

# **ENDING TUBERCULOSIS AND AIDS A JOINT RESPONSE IN THE ERA OF THE SUSTAINABLE DEVELOPMENT GOALS COUNTRY SUBMISSIONS**

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## INTRODUCTION

The Thematic Segment of the 42nd UNAIDS Programme Coordinating Board (PCB) meeting will be held on the 28th June 2018 and will focus on “ending tuberculosis and AIDS – a joint response in the era of the Sustainable Development Goals”.

In the preparation for the Thematic Segment, UNAIDS issued a call for submission of examples of interventions that have contributed to ending tuberculosis and AIDS. A total of 57 good practice submissions were received, showcasing the wide range of efforts at all levels to end discrimination in health-care settings from African States, from Asian States, from Eastern European States, from Latin American and Caribbean States, from Western European and Other States, and cases which cover multiple countries or regions

The submissions reflect the work of governments, civil society, United Nations and international organizations, as well as collaborative efforts. The case studies highlight different approaches in reducing the disproportionate burden of TB among people living with HIV ranging from measuring the levels of discrimination to providing better health-care access to affected people. Some of the submissions, for example, concentrate on how to prevent, identify, diagnose and treat HIV/AIDS and related opportunistic infections like TB, or how to better manage TB/HIV co-infection by strengthening the health system, while strengthening regional capacity and promoting regional innovation.

# I. AFRICAN STATES

## 1. BOTSWANA

### TITLE OF THE PROGRAMME: Six I's HIV/TB Communication and Advocacy Toolkit

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- **Programme is being implemented since:** 2013
- **End date of the programme:** Ongoing
- **Responsible parties:** Government, Civil society
- **Population reached:** People living with HIV, Health workers
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

According to the World Health Organisation (WHO), it is estimated that one-third of the 36.7 million people living with HIV and AIDS worldwide are co-infected with tuberculosis (TB). Sub Saharan Africa is the hardest hit region, with a 70% co-infection rate. If TB is left unaddressed, in the next 20 years almost one billion people will become newly infected, and 35 million will die of it. In response to this concern, the WHO has issued a policy on TB/HIV collaborative activities recommending interventions to reduce TB morbidity and mortality in people living with HIV, namely the Six I's for HIV/TB: Infection Control, Intensified Case Finding and Isoniazid Preventive Therapy, TB/HIV Integration, Initiating ARV treatment and Involvement of the Community; which should be integrated into HIV programmes of national health services in addition to the provision of Antiretroviral Therapy (ART). Immediate and full adoption of the Six I's for HIV/TB is an essential element of the HIV response in high-prevalence countries – however, in-context support is also needed to accelerate implementation of these simple measures that will have a tremendous impact on the HIV/ TB co-epidemic. This in turn requires enhanced communication and scaled up dissemination of the WHO's TB/HIV control recommendations to support the efforts of civil society and health workers to accelerate their implementation. In the spirit of joint responsibility and ownership for a targeted effort to address the dual epidemics, the AIDS and Rights Alliance for Southern Africa (ARASA), with support from the WHO and in collaboration with partner organisations from across the Southern African region, undertook to create accessible and scientifically accurate training and advocacy materials to promote the accelerated implementation of the Six I's for HIV/TB. The toolkit development process was shaped by the collective participation of TB/ HIV community activists,

health workers, journalists, traditional healers, government representatives, and WHO/TB technical and medical experts, from seven different Southern African countries. The process, which included a workshop in December 2010, followed by toolkit design and piloting in 4 countries (Swaziland, Botswana, Lesotho and Zambia) between December and March 2011, provided the opportunity for these key stakeholders to come to grips with the latest recommendations from WHO; understand and brainstorm on initiatives to respond to the current obstacles and identify opportunities as they relate to the implementation of the Six I's for HIV/TB in the region. This process informed the development of the toolkit in accordance with regional needs.

## **DESCRIPTION**

In 2013, the Botswana Network on Ethics, Law and HIV and AIDS (BONELA) was supported by ARASA and the International Treatment Preparedness Coalition (ITPC) to adapt and translate the HIV/TB 3Is Toolkit, developed by ARASA with support from WHO, to the local context. The toolkit provides accessible and scientifically accurate training and advocacy materials to promote the accelerated implementation of the Three I's to reduce TB morbidity and mortality in people living with HIV. The toolkit has recently been updated to cover Six I's. Other project activities included training TB buddies to provide support to people with TB, and health workers (TB focal persons at clinics); hosting consultative meetings with partners, as well as policy and lawmakers.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

BONELA reported that the 3 Is HIV/TB Toolkit was very user-friendly and effective for trainings with community members and health workers: "Because TB is a very clinical issue, there is a need for effective provision of information. A lot of NGOs are working on TB in the country, but there isn't enough knowledge or information about TB that is available and accessible. The 3 Is toolkit, is not as clinical in how its put together. Its more pictorial. If you're training a group of people, you've got posters and this TB hero which makes community education around TB much easier. Contact tracing is simplified. If we go to communities, we use the 3 Is toolkit as a reference. What came out from using the 3Is toolkit is our ability to build capacity around our TB buddies who then went into different communities and educated people around TB. This created demand. Some people were able to say: "Ok maybe I have TB" and actually go to the facilities and get themselves screened for TB.

## **LESSONS LEARNED AND RECOMMENDATIONS**

BONELA reported that, because of their interventions and the cascading of information, there was a significant increase in individuals seeking TB screening following the implementation of the project. Additionally, following the meetings held by BONELA, policy and lawmakers at the national level expressed support the 3 Is Toolkit and expressed an interest in incorporating aspects of BONELA's project into the country TB programme.

## **ANNEXES**

- <http://www.arasa.info/info/tool-kits-and-guides/>

## 2. COTE D'IVOIRE

### 2.1 TITRE DU PROGRAMME:

Amélioration de la détection des cas de tuberculose chez les personnes vivant avec le VIH

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- **Date de début du programme:** 1er Janvier 2016
- **Date de fin du programme:** 31 Décembre 2016
- **Responsable(s):** Gouvernement
- **Groupe(s) de population atteint(s):** Personnes vivant avec le VIH, Cas présumés tuberculeux vus en consultation avec frottis négatif
- **Le programme a-t-il été évalué/analysé?** Non
- **Le programme fait-il partie de la stratégie nationale de lutte contre le sida?** Oui
- **Le programme fait-il partie d'un plan national autre que la stratégie nationale de lutte contre le sida?** Non

#### INFORMATIONS DE BASE

En Côte d'Ivoire, comme dans la plupart des pays d'Afrique sub-saharienne, l'infection par le VIH a entraîné une recrudescence des cas de tuberculose. L'impact négatif de l'infection à VIH sur la situation épidémiologique de la tuberculose est en effet, considérable dans notre pays où, 36 à 40% des cas de tuberculose sont attribuables au VIH. En 2016, 21 710 cas de tuberculose ont été notifiés soit une incidence de 91 cas pour 100.000 habitants. Le pays avec une séroprévalence nationale du VIH de 3,7% (EDS, 2012), est profondément affectée par la double pandémie de la tuberculose et du VIH/SIDA. La co-infection tuberculose-VIH était de 22% en 2016. Les données du Programme National de Lutte contre la Tuberculose (PNLT) indiquent que la fréquence de la tuberculose ne diminue pas chez les enfants et les adolescents et qu'il n'y a pas de signes patents d'augmentation de la fréquence de cette maladie parmi les personnes âgées de 65 ans et plus. Ceci suggère fortement que la transmission de la tuberculose ne tend pas à diminuer dans la population. Plus de la moitié des cas de tuberculose sont notifiés dans Abidjan et sa région où la prévalence de l'infection par le VIH est la plus élevée du pays.

Le Centre Antituberculeux (CAT) de Koumassi est situé à Abidjan, notamment dans la Région sanitaire d'Abidjan 2, précisément dans le District Sanitaire de Koumassi- Port-Bouet- Vridi. C'est un centre de référence qui couvre une population de 700 000 habitants et une superficie



de 154,9 km<sup>2</sup>, ce qui fait une densité de 4519 hbts/km<sup>2</sup> pour la commune de Port-Bouët et de 5592 hbts/km<sup>2</sup> pour la commune de Koumassi. En 2015, il a été notifié 620 cas de tuberculose toutes formes dont 36 % de cas diagnostiqués cliniquement (Tuberculose Extra Pulmonaire, Tuberculose Pulmonaire Bactériologiquement non confirmée). La prévalence du VIH parmi les cas diagnostiqués sans preuve bactériologique de tuberculose avérée était de 38 % nettement supérieure à la moyenne nationale. Ce qui indique, d'une part, les difficultés diagnostiques de la tuberculose chez les PVVIH à partir de la microscopie et de la Radiographie pulmonaire conformément aux directives nationales.

D'autre part, un conseil et un dépistage du VIH étaient proposés uniquement aux 620 cas de tuberculose soit 22% des cas présumés malades de tuberculose examinés au laboratoire (2774) manquant ainsi des occasions de diagnostic de l'infection à VIH. Aussi, l'avènement du GeneXpert au CAT de Koumassi en 2015, était-il une opportunité pour améliorer la détection des cas chez les PVVIH présumés malades de tuberculose dont la microscopie était négative.

