Policy Guidelines for Collaborative HIV and TB Services for Injecting and Other Drug users.

UNODC/ UNAIDS/ WHO
What I will address

• What is the problem: Why a Policy guide?
• What does the policy guide say?
What is the problem?
Why a Policy guide?
Drug use and TB

• Drug users have 10-30 times rates of TB (if HIV –ve)

• HIV adds additional risks of TB
  – from 5-10% \textbf{lifetime} risk
  – to 5-10\% \textbf{annual} risk of TB

• Drug users are in and out of prisons. Can be up to 80%.
  – In prison TB rates for all are 10 to 50 times higher
Prisons and HIV

- 30 million people incarcerated each year
- most of them will return to the community
- The proportion of injecting drug users/drug users among the prison population can be very high up to 80%
- HIV prevalence in prison can be very high up to 65%
HIV and HIV/TB in prison: contributing factors

1. Over-representation of most vulnerable population groups for HIV: drug users, sex workers, low socio economic

2. All modes of HIV transmission occurring in the community, occur in prison:
   1. sexual transmission (consensual, forced)
   2. blood transmission (injecting drugs, tattooing, and nosocomial infections, fights)
   3. vertical transmission: mother to child transmission

3. Poor prison conditions: overcrowding, malnutrition, poor ventilation, hygiene help TB to spread

4. Poor prison management: violence, gangs, corruption

5. Low access to preventive, curative, reproductive and palliative care

Prisons are a breeding ground for HIV and TB epidemics
Explosive HIV spread among IDUs

*HIV prevalence among general population $\geq 1\%$
The need for a policy response

• The need for proper treatment: Human right
  – Service collaboration works better than Silo thinking
  – Adherence measures work
    • Treatment completion for TB Tx IPT and ART comparable to those not using drugs

• Failure to act: public health impact.
  – Poor treatment
    • high death rates & morbidity
  – The deadly mix in a vulnerable group:
    • High rates of HIV; High rates of TB.
    • poor treatment adherence

  -> increase in tuberculosis drug resistance
Drug users have poor access to services

- HIV prevention coverage is low
- Access to ART treatment is low.
- TB often off the radar for harm reduction services
- TB is the major killer of people living with HIV.
- "Achilles heel of ART"

High barriers to treatment

- Services in "silos"
- Missed opportunities for detection.. "low threshold" services
- Prejudice: adherence… co-morbidity…
- Prison and other closed settings may bar access to services
Public Health worries

Drug user+ - HIV

TB/ MDR TB

High mortality especially HIV

Transmission

Remain infectious

Drug resistant TB

Clinics

Prison

Families

Poor access to treatment

Adherence difficulties
What does the policy guide say?
Recommendations

A  Joint Planning Service providers
    1. National local Coordination body
    2. Plans w Roles and Responsibilities & M&E
    3. Human Resources and training available
    4. Support to operational research

B  Package of Care
    5. TB infection control plans in care settings
    6. Case finding protocols at services Drug users present
    7. Treatment services for TB and HIV available
    8. INH prevention available
    9. HIV prevention (Harm Reduction Package)

C  Overcoming Barriers
    10. Integrated services (Link TB/HIV treatment w. harm reduction
    11. Equivalence of care in Prisons
    12. Adherence support measures
    13. Comorbidity not to be used to withhold treatment
Recommendations: Collaboration between services

- Drug treatment Services
- Drug users & NGOS
- Primary care Services
- HIV Services
- Support/ Low Threshold Services
- TB Services
- Prison Services

Operational Research
Joint Coordination
Human Resources & Training
Joint Planning and M&E
Advocacy
The comprehensive harm reduction package for HIV and IDU

✓Needle and syringe programmes (NSP)
✓Drug treatment including Opioid Substitution Therapy (OST)
✓Voluntary HIV Counselling and Testing (VCT)
✓Anti-Retroviral Therapy (ART)
✓Sexually Transmitted Infections (STI) prevention and treatment
✓Condom programming for IDUs and partners
✓Targeted Information, Education and Communication (IEC)
✓Hepatitis diagnosis, treatment) and vaccination of A&B
✓Tuberculosis (TB) prevention, diagnosis and treatment

Source: WHO/UNODC/UNAIDS TECHNICAL GUIDE for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users
Recommendations
Overcoming Barriers

• Models of service delivery
  – holistic person centred way that maximizes access and adherence where possible in one setting.

• Adherence
  – specific adherence support measures for drug users including
    – Supervised therapy
    – linkage to Opioid Substitution Therapy,
    – Adherence counselling
    – adherence reminders
    – contingency management
    – ancillary services
Recommendations
Overcoming Barriers

• Common Co morbidities
  – viral hepatitis infection should not be considered a contraindication to HIV or TB treatment for drug users.

• Prisons
  – equivalence of care for prisoners with civilians and continuity of care on transfer in and out of prison.
It appears that over two-thirds of all people who inject drugs are living with HCV, regardless of their HIV status.
People who use drugs have 10-30% increased risk of getting TB.

75% of Drug users Have Hep C.

HEPATITIS C…
TB, HIV injecting drug use - Overlap

Injecting Drug Use

- 15.9 million people
- 66% overlap

TB
- 9.3 million people
- ? million people

HIV
- 33.3 million people
- 3 million people
- 1.4 million people

HEP C
- ? million people
Burning unresolved issues in revised ART guidelines:

Lack of WHO guideline for Hepatitis B and C management. Currently being addressed
Co-management of TB and liver disease

Liver disease with:

1. No clinical symptoms evidence of chronic liver disease
   E.g.
   - a past history of acute hepatitis,
   - hepatitis virus carriage,
   - current excessive alcohol consumption.

   Use Usual TB regimens but be vigilant- look out for jaundice.

2. If clinical evidence of chronic liver disease:
   - Clinical monitoring / liver enzymes and use less hepatotoxic TB regimens
   - eg (streptomycin, ethambutol, and a fluoroquinolone)
   - Expert consultation is advisable in treating patients with advanced or unstable liver disease.
Co-management of TB therapy and Opioid Substitution Therapy

- Methadone dosage needs to be considered in the TB treatment of IDUs.
  - As rifampicin is a potent inducer of cytochrome P450, it can lead to a reduction in circulating methadone levels, possibly requiring a substantially increased dosage.
  - Likewise for buprenorphine.
  - There are no reported interactions between methadone and rifabutin, so rifabutin may be an alternative.

Source: HIV/AIDS TREATMENT AND CARE CLINICAL PROTOCOLS FOR THE WHO EUROPEAN REGION, WHO, EURO Office
Further reading:

Treatment of Tuberculosis Guidelines WHO 2009
http://who.int/tb/publications

More information on TB drug interactions is available in Chapter 8.3 and the websites of the Global Drug Facility and the WHO Essential Medicines Library:

Antiretroviral Therapy for HIV Infection in Adults and Adolescents. 2006 revision.
Have just been updated and will be published shortly
And on the website of WHO. www.who.int/hiv

HIV/AIDS Treatment and Care for Injecting Drug Users
Clinical Protocol for the WHO European Region:
http://www.euro.who.int