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UBRAF thematic report: avoiding TB deaths

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Results

The estimated number of tuberculosis (TB)-related HIV deaths has continued to decline globally, but reaching the target on halving TB/HIV mortality by 2015 is slipping away. The new global estimates of the number of TB/HIV deaths has reduced by one third, from 540 000 in 2004 to 360 000 in 2013, although some countries have already reached or exceeded the 50% reduction in 2013. Despite continued progress, the testing coverage among TB patients has not increased with the same pace as earlier, hindering access to life-saving interventions.

1) Advocacy, collaboration and guidance

Increased advocacy at important conferences attended by HIV stakeholders [1] has helped raise the profile of TB/HIV, shape implementation strategies, define the research agenda and mobilize resources. Collaboration with key stakeholders has resulted in significant opportunities for scale-up, such as the United States President's Emergency Plan for AIDS Relief (PEPFAR) Blueprint for an AIDS Free Generation, and the Global Fund single TB and HIV concept note required from high burden TB/HIV countries. The 2012 WHO policy on collaborative TB/HIV activities recommends the *Three 'I's for HIV/TB* (infection control, intensified case-finding and isoniazid preventive therapy, or IPT) and early antiretroviral therapy (ART). These recommendations are also incorporated in the 2013 consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Of the 38 high impact countries who reported, 32 indicated having a policy on screening for TB and 27 on IPT. In 2013, globally, 48% of notified TB patients were tested for HIV and had their results. The testing rate was even higher in Africa, with 76% of TB patients tested for HIV. Although progress was made, it slowed down from past years. IPT was initiated in 2013 to almost 600 000 people living with HIV in 45 countries, more than double the number in 2010. It is also envisaged that WHO's new recommendations to increase eligibility for ART will have considerable impact on TB prevention. Data provided on infection control are weak, however, and enforcement and measurement need to be strengthened.

To reduce TB-related HIV mortality, timely detection and early initiation of ART are crucial. Since 2010 the number of TB patients tested for HIV has increased by over one third. Coupled with the scale-up of TB screening among people living with HIV, the roll-out of Xpert MTB/RIF (the molecular diagnostic system that can detect TB and resistance to the antibiotic rifampicin) has played a key role in confirming HIV-positive TB cases. Three years after WHO recommended and supported Xpert MTB/RIF as the primary diagnostic test for HIV-associated TB, 1843 GeneXpert instruments and 4.2 million Xpert MTB/RIF cartridges have been procured for 95 high-burden and low- and middle-income countries. Coverage of ART among TB patients found to be living with HIV reached 70% globally and in the 41 high TB/HIV burden countries, up from 60% in 2012.

However, substantial gap remains in reaching all those estimated to be in need of treatment: global number of HIV-positive TB patients started on ART in 2013 is equivalent to only 33% of the estimated 1.1 million HIV-positive people who developed TB in 2013.

The coverage of co-trimoxazole preventive therapy, which also lowers the risk of mortality among patients with HIV-related TB, was slightly higher in 2013, at about 85%.

[1] The AIDS 2012-affiliated high-level consultation, Transforming the HIV/TB response: defining the next 10 years in July 2012; the annual Conference on Retroviruses and Opportunistic Infections (CROI)-affiliated HIV/TB research frontiers meetings and sessions held at Women Deliver, Kuala Lumpur, May 2013, and the Harm Reduction International Conference, Vilnius, June 2013.

2) Advances in the workplace

Training and in-country support using ILO-developed materials, such as the *Step by step approach to integrating TB into existing workplace programmes*, the ILO-WHO *Guide to implementing TB and TB/HIV programmes at country level*, and the ILO-WHO *HealthWISE* training tools, has resulted in improved health-worker safety, reduced stigma and increased coverage of TB screening and HIV testing in the workplace. In India, Kenya, Mozambique and Zambia about 3 500 workers in both the formal and informal economies were screened for TB as a result of TB/HIV workplace programmes focusing on promoting TB case-finding. The ILO has strengthened capacity for national implementation of TB/HIV joint workplace policies and programmes by coordinating annual training sessions among participants from 22 high impact countries. The ILO has also reviewed the Southern African Development Community (SADC) code of HIV and employment and provided technical support to align it with the key principles of the International Labour Standard on HIV and the workplace.

UNICEF has contributed to the global childhood TB roadmap, adapting integrated community case management (iCCM) materials for early identification of TB/HIV coinfections in communities, generating evidence on the burden of TB/HIV coinfection at maternal and child health-care settings and supporting decentralized TB/HIV plans at the subnational level in selected countries. A 2012 paediatric HIV assessment in four countries determined TB burden and outcomes among children on ART, the findings of which will be submitted for publication in a peer review journal. UNICEF also helped South Africa develop paediatric and adolescent TB/HIV district planning. In the Central and Eastern Europe/Commonwealth of Independent States region, UNICEF is supporting the adaptation of TB/HIV guidelines.

UNODC has taken the lead in developing, translating and disseminating a comprehensive package of interventions for HIV prevention, treatment and care in prisons and other closed settings, which also address HIV-associated TB. UNODC has continued to provide in-country technical assistance for the scale-up of TB/HIV collaborative programming in the most-at-risk populations of people who use drugs and those in closed settings.