## **DESCRIPTION**

L'intervention a consisté à détecter des cas VIH positifs parmi les patients présumés tuberculeux dont les résultats de frottis se sont avérés négatifs. Ainsi, l'examen par le GeneXpert est demandé aux patients VIH positifs pour la confirmation de la tuberculose (sensible ou pharmaco résistante). Le but était de renforcer la prise en charge de la co-infection TB/VIH avec pour objectifs spécifiques:

- 1- Proposer un conseil et un test de dépistage du VIH à tous les patients présumés de la tuberculose;
- 2- Demander un examen du GeneXpert à la recherche de la tuberculose chez tout PVVIH ayant un examen de frottis négatif.

L'initiative a été implémentée uniquement au niveau du Centre anti tuberculeux de Koumassi. C'est un centre régional de prise en charge de la tuberculose qui dispose d'un laboratoire de microscopie (Optique et LED); d'un appareil de GeneXpert et d'appareils pour le suivi biologique des PVVIH. Au CAT, le circuit du malade est établi et affiché. Les patients présumés malades de tuberculose sont reçus au service d'accueil du CAT composé d'un médecin, d'un infirmier et d'un agent de santé communautaire. Il leur est délivré un bulletin d'examen de crachat pour la microscopie. Lorsque le résultat de BK est négatif, il leur est proposé le test du VIH. Si le consentement est obtenu, le test est fait selon l'algorithme national de dépistage du VIH en vigueur. Pour les patients dont le test du VIH revient positif, un examen par le GeneXpert est demandé. Il se fait sur l'échantillon de crachat ayant servi à la microscopie.

- Ceux chez qui l'examen de GeneXpert devient positif (MTB+/RIF- ou MTB+/RIF+), un traitement anti

tuberculeux et TARV sont proposés en fonction des Directives nationales.

- Ceux qui ont un examen négatif par le GeneXpert (MTB-) sont mis sous prophylaxie au Cotrimoxazole

et référés dans une structure de prise en charge du VIH.

Les interventions dans cette initiative sont mises en œuvre dans le cadre des activités de routine. Les intrants pour le dépistage du VIH, les cartouches et le calibrage de l'appareil de GeneXpert, les crachoirs et les médicaments sont assurés par le Programme National de Lutte contre la Tuberculose (PNLT) pour les antituberculeux et les ARV/CTX par le Programme National de Lutte contre le Sida (PNLS). La prise en charge de la tuberculose et du VIH est gratuite en Côte d'Ivoire. Les principaux partenaires sont le PNLT et le PNLS qui sont des programmes du Ministère de la Santé de Côte d'Ivoire. Ce programme est appuyé par un partenaire de mise en œuvre du PEPFAR en l'occurrence EGPAF.

## RESULTATS, REPERCUSSIONS ET IMPACT DU PROGRAMME

### Résultats:

- En 2016 le CAT de koumassi a déclaré 505 cas de tuberculose toutes formes confondues qui ont tous reçu le conseil et test du VIH.
- Le nombre de malades presumés tuberculeux est égal à 1741 dont 1236 avec des frottis négatifs
- Nombre de malades BK négatifs conseillés: 1236
- Nombre de tests VIH fait: 1236
- Nombre de tests positifs au VIH: 175
- Nombre d'examen GeneXpert fait: 175
- Résultat après le GeneXpert: TB+RIF-: 28

TB+RIF+: 4

Total TB: 32

### Ce que nous avons réalisé:

1. Une IEC efficace au patient durant toutes ses visites au CAT.
  - Le personnel a été formé sur la conduite d'une IEC efficace de lutte antituberculeuse et anti-rétrovirale.
  - Le service social, le service de distribution d'antituberculeux/ARV et les communautaires ont été dotés de boîtes à images.
2. Implication de tous les membres de la communauté dans le suivi des malades.
  - Les communautaires de l'ONG (SOLFEV) active sur le site ont été sensibilisés sur la tuberculose et le VIH.
  - Des proches du malade ont été identifiés pour la supervision du traitement.
  - Des séances d'information et de sensibilisation ont été organisées dans la communauté et au cours des consultations
3. Application des directives, des normes et procédures de prise en charge des patients tuberculeux et infectés par le VIH
4. Applications de la loi VIH et de la charte des patients tuberculeux/VIH dans le CAT

## ENSEIGNEMENTS TIRES ET RECOMMANDATIONS:

### Facteurs ayant contribué au succès du programme:

- Mise à disposition d'un local abritant le Centre antituberculeux par l'Etat de Côte d'Ivoire avec l'appui des bailleurs et des partenaires de mise en œuvre.
- Le CAT est équipé en matériels de laboratoire pour le suivi biologique des PVVIH (Fascount, Biochimie, Hématologie) et des patients tuberculeux (LED, GeneXpert, etc.), en médicaments ARV et antituberculeux.
- Le personnel est disponible en qualité et en quantité.
- La prise en charge des patients VIH et tuberculeux est globale sur le site (médicale et communautaire).
- Les activités sont supervisées par l'Equipe Cadre de District de façon trimestrielle et au niveau central de façon semestrielle par le PNLT/Direction Générale de la Santé avec l'appui des partenaires/bailleurs.

Ce programme a permis de rattraper un nombre important de PVVIH et de patients co-infectés TB/VIH grâce à l'examen du GeneXpert. Aussi, ce programme a permis de diagnostiquer et de traiter de façon précoce la tuberculose chez les PVVIH par les antituberculeux et les ARV permettant de rompre la chaîne de contamination de la tuberculose.

### Difficultés:

- Observation de pannes et ruptures fréquentes de cartouches de GeneXpert.

- Réticence des patients au dépistage du VIH du fait de la stigmatisation.
- Surconsommation des réactifs de VIH, des cartouches de GeneXpert et des consommables VIH et tuberculose.
- Référence et contre référence des PVVIH non tuberculeux dans les structures de prise en charge du VIH.

Recommandations:

- Rencontres de partages d'expériences au niveau district avec les autres entités VIH et tuberculose dans le cadre de la collaboration tuberculose et VIH,
- Organisation des réunions du comité élargi TB/VIH pour l'appropriation de ce programme au niveau national
- Passage à échelle de ce programme au niveau national
- Mise à disposition des appareils de GeneXpert dans l'ensemble des Centres Anti Tuberculeux pour le diagnostic de la tuberculose chez les PVVIH

**ANNEXES/RESSOURCES SUPPLEMENTAIRES:**

- Cadre de collaboration
- TB/VIH
- Directives pour la prise en charge des PVVIH par les ARV (Côte D'Ivoire)
- Loi VIH promulguée: Loi N°2014 - 430 du 14 juillet 2014
- Plan stratégique National VIH 2016 - 2020
- Directives 2015 de mise sous Cotrimoxazole (Côte d'Ivoire)
- Algorithme dépistage VIH (Côte d'Ivoire)

## 2.2 TITLE OF THE PROGRAMME:

La tuberculose chez les usagers de drogues à Abidjan en Côte d'Ivoire : prévalence, prise en charge et modèle d'accompagnement communautaire

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- **Date de début du programme:** Octobre 2016
- **Date de fin du programme:** Mars 2018
- **Responsable(s):** ONG
- **Groupe(s) de population atteint(s):** Personnes qui consomment ou s'injectent des drogues
- **Le programme a-t-il été évalué/analysé?** Non
- **Le programme fait-il partie de la stratégie nationale de lutte contre le sida?** Oui
- **Le programme fait-il partie d'un plan national autre que la stratégie nationale de lutte contre le sida?** Oui. Programme national de lutte contre la tuberculose

### INFORMATIONS DE BASE

L'Afrique de l'Ouest est devenue une terre de transit privilégiée pour le trafic d'héroïne et de cocaïne depuis le milieu des années 2000. Avec les crises sociales et politiques, l'urbanisation croissante et les changements de mode de vie, une forte augmentation du nombre d'UD s'observe. En Côte d'Ivoire, une étude bio comportementale menée par MdM en 2014 (1) au sein des « fumoirs » (scènes ouvertes de consommation) d'Abidjan a montré que les principales drogues consommées sont l'héroïne et la cocaïne, principalement par voie inhalée. Les fumoirs se trouvent dans toute la ville et constituent des lieux de vente et de consommation de drogues, voire de vie pour les UD les plus précaires. On estime à 6 000 le nombre d'UD précaires à Abidjan. En ce qui concerne les usager.e.s de drogues par voie intraveineuse (UDVI), il y en aurait entre 100 et 300.

Avec la baisse de l'incidence de la TB, le fardeau de la maladie est de plus en plus porté par des souspopulations urbaines vivant dans des conditions précaires(2,3), y compris les UD. De plus, l'usage de drogues est associé à une prévalence élevée de l'infection tuberculeuse (comme l'a montré l'étude de Mdm de 2014 (1)). Par ailleurs, les UD ont un risque accru de développer des formes de TB résistantes aux antibiotiques car ils combinent, dans un contexte de précarité, des difficultés d'accès aux soins, une mauvaise observance au traitement, des ruptures de soins (notamment en lien avec des incarcérations) et des co-morbidités (e.g. VIH,

hépatite C, hépatite B) (4,5-10). Malgré les nettes améliorations enregistrées depuis le début des années 2000, la tuberculose reste un problème majeur de santé publique en Côte d'Ivoire. En ce qui concerne le VIH/SIDA, la Côte d'Ivoire est un pays en situation d'épidémie généralisée, avec une prévalence estimée à 2.7% en 2016 (11). Les UD font partie des populations clés comme les Hommes ayant des relations Sexuelles avec d'autres Hommes (HSH) et les Travailleuses du Sexe (TS) pour lesquels les prévalences du VIH/SIDA sont plus élevées. Dans le cadre de la co-infection VIH/TB, les recommandations nationales incluent une proposition systématique de dépistage VIH à tout patient TB positif (TB+) Un référencement vers les centres de prise en charge VIH est alors proposé aux patients et une proposition immédiate de traitement antirétroviral (ARV) est faite. Ainsi, en 2013, 90% des cas de tuberculose enregistrés ont été testés au VIH dont 25% se sont révélés séropositifs ; 54% des co-infectés TB/VIH ont été mis sous ARV.

