clients for ART (in those not already on treatment). Start TB treatment.

---

**Suspect TB**
- TB suspected on prior visit—check register for results and respond per guidelines.
- If positive sputums
- If negative and still symptomatic, see Acute Care guidelines A54.
- If all negative and no signs.

**Active TB**
- New positive sputums or TB Treatment Plan from district—start TB treatment.
- No signs or symptoms of TB or on IPT prophylaxis.
- No signs or symptoms of TB and not on IPT prophylaxis or TB treatment.

**No suspicion of TB**
- Send 3 sputums. Refer if not producing sputums or other symptoms.
Ghana: TB-HIV interventions 2006-2012

% HIV pos on CPT
% HIV pos on ART
% HIV pos
% tested for HIV
GHANA NATIONAL TB CONTROL PROGRAMME

REGISTER OF PLHIV SCREENED FOR TB

2010

THE GLOBAL FUND
Malawi: Trend of selected Key TB-HIV indicators
Zambia: Trends of key indicators

TRENDS OF TB/HIV SERVICES FOR 2007 - 2009

PERCENTAGE

SERVICE

Teasted  HIV+  CPT  ART

2007  2008  2009

2007

2008

2009
Mozambique: Key Achievements

- Proportion of TB patients tested for HIV has risen from 24% in 2006 to approximately 86% by the end of 2009

- Proportion of HIV positive TB patients started on CPT has risen from 17% in 2006 to 89% by the end of 2009

- The proportion of eligible TB patients accessing ART is declining significantly since 2006 (46% in 2006, 33% in 2007, 30% in 2008 and 22% in 2009),
Emerging themes
Positive region wide observations

1) Sufficient and ever growing global / regional and local policy guidelines landscape to facilitate delivery of recommended integrated TB/HIV services

2) High and rising HIV testing among TB patients - exceeds universal coverage cut-off point of 80%

3) Slow but sure decline in prevalence of HIV among tested TB patients within countries....consistent with the trend of community HIV prevalence due to increasing ART coverage?

4) High CPT implementation (mostly > 90%) among HIV infected TB patients

5) Increasing but still unacceptably low % of dually infected TB patients on ART
Areas requiring further scale up actions

1) In general, TB and NACP dichotomy remains especially at Central levels
2) TB clinics / system not enabled to provide HCT on site
3) Inadequate government financing of TB and HIV core services .... there is rampant reliance on donor financing for HIV test kits and ARVs
4) Fairly common incidences of shortages and actual stock out of HIV test kits, TB reagents, ARVs and anti-TB medicines
5) Despite gradual increase, still unacceptably low access to ARVs by TB/HIV dually infected persons
6) Challenges to implementation of IPT policy among PLWHIV remain ... IPT is still generally prescribed only for children contacts of sputum smear positive index cases
Areas requiring further scale up actions (2)

7. Uncoordinated and sometimes unguided introduction and roll out of new TB diagnostic technologies, especially Xpert MTB/Rif

8. Weak supply chain management systems for core commodities

9. Incidences of limited number of TB registration sites to absorb cases from ICF

10. Too frequent / unstable global policy guidance leading to backlog of policy updates at country level .... outdated national guidelines

11. Weak M & E linkages for efficient tracking of collaborative activities impact indicators

12. Still overly centralized and specialized ART services to meet the demands of decentralised and liberalised TB services
WHERE DO WE GO FROM HERE IN THE AFRICAN REGION WITH REGARD TO TB/HIV COLLABORATIVE ACTIVITIES?

1) to meet population health needs ... two diseases, one patient
2) remove financial barriers to health care;
3) to reduce incidence of catastrophic health expenditures
4) this should facilitate the attainment of national and internationally agreed health goals and targets; and
5) ultimately contribute to better quality of life, poverty alleviation and human development.
2) FACILITATE POLICY REVIEW OF HIV AND TB GUIDELINES IN HIGH HIV & TB BURDEN AFRICAN COUNTRIES TO ALIGN WITH CURRENT RECOMMENDATIONS AND OPPORTUNITIES
WHO TB/HIV POLICY: FROM INTERIM TO DEFINITE
## THE 2012 WHO TB/HIV POLICY