3) Nutrition assistance can improve treatment

The WFP's food and nutrition assistance programme has reached more than 46 000 malnourished clients in 15 countries and 80 059 household members. The WFP has also worked with partners to increase access to collaborative TB/HIV activities. For example, efforts to increase access to the Food by Prescription programme for co-infected clients in Swaziland has helped strengthen referral and follow-up across HIV and TB programmes as well as improve data management for HIV and TB by integrating nutrition indicators. In 2012–2013, WFP provided nutrition supplements and household food assistance to malnourished TB patients living with HIV, resulting in improved treatment outcomes. WFP provided support to the Ministry of Health in Swaziland to improve recording and reporting, and purchased information technology equipment for ART and TB units, which will be used to establish single patient files, enabling easier and faster data management and reporting, including on nutrition indicators.

WHO has worked with partners to disseminate TB/HIV policy via technical support to countries during programme reviews and through the review of regional and national action plans, policies and guidelines. In collaboration with key stakeholders, WHO has convened meetings for more than 26 African countries, 13 Western Pacific countries and 10 South-East Asia countries to share information

on bottlenecks and enablers, and examples of good practice for intensifying collaborative action and bolstering monitoring and evaluation.

Constraints, challenges and lessons learned

Halving TB deaths among people living with HIV by 2015 is at risk of not being achieved. While high impact countries like South Africa and India have made significant strides at increasing testing, followed by increasing number of people on treatment, many other countries have slowed down their scale-up. This has posed a challenge by slowing down the initiation of treatment, hence keeping the mortality rates at high levels and hindering progress towards the 2015 target. Positive cases of programme integration and service delivery can be shared from Cambodia, Ethiopia and Malawi; these countries have reduced mortality by more than 50%, with high ART coverage rates and by implementing IPT. There has been a steady increase in ART coverage among TB patients living with HIV, although it is still a long way short of the 100% target, and data on adherence and timeliness of initiation need also to be captured. Decentralizing facilities providing ART in India has had an impressive impact on coverage among TB/HIV patients since 2009; treatment sites are now required to report on ART initiation within two weeks of starting TB treatment.

The clinical management of TB patients with early ART and TB co-treatment can be complicated, and early ART can give rise to tuberculosis-immune reconstitution inflammatory syndrome, or TB IRIS, which can deter clinicians from timely initiation, despite the increased benefits of early ART outweighing the lower risk of mortality.

Globally, more than half of all TB patients reportedly do not know their HIV status and routine TB screening has not been reported among people living with HIV in more than 70% of countries. Similarly, more than 80% of countries are still not reporting implementation of IPT. Further assistance to scale up collaborative TB/HIV activities and strengthen recording and reporting will be crucial. To this end, WHO is revising guidelines to monitor and evaluate collaborative TB/HIV activities, and updating the Three Interlinked Patient Monitoring System to help countries better capture data.

Early diagnosis of TB remains challenging in many high TB/HIV burden countries, where Xpert MTB/RIF is not widely distributed and the available diagnostic tools, microscopy and culture, are limited in diagnosing smear negative, or where there is limited collaboration between services. HIV-associated TB in children remains among the most neglected areas of the response, with the absence of optimal diagnostics a major problem. Access for most-at-risk populations, such as people who inject drugs and prisoners, also continues to present challenges, and disaggregated data showing the true extent of the TB/HIV burden within these populations are limited. Inadequate data and underestimation of the burden of TB/HIV in children is also common. Closer collaboration is needed across the different health services (TB, HIV, maternal newborn and child health, harm reduction) and between the health ministries and other line ministries overseeing labour, social support, justice, migration, defence and prisons, to increase the data and evidence, and to create a favourable legislative and social environment for joint management.

Key future interventions

Cosponsors will collaborate to ensure a high global profile of TB/HIV research and implementation through important international forums, such as the International AIDS Society, the Conference on Retroviruses and Opportunistic Infections, Harm Reduction International and the International

Conference on AIDS and (sexually transmitted infections) STIs in Africa, and to foster strategic partnerships through key stakeholder networks.

Support for scaling up TB/HIV interventions will continue, including the use of the Xpert MTB/RIF diagnostic tool in HIV settings, and Cosponsors will work to maximize the impact of Global Fund TB/HIV investments. Normative work will include the revision of TB infection control guidance, the treatment of latent infection and guidance on smear negative TB. Operational research will review the TB/HIV cascade of care to minimize weaknesses in the chain. To improve the monitoring and evaluation of impact and quality delivery of services, the updated Three Interlinked Patient Monitoring System will be finalized along with new guidelines on monitoring and evaluation with new indicators; these will also be incorporated into the consolidated guidelines on strategic information for HIV. Joint efforts will be made to build the body of evidence on the TB/HIV burden and the impact of collaborative TB/HIV activities in maternal and child health-care settings. Such efforts will be in addition to further optimizing maternal and childhood TB/HIV treatment in the broader context of paediatric and adolescent HIV programmes as well as in nutrition and community health programmes. To further bolster detection and continuity of care, workplace and community platforms will continue to be strengthened and expanded, and efforts will be made by Cosponsors to help integrate TB/HIV activities into services meeting the needs of key populations, including prisoners, people who inject drugs, pregnant women and children.

Supporting documents

- *ILO: HealthWISE action manual* and *ILO trainers' guide*
- *UNODC WHO policy brief: HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions (2013)*
- *UNICEF WHO roadmap for childhood tuberculosis, 2013*
- *WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders (2012)*
- *WHO policy update – automated real-time nucleic acid amplification technology for rapid and simultaneous detection of tuberculosis and rifampicin resistance: Xpert MTB/RIF system for the diagnosis of pulmonary and extrapulmonary TB in adults and children (2013)*

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