Bien que les UD soient particulièrement à risque d'infection par la TB, il existe très peu de données permettant d'estimer la prévalence et le nombre d'UD concernés par la tuberculose en Côte d'Ivoire ou d'évaluer la cascade de soins des UD TB+. En ce qui concerne le diagnostic de la TB chez les UD, il existe très peu de données sur l'utilisation des méthodes de dépistage basées sur la biologie moléculaire, telle que le Genexpert (Xpert MTB/RIF®). Pourtant l'OMS recommande depuis 2011 l'utilisation de ces techniques comme test initial de diagnostic chez les individus pour lesquels il y a une suspicion de TB résistante ou de co-infection VIH/TB (12). Pour ce qui est de la prise en charge, il est recommandé de mettre en œuvre un suivi renforcé des patients et la prise de traitement supervisée (stratégie « DOT » (Directly Observed Treatment), recommandée notamment chez les patients susceptibles d'avoir des problèmes d'observance) (9).

Face à ce manque général de données en Côte d'Ivoire, il était donc important de réaliser une « étude action » pour mieux connaître l'importance de la TB au sein des UD d'Abidjan et pour montrer qu'une approche communautaire favorise le maintien dans les soins.

## **DESCRIPTION**

Notre recherche opérationnelle s'est déroulée sous l'égide du Programme National de Lutte contre la Tuberculose (PNLT) et en collaboration avec l'Institut Pasteur de Côte d'Ivoire. Elle a été réalisée dans 2 grands fumoirs d'Abidjan : Yopougou et Treichville. Elle comportait deux volets : un volet « diagnostic » et un volet « traitement ».

- Volet « diagnostic » : Ce volet de l'étude était une enquête transversale d'estimation de la prévalence. Après une sensibilisation et un consentement éclairé, un dépistage systématique de la TB était proposé dans le fumoir à tous les UD fréquentant celui-ci. Ce dépistage était réalisé par collecte d'expectoration pour analyse par examens directs et par GeneXpert. Un examen médical pour la recherche des signes cliniques de TB, une radiographie pulmonaire et un test VIH ont complétés l'inclusion dans l'étude. Les participants Xpert® positifs ont été considérés comme ayant une TB pulmonaire confirmée.
- Volet « traitement » : Pour évaluer la cascade de soins, les UD TB+ traités pour la tuberculose et bénéficiant du soutien communautaire ont été suivis pendant tout leur traitement TB. Ce volet a été proposé à toutes les personnes dépistées positives pour la tuberculose pulmonaire dans le cadre de l'étude, qui sont venues chercher leurs résultats et qui ont acceptées d'être référencées et de commencer un traitement pour leur TB au sein d'un Centre Anti Tuberculeux (CAT). L'approche communautaire consistait à faire le lien entre les UD et les CAT mais aussi à faire le suivi de la prise des médicaments par des Educateurs Pairs (EP), à réaliser des entretiens psychosociaux régulières, à apporter un soutien financier pour l'alimentation et le transport, à mener des groupes d'entraide (groupes d'autosupport) et enfin, à effectuer des visites de médiation familiale. Ce dispositif, pour 40 patients suivis, a été mise en place par : 1

coordinateur, 2 superviseurs communautaires non consommateurs, 5 éducateurs pairs (soit 8 patients suivis par EP).

### **RESULTATS, REPERCUSSIONS ET IMPACT DU PROGRAMME**

- 545 UD ont été sensibilisés et parmi eux, 532 (97.6%) ont participé à l'étude ;
- La prévalence de la TB pulmonaire est de 9,8% [IC : 7,4%-12,7%] soit 40 fois plus que dans la population générale - si on extrapole à la population d'UD à Abidjan, il y aurait entre 600 et 1 000 UD avec une TB ;
- Parmi les UD avec une TB+, 17,3% ont une tuberculose résistante à la rifampicine/TB-RR (RIF+) ;
- La prévalence du VIH est de 5,4% soit près du double de la prévalence nationale. Mais seulement 15,4% des UD TB+ sont co-infectés avec le VIH ;
- L'approche communautaire, malgré les défis de suivi de cette population, a permis le maintien des UD dans les soins jusqu'à la guérison : parmi les 40 UD TB+ ayant démarré un traitement anti-tuberculeux dans un CAT, 60% sont guéris ou ont fini leur traitement ;
- L'utilisation du Xpert® pour le diagnostic permet de mieux dépister les UD. En effet, comme les patients vivant avec le VIH, les UD sont souvent immunodéprimés et malnutris du fait de leur précarité et de leur mode de vie.

Si nous utilisons l'algorithme national (signes cliniques + examen microscopie direct), nous ne dépisterions que 24% des UD avec une TB. Ainsi, 76% des UD avec une TB dans notre étude n'auraient pas été diagnostiqués - et donc pas traités.

Notre recherche opérationnelle a montré que :

- Les UD d'Abidjan sont particulièrement à risque de TB pulmonaire (et particulièrement de la TB-RR) et doivent être absolument considérés comme une population clé dans les politiques de lutte contre la TB comme ils le sont déjà dans les politiques de lutte contre le VIH/SIDA;
- Les UD infectés par la TB sont faiblement co-infectés par le VIH/SIDA. Il est donc indispensable de mettre en place des campagnes de sensibilisation et de dépistage spécifiques pour la TB. Les campagnes de sensibilisation et de dépistage contre le VIH/SIDA doivent servir de modèle.
- Pour atteindre l'objectif de l'OMS de l'élimination de la TB en 2035, il est essentiel et urgent de cibler les efforts sur le dépistage et le traitement auprès des UD, avec notamment :
  - o L'amélioration du diagnostic avec l'utilisation du Xpert® dans les algorithmes nationaux pour les populations clés comme les UD ;
  - o La mise en place d'un accompagnement communautaire au plus près des UD tout au long de la cascade de soins.

### **ENSEIGNEMENTS TIRES ET RECOMMANDATIONS**

Les difficultés rencontrées au cours de l'étude :

- Plusieurs UD ne sont pas venus chercher leurs résultats et les recherches de ces patients se sont avérées infructueuses.
- Des incarcérations régulières des UD, avec difficultés du maintien de la DOT, ont conduit à la suspension des traitements anti-TB en cours et à la dégradation de l'état général de santé des UD TB+ incarcérés.
- La grande mobilité des UD en général, due aux descentes policières, à la fermeture de certains fumeurs et à la recherche de drogue de « meilleure qualité » rend le suivi et la DOT par les EP difficile.
- Pour les UD co-infectés (TB-VIH), déjà connus VIH+, il a été difficile de faire le lien avec les structures de soins VIH. Les EP connus au niveau des CAT étaient inconnus dans les structures de suivi VIH.
- Devant la dégradation de l'état général de certains UD TB+, surtout ceux co-infectés TB/VIH, les parents ont souvent tardivement recours à l'hospitalisation, conduisant parfois au décès de l'UD.

- Le rétablissement des liens familiaux, ont nécessité la présence de communautaires non UD, car certaines familles connaissant les EP comme des UD, ne souhaitent pas que ces EP fréquentent les leurs.

Les succès de l'étude :

- Cette étude réalisée avec le PNLT a permis l'appropriation rapide des résultats par la partie nationale qui peut porter le plaidoyer.
- Les politiques de santé publique doivent prioriser la prise en charge de la TB chez les UD. En effet, les UD sont un réservoir de TB (et particulièrement de TB-MR) et cette population est en contact permanent avec la population générale (habitation, transport...).
- Cette recherche opérationnelle ("dans la vraie vie") a mis en évidence qu'un suivi communautaire des UD permet d'atteindre des taux de guérison très satisfaisants chez une population difficile à suivre ce qui permet d'envisager l'élimination de la TB si un investissement financier et humain est dédié à cette population.

## **ANNEXES**

- Description des résultats de l'étude
- Le poster présenté à l'AFRAVIH (Bordeaux 2018)
- L' Abstract retenu à la conférence AIDS (Amsterdam 2018) –
- Bibliographie

### 3. DEMOCRATIC REPUBLIC OF CONGO

**TITLE OF THE PROGRAMME: Integrated HIV/AIDS Program Haut-Katanfa and Lualaba (IHAP-HK/L)**

#### **CONTACT PERSON**

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- **Programme is being implemented since:** October 2016
- **End date of the programme:** September 2017
- **Responsible parties:** NGO
- **Population reached:** People living with HIV
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### **BACKGROUND**

Tuberculosis is the biggest infectious disease ‘killer’ of PLHIV, responsible for more than a 1/3 of AIDS-related deaths. Systematic TB screening allows early TB diagnosis and treatment as well as timely Tuberculosis Preventive Treatment (TPT) initiation. Nonetheless, only 53% of PLHIV in PEPFAR countries were screened for TB in 2017.