<table>
<thead>
<tr>
<th>A. Establish and strengthen the mechanisms for delivering integrated TB and HIV services</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.1. Set up and strengthen a coordinating body for collaborative TB/HIV activities functional at all levels</td>
</tr>
<tr>
<td>A.2. Determine HIV prevalence among TB patients and TB prevalence among people living with HIV</td>
</tr>
<tr>
<td>A.3. Carry out joint TB/HIV planning to integrate the delivery of TB and HIV services</td>
</tr>
<tr>
<td>A.4. Monitor and evaluate collaborative TB/HIV activities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Reduce the burden of TB in people living with HIV and initiate early antiretroviral therapy (the <em>Three I’s for HIV/ TB</em>)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.1. Intensify TB case-finding and ensure high quality antituberculosis treatment</td>
</tr>
<tr>
<td>B.2. Initiate TB prevention with Isoniazid preventive therapy and early antiretroviral therapy</td>
</tr>
<tr>
<td>B.3. Ensure control of TB Infection in health-care facilities and congregate settings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Reduce the burden of HIV in patients with presumptive and diagnosed TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.1. Provide HIV testing and counselling to patients with presumptive and diagnosed TB</td>
</tr>
<tr>
<td>C.2. Provide HIV prevention interventions for patients with presumptive and diagnosed TB</td>
</tr>
<tr>
<td>C.3. Provide co-trimoxazole preventive therapy for TB patients living with HIV</td>
</tr>
<tr>
<td>C.4. Ensure HIV prevention interventions, treatment and care for TB patients living with HIV</td>
</tr>
<tr>
<td>C.5. Provide antiretroviral therapy for TB patients living with HIV</td>
</tr>
</tbody>
</table>
### WHO 2010 ART guidelines (and indicative 2013)

<table>
<thead>
<tr>
<th>Target Population</th>
<th>ART guideline</th>
<th>Outlook for 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV+ asymptomatic patients</td>
<td>CD4 $\leq$ 350 cells/mm$^3$</td>
<td>CD4 $\leq$ 500 cells/mm$^3$</td>
</tr>
<tr>
<td>ARV-naïve individuals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV+ pregnant women</td>
<td>CD4 $\leq$ 350 cells/mm$^3$</td>
<td>CD4 $\leq$ 500 cells/mm$^3$</td>
</tr>
<tr>
<td></td>
<td>irrespective of clinical symptoms or WHO</td>
<td>irrespective of clinical symptoms or WHO</td>
</tr>
<tr>
<td></td>
<td>clinical stage 3 or 4</td>
<td>clinical stage 3 or 4</td>
</tr>
<tr>
<td></td>
<td>irrespective of CD4 cell count</td>
<td>irrespective of CD4 cell count</td>
</tr>
<tr>
<td></td>
<td></td>
<td>.... and B Plus</td>
</tr>
<tr>
<td>HIV/TB co-infection</td>
<td>Presence of active TB,</td>
<td>Presence of active TB,</td>
</tr>
<tr>
<td>ARV- naïve individuals</td>
<td>irrespective of CD4 count</td>
<td>irrespective of CD4 count</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings
WHO 2010 IPT/ICF Recommendations

- Use of four-symptoms screening algorithm to rule out active TB and offer IPT
- Four symptoms include cough, fever, weight loss and night sweats
- Past history of TB and current pregnancy should not be contraindications for IPT
- TST or chest radiography are not required
TREATMENT OF TUBERCULOSIS

COMPLEMENTARY PMDT GUIDELINES...2008 & 2011

Guidelines for the programmatic management of drug-resistant tuberculosis
EMERGENCY UPDATE 2008

Guidelines for the programmatic management of drug-resistant tuberculosis
2011 update
OPPORTUNITIES OFFERED BY RAPID MOLECULAR DIAGNOSTIC TECHNOLOGIES
COUNTRIES IN AFRICAN REGION WITH XPERT MTB-RIF TECHNOLOGY AS OF 19 MARCH 2013. SOURCE: WHO GLI WEBSITE
Countries with the largest numbers of procured cartridges under concessional pricing, as of 30 September 2012:
- 780,610: South Africa
- 85,560: India
- 44,430: Kenya
- 41,180: Zimbabwe
- 40,980: Tanzania
- 33,620: Brazil
- 31,000: Pakistan
- 26,310: Swaziland
- 22,520: Nigeria
- 21,930: Mozambique
3) IMPLEMENTING AND ENFORCING ACCOUNTABILITY FRAMEWORKS ... MONITORING AND EVALUATION

1) Political
   - Stewardship
   - Policy and guidance
   - Financing

2) Programmatic:
   - Conceptualization and design: .... Capacity to innovate, evaluate and implement
   - Programme implementation:
     a) **Program coverage**: Extent to which a program is reaching target population – *anchor efforts on UHC*
     b) **Program delivery**: Degree of congruence between planned and actual provision of services and treatments – minimum standards of care
     c) **collecting information about resource expenditures**
     d) **collecting information on compliance with moral, legal and regulatory requirements**

3) Utility – Effectiveness and efficiency of interventions
   - Programme **impacts**: extent to which programme produces desired outcomes
   - Programme efficiency: benefits in relation to costs
3: IMPLEMENTING AND ENFORCING ACCOUNTABILITY FRAMEWORKS ... MONITORING AND EVALUATION (CONTINUED)

4) Surveillance, operations research and impact measurement

- Improved routine surveillance
- Conduct of special surveys
- Operations research and application – policy to practice
- etc
OBRIGADO

---- COMMENTS

— QUESTIONS ... TO COME