#### **DESCRIPTION**

An essential package of TB/HIV interventions were implemented by the Program for Appropriate Technology in Health (PATH) under USAID’s Integrated HIV/AIDS Program (IHAP) in two provinces in DR Congo: Haut-Katanga and Lualaba (HK/L). Near all of the PLHIV from health zones supported by PEPFAR in HK/L were screened for TB in 2017. Key elements of the essential package of TB/HIV interventions include:

1. On-site support PATH hired and trained 21 technical officers (TO) and site support coordinators (SSC) to provide on-site support at all health facilities located in the 16 health zones (Zones de sante) supported by PEPFAR. TO and SSC are typically nurses or physician generalists who have been working in the HautKatanga and Lualaba provinces before being recruited by PATH. TO and SSC are involved in HIV case findings, PMTCT, and HIV care and treatment. All TO and SSC are provided an initial 1- month training on programmatic management of HIV. This includes an 8 –day module on adult-focused teaching approaches (andragogy). The training materials are available.



2. Training of Health Care Providers Regular training on HIV programmatic management including TB/HIV are provided to all health care providers in the catchment area at least once a year.

3. Continuity with previous mechanism IHAP is a follow-on of ProVIC, a 7-year \$49 million USAID project (2009–2016), implemented by PATH, with the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), the International HIV/AIDS Alliance (IHAA), and Chemonics International (CI). Most of PATH's current staff (80%) were involved in ProVIC.

4. Relationship with the MOH PATH has been able to establish a productive and straightforward relationship with the health facilities through formal MOUs that clarify responsibilities and expectations. A template of the MOU is available

5. Monitoring tool A hard copy of the WHO TB screening tool has been provided to all health care workers. This tool is widely used and can be easily reproduced

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

22,444 out of 22,544 (99%) PLHIV in Haut-Katanga and Lualaba were screened for TB in 2017. Among those screened 21,523 (95.9%) were found negative and 921 (4.1%) were screened positive.

### **LESSONS LEARNED AND RECCOMENDATIONS:**

USAID's Integrated HIV/AIDS Program (IHAP) in the Democratic Republic of the Congo (DRC) achieved 99.5% screening among PLHIV in the Haut-Katanga and Lualaba provinces. The essential package of TB/HIV interventions implemented by PATH, has been successful in screening nearly all of the PLHIV in health facilities supported by PEPFAR.

### **ANNEXES**

TB/HIV Cascade data from Panorama 2017 Q4.

## 4. ESWATINI

### 4.1 TITLE OF THE PROGRAMME: Test and Start

#### CONTACT PERSON

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- **Programme is being implemented since:** 2016
- **End date of the programme:** ongoing
- **Responsible parties:** Government, Civil Society, UN or other inter-governmental organization
- **Population reached:** People living with HIV, Children, Women and girls, Young people/adolescents
- **Has the programme been evaluated/assessed?** Yes. University Research Company (URC Swaziland)
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** Yes. It provides feedback to SHAPMoS.

#### BACKGROUND

Cabrini Ministries is a non-profit, faith based community care organization operating in the rural Lubombo Lowveld of Eswatini. Since 2004, Cabrini has focused on providing quality Integrated HIV services to the immediate area and expanding with time, emphasizing on family-centered and community based HIV care interventions. Eswatini, despite having the highest HIV incidence rate in the World, took up on the WHO recommendation for initiating HAART for all HIV+ clients. Statistics showed that the HIV prevalence of people age 15-49 infected with HIV has always been in the rise, resulting to 28.8% (<https://knoema.com/atlas/Swaziland/HIV-Prevalence>) thus Cabrini Ministries wanted to be part of the 90-90-90 strategy by ensuring that 90% of the population are tested, 90% of them if positive are initiated to care and 90% are virally suppressed. (<http://www.unaids.org/en/resources/documents/2014/90-90-90>)

#### DESCRIPTION

In October 2016 Cabrini Ministries in conjunction with the University Research Co, LLC (URC) conducted an in-service training which was introduced by the Ministry of Health, test and treat program, whereby a total of 21 health care workers were trained. A new facility Client flow chart was designed to incorporate test and start, community mapping for underserved areas was done to identify community ART sites, community engagement and health talks to increase

awareness. The Test and treat program was rolled out in the community in the second week of October 2016. Clients continuously educated about the importance of starting ART early, which resulted in Pre-ART patients taking the lead in the enrollment of ART.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Methods: The ART initiation process happens both at facility and at outreach, for every new client who comes in and offered HIV test and test positive, baselines bloods are collected and first counselling done for life long anti-retroviral treatment. The nurses initiate the client on the lifelong Anti-Retroviral treatment basing on thorough physical examination and screening on the same day and the client is initiated on HAART according to WHO guidelines and given 2 weeks review at which results for baselines are reviewed and interpreted and client re-assessed. Second counselling for life long Anti-Retroviral treatment is done, baselines reviewed and interpreted and one month refill given for a period of 6months. Ongoing adherence and psychosocial support is provided during each visit.

Results:

1. More clients were initiated same day after staff in-service training, and education awareness on Test and Start given to the clients.
2. By March fewer clients remained on Pre-Art because they were still receiving on-going counselling and not yet ready to start HAART.
3. Retention rate is consistent with initiation rate due to health education given as evidenced by the number of clients who remained on care since the beginning of test and start.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Lessons Learnt:

1. Community based organisation are better placed to give information and good health care programs due to the good relationship between the clients and the organisation.
2. Combination of Test and start, health education and patient participation result in better treatment outcome as evidenced by zero deaths since the inception of Test and start.
3. HIV care and treatment acceptance and retention rate is high if health care package is delivered at once to the client.
4. Patient centred care promotes acceptance of new health programs.
5. Better informed health care workers deliver quality health care package to clients.

Conclusion: Continuous capacity building on health care staff combined with patient centered client flow and client centered education achieves 90% initiation of clients same day and retained into care.

### **ANNEXES**

- (<https://knoema.com/atlas/Swaziland/HIV-Prevalence>)  
(<http://www.unaids.org/en/resources/documents/2014/90-90-90>)

## 4.2 TITLE OF THE PROGRAMME: TB and HIV integration in eSwatini

### CONTACT PERSON

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- **Programme is being implemented since:** 2008
- **End date of the programme:** /
- **Responsible parties:** Government, Civil Society
- **Population reached:** People living with HIV, Children, Women and girls
- **Has the programme been evaluated/assessed?** Yes
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

TB is the leading cause of morbidity and mortality among PLHIV. Early antiretroviral therapy (ART) is recommended for all persons with TB and HIV, with multiple trials demonstrating that it reduces mortality and loss-to-follow-up, particularly in persons with advanced HIV disease. One limiting factor may be that TB and HIV clinics are often physically separate, and run by different programs. Separate and uncoordinated clinical care imposes heavy burdens on co-infected patients, potentially compromising adherence, retention and treatment outcomes. This was the case in eSwatini before 2008, when TB and HIV clinics were separated and TB mortality was high, particularly among PLHIV.

### DESCRIPTION

TB/HIV integration in eSwatini was based on recommendations from the WHO and was supported by epidemiologic, clinical trial, and programmatic evidence. The specific collaborative activities included the decentralization and co-location of TB and HIV facilities throughout the country and the integration of HIV care into TB clinics, so that PLHIV with TB could be managed exclusively in the TB clinics for the duration of TB treatment. After TB treatment patients are transitioned back to the HIV clinic for ongoing HIV care.

Effecting this integration required firm political commitment, with close collaboration of the national TB and HIV programs and the declaration of TB as a national emergency. An essential early activity was the formation of a National TB/HIV coordinating committee (NCC), with representation from the eSwatini National AIDS Program, the National Tuberculosis Control Program, implementing partners, civil society and community partners. The NCC was responsible for developing the plans to decentralize and integrate TB and HIV care, and advancing a policy shift to allow nurses, including nurses in the TB clinics, to initiate and provide antiretroviral treatment. Subsequent activities included moving laboratory services, such as testing for viral load and TB

screening (Xpert), closer to patients, which facilitated (among other things), improved TB case finding among PLHIV and rule out of TB disease before initiation of isoniazid preventive therapy. Since its formation, the NCC has met quarterly, developing communication strategies and aggressive social mobilization.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

These policy changes, integrated service delivery, training, and social mobilization campaigns have yielded high impact results. As of 2016, 99% of TB patients had a known HIV status, of whom 70% were HIV-positive and 94% were receiving ART. Between 2007 and 2013, the death rate from TB decreased from 19% to 9% (eSwatini MOH 2014), and since 2010 there has been a dramatic decrease in the TB case notification rate (Haumba, PHA 2015). A retrospective cohort evaluation of program data found 99% ART uptake by HIV+ TB patients by six months of TB treatment initiation. This is much higher than published results from other integrated and non-integrated settings in sub-Saharan Africa (Pathmanathan IAS 2017). Among PLHIV not already on ART at TB treatment initiation, almost 90% initiated within eight weeks, per national guidelines - with median time to initiation of only about 2 weeks. This also far surpasses achievements in similar settings, perhaps validating recent initiatives in eSwatini such as task-shifting to nurse-led ART initiation and successful integration of HIV services into TB clinics. Among sampled PLHIV, 97% had TB screening documented at their last HIV care or treatment visit within the study period. Although only half of those with a positive screen had a documented diagnostic evaluation (still a weakness within the program), all patients with a TB diagnosis received TB treatment (and some were treated empirically), with a treatment success rate of 85%. Unfortunately, only 7% of those eligible for IPT were documented to have received it, indicating a persistent challenge that is being addressed aggressively by the TB and HIV programs today.

### **LESSONS LEARNED AND RECOMMENDATIONS**

This model of care relied on several shifts in the national environment, including declaration of TB as an emergency, developing national TB/HIV guidelines that align with WHO recommendations, consistent collaboration between the National TB and HIV programs, and formation of the NCC. Major policy shifts included allowing nurse-led ART initiation and management (including TB nurses) and decentralization of TB and HIV treatment to primary health centers.

### **ANNEXES**

N/A

## 5. ETHIOPIA

**TITLE OF THE PROGRAMME: Using a Comprehensive Health Model to Screen Healthcare Workers for TB and HIV, Dire Dawa, Ethiopia**

### **CONTACT PERSON**

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- **Programme is being implemented since:** 2016
- **End date of the programme:** /
- **Responsible parties:** Government, Technical Agency - CDC
- **Population reached:** People living with HIV, Health care workers
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** No

### **BACKGROUND**

Globally, there were approximately 10.4 million new infections and 1.7 million deaths (400K among persons living with HIV) due to tuberculosis (TB) in 2016. Ethiopia is one of 22 countries that account for 80% of the world's TB cases, with an estimated TB prevalence and incidence of 200 and 177 per 100,000 population, respectively. HIV co-infection among TB cases is estimated at 11%. Although healthcare workers (HCWs) are at increased risk for developing tuberculosis (TB), routine HCW TB screening is rare in low- and middle-income countries, where the HIV and TB burdens are high. In Ethiopia, there is no standardized system for monitoring occupational health among HCWs. We sought to determine the feasibility and acceptability of routine HIV and TB screenings among HCWs.

### **DESCRIPTION**

In 2016, a HCW health screening program was initiated at 10 public sector health facilities in Dire Dawa, Ethiopia. Dire Dawa Administration (DDA) is one of the two special city administrations located in the eastern part of Ethiopia, 515 kilometers away from the capital Addis Ababa with a population of about 427,000 in 2014; 86% of DDA's population resides in the urban areas. The 10 participating sites contributed 91% of the reported TB cases in Dire Dawa. Prior to program launch, the Regional Health Bureau conducted site visits to assess opinions and concerns of HCWs about the screening program and to inform implementation strategies and development of program tools. A health screening package was developed which included standardized screening tools for quarterly TB symptom screening (using WHO screening algorithm) and anthropometric measurements, and annual HIV and blood sugar tests,

and blood pressure measurements. At each facility, project teams were trained on screening procedures and confidentiality protections. All staff at the participating facilities were eligible and invited to participate in the screening program.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

From March 2016 – March, 2017, four quarterly screening cycles were conducted. Overall, 85% of HCWs participated in at least one round of screening; participation ranged from 70% in round 1 to 91% in rounds 3 and 4; 60% of HCWs participating in all four quarterly screenings. HIV test acceptance was 94%. Overall TB incidence was 806 per 100,000 HCWs; TB incidence was nearly 4-fold higher among HCWs with documented HIVinfection. Over the year, TB incidence among HCWs at the participating sites decreased by 87%.

### **LESSONS LEARNED AND RECCOMENDATIONS**

This collaborative TB HIV program activity led to a successful model for providing confidential, worksite HIV and TB screening services for HCWs. HCWs acceptance of workplace health screening including TB and HIV was very high. Using a comprehensive health screening model may foster participation by minimizing stigma and promoting overall wellness among HCWs. These findings show the health benefits and impact of active TB case finding among HCWs. Routine TB and HIV screening of HCWs is feasible and can be successfully implemented in low-resource, high burden settings.

### **ANNEXES**

N/A

## 6. LESOTHO

**TITLE OF THE PROGRAMME:** PROvide Miner-friendly Services for Integrates TB/HIV Care Study (PROMISE Study)

### CONTACT PERSON

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- **Programme is being implemented since:** 2018
- **End date of the programme:** 2021
- **Responsible parties:** Government, Civil society, Private Sector, Academic institution
- **Population reached:** People living with HIV, Miners (especially exposed to silica), Children, Women and girls
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

In Lesotho, the HIV prevalence is estimated at 25.6% and the estimated TB incidence is 724 per 100,000, both of which are the second highest rates globally. In addition, 73% of TB patients are co-infected with HIV. Basotho migrant miners, who live in Lesotho but work in South African mines, and their families, are among those with the greatest risk of HIV and TB. In 2014-2015, in three Lesotho TEBA mining employment offices, among miners and miners' family members, 32% of presumptive TB cases without a documented HIV status tested for HIV were HIV-positive. Overall, 7% of individuals with presumptive TB newly tested HIV-positive, and 7% were known HIV-positive. The TB incidence among South African miners is estimated at 3,000-7,000 per 100,000 per year, 7-fold higher than the general population. Testing, linkage, and retention of miners and their families along the TB/HIV care continuum are suboptimal, resulting in poor TB treatment outcomes compared with the general population. Implementation science research is urgently needed to determine an effective strategy for improving early detection of HIV and early initiation of antiretroviral therapy (ART) and isoniazid preventive therapy (IPT) among migrant miners and their families.



## **DESCRIPTION**

The PROvide Miner-friendly SErvices for Integrated TB/HIV Care (PROMISE) Study in Lesotho, funded by PEPFAR through CDC and implemented by ICAP at Columbia University, is a mixed methods implementation science study that evaluates the effectiveness, feasibility, and acceptability of integrated TB/HIV services (early ART and concurrent IPT) for migrant miners and their family members provided in miner-friendly service venues (MF).

The program uses a prospective cohort study design to evaluate the effectiveness of family-focused, integrated TB/HIV services for Basotho migrant miners and their family members provided six days per week at MF, compared to public sector health facilities (PS), which routinely deliver HIV/TB integrated care for the general population. All participants have been or will be assessed at the time of HIV testing (baseline), and at months 3, 6, and 9. This study measures two primary outcomes: 1) ART initiation and 2) IPT initiation. Secondary outcomes include: 1) CD4 count at enrollment; 2) time to ART initiation; 3) time to IPT initiation; 4) 6- and 9-month ART retention; 5) 6-month viral load (VL) suppression; 6) IPT adherence; 7) ART adherence; and 8) IPT completion. Additionally, the study assesses the feasibility of the MF intervention strategy by measuring HIV testing yield, linkage to care, time spent accessing ART and IPT services, and costs associated with delivery of the MF intervention, compared with PS. It also assesses acceptability of the MF intervention strategy by exploring patients' and health care providers' perceived barriers, facilitators, and preferences to understand how they impact uptake and delivery of the MF intervention. Furthermore, it will assess the tolerability of concurrent ART and IPT among miners and their family members living with HIV.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Since, this study has just started enrolling participants and collecting data on March 13, 2018, neither data on outcomes nor impact of the program can be assessed at this stage. However, we expect that the study will leverage longstanding collaborations among ICAP, the Lesotho Ministry of Health, National University of Lesotho, TEBA and a well-trained, highly productive team. These partners will develop substantial experience in implementation science research in a subSaharan African country to identify an effective, feasible and acceptable TB/HIV service delivery model for migrant miners and their families that addresses barriers to implementation of early ART and IPT. The ultimate goals of the project are to 1) improve health outcomes among migrant miners and their families, a hard-to-reach population that represents a hotspot of TB/HIV transmission in Lesotho and in PEPFAR programs more broadly; and 2) strengthen the implementation science research capacity of national and local institutions.

## **LESSONS LEARNED AND RECOMMENDATIONS**

This non-traditional service venue offers the opportunity to diagnose HIV, rule out TB, and provide early ART and IPT to this vulnerable and hard-to-reach population. In addition, lessons learned and recommendations have also included 1) running an electronic data quality checking and reporting program right at the start of the program and regularly afterwards not only helped capturing the quality issues for the timely resolutions but also the issues related to the program implementations for the timely improvements such as performance issues of some lay counselors; 2) motivating lay counselors and providing more training to them may also help to increase the number of enrollment.

## **ANNEXES**

N/A

## 7. MALAWI

### 7.1. TITLE OF THE PROGRAMME:

Paradiso TB Patient Trust - strengthening community engagement to end TB

#### CONTACT PERSON

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- **Programme is being implemented since:** 2015
- **End date of the programme:** Ongoing
- **Responsible parties:** Civil society
- **Population reached:** People living with HIV, Children, Women and girls, Young people/adolescents, TB patients and people with TB/HIV, including people with presumptive TB
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** Yes – Plan: NTO 2015-2020 (TB)

#### BACKGROUND

The project presented below demonstrates how local communities and civil society organisations may assist in controlling and ending TB, and also how the effect can be documented.

The project is implemented in Malawi, one of the forty countries grouped as having "Low human development" in the latest Human Development Report. Malawi is ranked as low as number 170 out of 188 countries on the Human Development Index, and continues to be highly dependent on foreign aid. In 2016, according to the latest WHO TB report, total TB cases notified was 16 959. Of all TB patients in Malawi as many as 53 % are HIV+. Luckily 97 % of the people with a known coinfection of TB/HIV are on ART. Nevertheless, these national data show that you can not work with one of these disease and ignore the other. They often go hand in hand, and interventions of all kinds must acknowledge this.

During the last few years around 17 000 people have been found sick with TB every year (WHO annual TB reports). According to a recent TB prevalence survey in the country (published 2016), this is less than half the number of estimated cases. The estimated number of people sick with TB in Malawi is close to 35 000 per year, according to the survey. The latest WHO TB report shows that treatment coverage in Malawi is low, at only about 54%, indicating that almost half of

all those sick with TB are not being found, nor treated. This fact pose a huge challenge in TB control in the country and there is an apparent need to find the missing cases.

Paradiso TB patients Trust was formed by TB patients or people affected by TB, many of whom were/are people living with HIV. Paradiso is the only organisation of its kind in the country and operates today in seven district through numerous local TB Clubs and more than 1 400 members/volunteers. Working to fight TB and finding the missing cases is a key priority of the organisation. The question is who they are, all these "missing TB cases", where they are, and why they do not seek health care, or why they do not end up on TB treatment? We know that lack of information, stigma and fear is part of the answer. And we know that the work of Civil Society and local community contributes to finding more of the missing cases than the health system is able to do on their own.

Our partner reach out to people and communities with quality information about TB and HIV, ready to support as peers (ex- TB patients support current TB patients), in various ways. At present the program is implemented in five of the nine districts in the Central region and two districts in the Southern region. Central region alone cover more than forty percent of the total population, according to the National Statistical Office (web). In total Malawi has 3 regions and 28 districts, total population is about 18 million (WHO).

## **DESCRIPTION**

LHL International TB Foundation (Norway) formed a formal partnership with Paradiso TB patient Trust more than a decade ago. The financial and technical support from LHL International has focused on organisational strengthening of Paradiso in order to enable them to reach further in their fight against TB. The support has enabled the organisation to develop and expand geographically, from operating in one district to seven. The overall objective of the Project/collaboration (2015-2017) was to reduce the burden av TB in Malawi.

Paradiso TB patient Trust is now a key player in the TB sector in Malawi, and the only organisation of its kind in the country. Being a TB and HIV patient organisation they fully represent the voice of the patients themselves. Paradiso has more than 1 400 members (tripled in 3 years) and volunteers and implements activities in all seven districts and their local communities through almost fourty local TB Clubs/branches. The organisation plays an important role in the fight against TB in the districts where it operates, spreading information about TB and HIV, fighting stigma, screening people for symptoms, referring people with symptoms to the nearest clinic and following up TB patients (many of whom are HIV+) that are on treatment. They also do contact tracing.

All local branches are formed as TB Clubs, located in the communities and linked to the local health facilities. They work hand in hand with the public coordinators and health facilities, as well as With local chiefs, Groups of elderly and traditional healers. Paradiso has, during 2015-2017, developed and piloted a system that help document how many people actually go to the clinic for testing after being approached by a Paradiso volunteer and screened for symptoms. The system is called the "Card system", because people found with symptoms are given a Paradiso ID card that they can show at the clinic and use as referral. This enables the organisation to track a person from the point of receiving TB information up to the time of TB testing at the health facility. The cards are collected at the clinics and may be reused by Paradiso volunteers.

The pilot and the general work of Paradiso is in line with the NTP-NSP Plan, 2015-2020, Paragraph 6.1,7.

## **RESULTS, OUTCOMES AND IMPACT OF THE POGRAMME**

Paradiso has reached out to several thousand Malawians with quality information about TB and HIV. Information dissemination has been done through various channels, general awareness raising in the communities, role play, TB talks in the clinic, focus group discussions, radio talks

and other media coverage. In addition, patient friendly written material has also been disseminated. The organisation's many volunteers (Former TB patients, many living with HIV) have done a tremendous job in assisted more than 5 150 people through the course of TB treatment. Treatment success has been almost 100% among these.

Through the Card System, piloted in Michinji District in Central region, Paradiso was able to further document the effect of their work. Compared with 2015 data from the district the organisation has contributed to a 23% increase in case notification. This success has been acknowledged by health officials in the district and nationally, and clearly demonstrates the organisation's contribution to finding more of the missing cases.

## **LESSONS LEARNED AND RECOMMENDATIONS**

Paradiso has, in our view, showed that the "TB Card System" is a tool that can assist grassroots organizations in documenting and demonstrating the effect of interventions similar to that of Paradiso; ie. tracking all identified presumptive TB cases from local communities to the health facilities, a method of showing the effect of key activities such as information dissemination, screening for symptoms, doing health talks, other awareness raising activities and contact tracing.

The fact that the volunteers themselves have been, or are, affected by TB and many are HIV+ they know better than anyone how to approach people in similar situation, what to say and how to support. The volunteers also help combat stigma because they are living proof that you can lead a good and healthy life even though you are HIV positive and they also show that TB is curable. Involving TB patients themselves and people living with HIV, or former TB patients is very effective.

Good collaboration and coordination with public health officials and key persons at the local clinics and in local and district administration has made this project possible.

Paradiso will start implementing a similar card system in all districts where they operate. Eventually the documented effect of Paradiso in TB control in Malawi will hopefully pave the way for government support beyond the existing political and moral support. The system, and the type of assistance and interventions done by Paradiso volunteers, should be available in all communities, to all people, throughout the country. If Malawian health authorities want to find all the missing TB cases in the country this is definitely a place to start.

## **ANNEXES**

N/A

## 7.2 TITLE OF THE PROGRAMME:

Expanding HIV in TB Services in Prison: Experience from Zomba Prisons, Malawi

### CONTACT PERSON

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- **Programme is being implemented since:** 2014
- **End date of the programme:** /
- **Responsible parties:** Government, UN or other inter-governmental organization, NGO
- **Population reached:** People living with HIV, Prisoners and other populations in closed settings
- **Has the programme been evaluated/assessed?** Yes, Dignitas International through a cross-sectional audit of ART and virological outcomes. A paper has been published in the Journal of International AIDS Society on the programme evaluation
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** Yes – Plan: TB policy in Malawi prisons

### BACKGROUND

Tuberculosis (TB) remains a major global health problem and is in the top 10 of causes of death worldwide. TB and HIV rates are generally higher in prisons than in the general population. Overcrowding, poor nutrition and insufficient preventive services contribute to very high risk of TB and HIV in African prisons. Malawi among the 20 countries with highest TB incidence among people living with HIV and is a focus country in the End TB Strategy era 1. We report on the HIV cascade and TB case finding best practices at the Zomba Central Prison (ZCP) based on routinely collected program data from 2014 - 2017.

### DESCRIPTION

In 2014, Dignitas International (DI) in collaboration with Malawi Prison Health Services and Zomba District Health Office introduced a comprehensive package of interventions to prevent, screen and treat HIV, TB, Hepatitis B virus and STIs at the ZCP (on average approximately 2300 prisoners at any point) and 4 satellite prisons (approximately 1000 prisoners at any point in time) in Zomba district. At the ZCP, prisoners are routinely screened at entry and release from prison and prisoners can access the clinic at the ZCP premises at any time for testing or care. Mass screening campaigns are conducted biannually at the ZCP and the 4 satellite prisons. In addition, primary health care outreach services including HIV testing and treatment are provided fortnightly at the satellite prisons. HIV treatment is provided according to national HIV guidelines (including “test-and-treat”). TB case finding follows national TB policy in prisons, using sputum MTB/RIF Xpert as the first screening test and includes a facility-based infection

control protocol. At the national level, the National TB Control Program and the Department of HIV/AIDS coordinate the provision of HIV, TB and STIs tests reagents while at the facility/district level, implementing partners (DI and Challenge TB – support with funds for the mass screenings and provide mobile X-ray machine), Prison Health Services and Zomba District Health Office coordinate the implementation of the program activities.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

From January 2013 to December 2017, 16,226 HIV tests were done among prisoners with unknown HIV status, 679 prisoners with new HIV diagnosis were identified of whom 611 (90%) were started on ART (Table 1). There has been an increase in the uptake of HIV and TB services due to the mass screening campaigns with coverage of HIV testing per prison ranging from 49 % at the ZCP to 90 % at the satellite prisons (Table 2). The overall HIV prevalence at the ZCP decreased from 35 % in 2015 to 23 % in 2017 while at the satellite prisons, it remained stable at 12 % from 2015 to 2017.

By December 2017, 1760 prisoners had ever been registered on ART at the ZCP clinic, of whom 648([80 %] Alive on ART/ {cumulative – transferred out} x 100%) were alive on ART, 45(2.6%) had defaulted, 3(0.2%) had stopped ART, 110(6.3%) had died and 954(54%) were transferred to another clinic. Prisoners eligible for routine viral load monitoring at ART duration milestones from 2014 - 2017, had a viral load suppression NON SI COPIA!!!! RIPROVA

### **LESSONS LEARNED AND RECCOMENDATIONS**

Advocacy and strong collaboration at the national level between the government departments and implementing partners (IP) led to the set-up of national steering committee and technical working group on Prison Health Services. This materialized in coordinated funding for the provision of human resource and material support for prison health program activities, the development of dedicated HIV and TB guidelines for prisons, a TB/HIV Policy in Prisons and a Prison Health Toolkit<sup>2</sup>, resulting in high quality HIV and TB services for prisoners. Several challenges remain and require urgent attention. Insight into linkage of prisoners into general TB and ART services upon release from prison is poor and needs more attention as such linkage has been found challenging in other countries. The constitution of Malawi prosecutes men who have sex with men, which hampers comprehensive HIV prevention services such as provision of condoms and lubricants despite indications that such sexual practices take place in prison settings<sup>3,4</sup>. Despite continued advocacy, no meaningful improvements in rampant overcrowding and poor nutrition in prisons have been made.

Combined symptomatic screening, expert MTB/Rif and mobile X-ray increased the yield of TB screening. Structured screening for HIV and TB should be continued to increase access to HIV and TB services in prisons. Provision of incentives such as tablets of soap and healthy food products increased coverage of the screening campaigns.

### **ANNEXES**

N/A

## 8. MOZAMBIQUE

### 8.1 TITLE OF THE PROGRAMME: Hope Project

#### CONTACT PERSON

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- **Programme is being implemented since:** 2014
- **End date of the programme:** /
- **Responsible parties:** Civil Society
- **Population reached:** People living with HIV, Children, Women and girls, Young people/adolescents
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

In Mozambique only 59% of people living with HIV and AIDS know about their sero-positive status, 46% of them are put on ART and 70% of those on ART adhere to treatment after one year of treatment initiation. Persisting high level stigma around HIV testing and ART intake, geographic barriers to health facilities, reluctance of the men to go for HIV testing and rapid drop outs from ART are key factors. ADPP Mozambique, a premier NGO of Mozambique has developed an effective model of HIV testing and ART adherence through two of its communitybased HIV index-case tracking projects in Maputo city and Maputo province respectively. (Data source: Country Operational Plan PEPFAR 2018)

#### DESCRIPTION

The project had more than 100 field counselors and around 10 supervisors who implemented the activities in collaboration with the local public health facilities. The interventions included bringing household contacts and sexual partners of index HIVinfected under home-based HIV C & T, ART initiation of newly infected cases under country's Test & Treat strategy, symptomatic TB screening of the household members and testing of the presumptives through referral and follow up and/or sputum collection and transportation, adherence and retention services both for ART and ATT through community support groups, stigma reduction, nutritional education and socioeconomic supports and retrieval of loss-to- follow up cases. The project used a unique IT-based mobile application to track patients in the community and linking them to health-facilities.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Between 2015 - 2017, the two projects of Maputo screened a total of 459,876 household members of 97,665 HIV index cases (out of estimated household members between 439,492 to 488,325, more than 100% coverage of household members), detected 43,911 HIV-infected (10% of tested), initiated ART for 40,551 (92% of infected) of whom 34,601 (85% of those on treatment) showed viral suppression after one year of treatment initiation. The result further showed very high level HIV seropositivity among the sexual partners of index HIV cases (65% to 85%) comparing household members (10%). High level seropositivity (10% +) has been observed among youths and orphans at the households while children belonging to index cases reveal low sero-positivity (1-3%). In terms of TB screening and care these projects, together with their routine HIV activities also screened 201,673 household members for TB, detected 1891 TB patients (all types) who were put on treatment and so far 1638 of them successfully completed TB treatment (87%) in 2017. In 2016, the same two projects, had screened 221,078 family members for TB, detected 1676 TB patients (all types) who were put on treatment and 1317 of them completed treatment successfully (79%). The projects so far detected 19 TB patients by screening 9773 household members for TB in 2018 and they are currently on treatment.

## **LESSONS LEARNED AND RECOMMENDATIONS**

ADPP's community-led and IT-based treatment adherence system, extensive door-to-door campaigns and peer outreach activities showed the desired results that the national program aims to achieve in the line of 90-90-90 targets, both for HIV and TB.

## **ANNEXES**

Published paper: ADPP Mozambique made an oral presentation in the late-breaker session of the 48th Union World Lung conference in Mexico in 2017. The name of the paper was 'ADPP Mozambique's strategies to track and support index HIV cases and their contacts through community-based interventions have been protecting PLHIV against TB in Mozambique.' The abstract of the presentation was published in the Abstract Book of the Conference.



## 8.2 TITLE OF THE PROGRAMME: Hope Project

### CONTACT PERSON

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- **Programme is being implemented since:** 2014
- **End date of the programme:** /
- **Responsible parties:** Civil Society
- **Population reached:** Young people/adolescents
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

The National HIV prevalence survey of Mozambique (2015) revealed maximum new infections among adolescent (10-19) and young adults (20 – 24). ADPP Mozambique, a premier National level NGO conducted a KAP study (2017) among young people of Matola district of Maputo province, Mozambique to 1) take stock of their knowledge, attitude and practices on HIV & AIDS, related services and PLHIV and 2) utilize observations of the study for advocacy and programmatic decisions. (Data source: National HIV Prevalence Survey 2015 Report of MoH, Mozambique)

### DESCRIPTION

ADPP engaged 147 community counselors and 9 supervisors from its ongoing Hope Humana project (that offered home-based C&T/HCT to household members of newly diagnosed index cases) of Matola district in the study. Structured questionnaires developed from standard research questions. A sample size of around 400 (targeted age-groups were 10 to 14, 15 to 19 & 20 to 24) was estimated to be interviewed inside households of index cases during routine HCT of Hope Humana project while around 150 to be interviewed outside those households through random selection. ADPP trained counselors and supervisors of Hope Humana project on data collection methodologies before study.

### RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Of total 502 viable interviewees (63 samples discarded) 392 ever heard of HIV & AIDS (78%) and 87% of them (342) knew AIDS is a disease. Out of those who knew AIDS is a disease a) 68% males and 61% females knew at least two correct ways of HIV transmission, b) 64% males and 57% females knew at least two correct ways of HIV prevention, c) 76% males and 73%

females knew what ART is, d) 16% males and 12% females ready to disclose their status to partners & families if ever been found positive, e) 2.5% females and 2.1% males agreed to treat PLHIV respectfully, f) 70% of females and 29% of males ready to start ART on their own decisions if ever been found infected, g) 79% of females and 100% males said they were tested for HIV.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Irrespective of high service utilization (probably due to HCT) mediocre HIV knowledge and high stigma with gender variations still exist among young population. This should be urgently addressed in Hope Humana project and NACP of Mozambique.

### **ANNEXES**

ADPP Mozambique conducted the KAP survey in 2017 in the operational areas of Hope Project in Maputo city and Maputo province as a rapid assessment to know the overall perception of younger population on HIV & AIDS in the current context.

### 8.3 TITLE OF THE PROGRAMME: Challenge TB Project

#### CONTACT PERSON

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- **Programme is being implemented since:** 2016
- **End date of the programme:** /
- **Responsible parties:** Civil Society
- **Population reached:** General Community
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

TB case notification is a major challenge in Mozambique. The National TB Program (NTP) collaborated with the USAID Challenge TB (CTB) project and ADPP Mozambique, a premier NGO of the country to enhance notification in the highly populated provinces of Nampula and Zambézia.

#### DESCRIPTION

The NTP in Mozambique, is responsible for policy, coordination, and overall implementation of TB services. The USAID CTB project, led by FHI 360, provides strategic leadership and Description: technical assistance to the NTP, including monitoring and supervision, in the implementation of TB activities in 4 provinces. With funding assistance of CTB, ADPP Mozambique implements community-based case-finding activities in 7 districts in Nampula and 10 districts in Zambézia. The activities include door-to-door active case finding, contact screening, sputum collection and transportation, household education and stigma reduction, HIV testing of new TB patients, capacity building of cough officers, engagement of TB activists, observance of community-level cough days, and community treatment support and mentoring .

#### RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

TB case notifications increased in Nampula (12% increase in 2016; 40% in 2017) and in Zambézia (44% increase in 2016; 30% in 2017). These were the highest increases reported from all the provinces in Mozambique during 2016-17. The TB cases notified through CTB and with ADPP's implementation contributed to 55% of total additional cases notified in Nampula in 2016, and 51% in 2017. Similar contribution in Zambézia was 23% in 2016 and 64% in 2017. Overall, CTB & ADPP contributed to 12% of the total additional cases notified in the country in

2016 and 32% in 2017. During this time, the overall estimated national treatment coverage increased from 45% in 2016 to 54% in 2017.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Community-based interventions that engage civil-society partners can improve NTP performance and increase case finding. Similar interventions can be replicated in other lowperforming provinces to meet national TB elimination goals.

### **ANNEXES**

N/A

#### 8.4 TITLE OF THE PROGRAMME:

Household and Family-Centered Approach to Improve TB Screening and Diagnosis, HIV Testing, and Linkage to Care (Mozambique)

#### CONTACT PERSON

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- **Programme is being implemented since:** 2017
- **End date of the programme:** 2018
- **Responsible parties:** Government, Technical Agency - CDC
- **Population reached:** People living with HIV
- **Has the programme been evaluated/assessed?** Yes, Implementation Science Evaluation
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

In Mozambique, the majority of TB is undiagnosed (estimated TB case detection is 39%) [1]. To enhance case-finding, the Ministry of Health (MoH) in Mozambique recommends contact tracing for all persons exposed to someone newly registered for treatment of TB disease, including household contacts [2, 3]. It is estimated that more than 100,000 children aged less than 15 years lived in households with adults diagnosed with pulmonary TB disease in Mozambique in 2014 and are therefore recommended to have evaluation for TB disease [4]. Contacts aged less than 15 years are recommended to have follow-up evaluation at the Child at Risk Clinic (CCR) and those aged less than 5 years should receive 6-months of Isoniazid Preventive Therapy (IPT) if they do not have TB disease. It is also recommended that children and adults living with HIV be regularly screened for TB during HIV consultations and provided IPT to prevent TB disease.

fBecause of the high prevalence of HIV among persons with TB disease in Mozambique (52%), TB clinics also represent a highyield setting for diagnosing HIV among people being evaluated for or diagnosed with TB and also for other members of their household [1]. Screening for TB and testing for HIV among family members of persons with TB disease may help improve identification of both adults and children with HIV, TB, and TB/HIV to allow earlier initiation of anti-retroviral therapy (ART) and/or TB treatment and ultimately reduce morbidity and mortality related to TB/HIV. According to Mozambique's current national guidelines, persons with HIV who have TB disease are eligible for ART [2, 3]. Enhanced case finding for HIV among persons with TB and their contacts can identify additional persons eligible for ART (e.g. pregnant women, persons meeting CD4 criteria, etc.) and thus enhance efforts to reach the PEPFAR 90-90-90 targets.

## **DESCRIPTION**

This project aims to improve the implementation of currently recommended contact tracing strategies by prioritizing household contacts of patients newly enrolled on TB treatment for home visits. TB index cases diagnosed at a health facility and enrolled in our study receive home visits by community health care workers (CHWs) to conduct contact tracing of household members. Household contacts receive HIV rapid testing, TB symptom screening, referred to health facilities for drop-off of home collected diagnostic specimens and linkage to ART/TB care/IPT initiation for those eligible. This project also aims to optimize active case finding by developing and implementing a package of tools. These tools include an electronic contact tracing register, clinical referral tools and decision-making guides, household peer supporters, and healthcare worker sensitization and training in pediatric TB diagnosis and TB and HIV care. This project involves implementation of programmatic components already recommended by WHO and the Ministry of Health in Mozambique.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

During the 30 day pilot of our study, 1 person was identified to have HIV infection and 15 TB index patients diagnosed via GeneXpert testing consented to receiving home visits. Amongst the 15 households visited, a total of 57 household contacts were identified (3 ≤5 years of age, 18 6-14 years of age, 36 ≥15 years of age). Amongst the 7 adults identified with symptoms, 5 delivered samples to the health facility resulting in 4 being initiated on TB treatment. Amongst the 21 children

**Finish!!!!!!**

## **LESSONS LEARNED AND RECOMMENDATIONS**

During the pilot, many household contacts that were identified and referred to the health facilities failed to show, especially amongst pediatric contacts. One of the main reasons that was given was distance required to travel and lack of money to pay for public transport to reach health facilities. Though CHWs were originally intended to bring home collected specimens to the health facility for testing, this was changed to having the household contacts bring the samples due to feasibility barriers. We are currently addressing this issue by including smaller peripheral health facilities potentially closer to the households but without GeneXpert testing capabilities to serve as sample drop-off points, IPT initiation and NPA collection sites. Additionally, better ability at the peripheral sites to capture initiation and continuation of ART needs enforcing. Recommendations would include the budgeting of transport vouchers to the facilities for household contacts into the study, or providing transportation options for CHWs to do home specimen collections and transport to facilities on a daily basis.

## **ANNEXES**

N/A

## 8.5 TITLE OF THE PROGRAMME:

### Mineworkers' Access to Treatment and Care for HIV and TB (MATCHT)

#### CONTACT PERSON

Name: Susan Cookson

Title: Team Lead/Medical Officer

Organisation: CDC

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- **Programme is being implemented since:** 2017
- **End date of the programme:** /
- **Responsible parties:** Government, UN or other inter-governmental organization, Technical Agency - CDC
- **Population reached:** People living with HIV, Miners (especially exposed to silica), Migrants (documented and undocumented), refugees or internally displaced populations
- **Has the programme been evaluated/assessed?** Yes, Implementation Science Evaluation
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

It is estimated that as much of 30% of tuberculosis (TB) in Southern Africa is a result of transmission among and from mineworkers. The incidence of TB among gold miners in South Africa is among the highest in the world, at 3,000-7,000 per 100,000, with an 80% HIV co-infection rate. In 2015, 70,000 Mozambicans were currently working in South Africa's gold mines, and 140,000 Mozambicans had previous experience working in the South African mines. The mining sector involves migration patterns between an individual's residence and place of work ('circular' migration), which may facilitate spread of TB disease and HIV.

#### DESCRIPTION

A collaborative pilot program, "Mineworkers' Access to Treatment and Care for HIV and TB" (MATCHT) between the Centers for Disease Control and Prevention, the International Organization for Migration, Right to Care, and the AURUM institute was implemented to provide linkage to care and support continuity of care for persons with TB (including TB/HIV). Several approaches are being used to identify Mozambican mineworkers currently working in South Africa. A cross-border program was established to find mineworkers with TB, link them to care on either side of the border, and facilitate treatment adherence. The program utilizes community health workers in Mozambique and a nurse call-center and field staff in South Africa.

In South Africa, Kawena, a goods supply distributor, provided TB/HIV education and referrals to mobile screening conducted in mining areas. In Mozambique, TB registers at 18 health facilities in areas where mineworkers reside are being routinely reviewed (January 2017-March current) to identify current and former mineworkers diagnosed with TB. During the December 2017

holiday, we worked with traditional healers and community leaders to conduct house-to-house TB and HIV screening among mineworkers returning to their family residence. In addition, we are conducting contact tracing among for families or persons residing with (e.g., while at the mines in South Africa) index cases of TB. This includes TB symptom screening (and sputum collection for presumptive TB), referral to health facilities for all children, and HIV counseling and testing. Persons who are identified with TB or HIV are linked to care and then if TB (+/- HIV), supported by the MATCHT program for continuity of care (until end of TB treatment).

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Demand creation for TB screening at mobile sites in South Africa mining areas was mobilized through 13,000 text messages to mineworkers registered with Kawena and 200,000 flyers distributed to mineworker communities. A total of 674 mineworkers were screened at the mobile vans over 6 screening days; 259 were Mozambican. Three persons screened were identified with TB, and 29 of 259 were identified with HIV and included in the program. In Mozambique, 35 mineworkers identified through TB registers, 6 through traditional healers, and 4 through house-to-house case finding have been referred into the cross-border program. To date, we have identified 26 persons among household contacts of TB cases in Mozambique; these have been referred into the MATCHT program. This program is ongoing.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Utilizing multiple approaches, this program has identified Mozambicans diagnosed with TB and/or HIV that have either not been previously diagnosed or that have interrupted treatment due to migration for work in the mines of South Africa. We have successfully established a cross-border system to provide linkage and continuity of care for these persons as they migrate to/from South Africa and Mozambique. Expansion of this type of program to provide generalized health support for Mozambicans who have previously or are currently working in the mines of South Africa has potential to improve the health of both Mozambicans and South Africans

### **ANNEXES**

N/A



## 9. NIGERIA

### TITLE OF THE PROGRAMME: GomSACA Wave 5 TB REACH Project

#### CONTACT PERSON

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- **Programme is being implemented since:** 2017
- **End date of the programme:** 2018
- **Responsible parties:** Government, Civil Society, UN or other inter-governmental organization
- **Population reached:** Migrants (documented and undocumented), refugees or internally displaced populations
- **Has the programme been evaluated/assessed?** Yes. Evaluated twice by the External Monitoring & Evaluation Officer from the United Nations Office for Project Services
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** Yes. Plan: The National TB Strategic Plan 2015 to 2020

#### BACKGROUND

Three States (Adamawa, Gombe and Yobe) in North-Eastern Nigeria are affected by the massive movement of IDPs as a result of the ongoing Boko Haram insurgency. There are over 298,300 Internally Displaced Persons (IDPs) in 26 Camps/Camp-like settings which includes 7 formal IDP Camps in addition to over 1,300 Host Communities in 12 of the 49 LGAs in these 3 States as at June 2016. This has placed a remarkable strain on already overstretched health system. Inadequate access to health services, inadequate housing and overcrowding, malnutrition and high rates of HIV are factors influencing the transmission of TB among IDPs. Although Nigeria has one of the highest TB burdens in Africa, case detection rates remain low (24% in 2016). With support from Stop TB Partnership through its Wave 5 TB Reach grant in 2017, TB control service was launched in IDP camps and host Communities of Adamawa, Gombe and Yobe States

#### DESCRIPTION

The project aims to fast track the detection and linkage to treatment care and support of TB and HIV cases among IDPs in the 3 targeted States of North Eastern Nigeria. ACF among IDP populations in 7 camps and host communities was implemented from 1st June 2017 to 31st March 2018 in the 3 States. The process involved mapping, advocacy, identification of Community Volunteers (CVs), reorientation of Health Workers (HWs) and training of the CVs on

sputum collection, transportation, and documentation. Sputa were tested by Xpert MTB/Rif while children were screened using TB scorecards and X-Rays. In collaboration with Community Leaders and IDP camp officials, 97 IDP host communities were screened for TB and HIV; CVs transported sputum and provided treatment support for diagnosed TB cases. 2 Community Based Organizations (Janna Health Foundation and Suffabel Community Development Initiative) in collaboration with the 3 State TB Programmes and the 3 State Agencies for HIV/AIDS Control coordinate the implementation of the project in the 3 States. Similar interventions targeting the IDPs is contained in the National TB Strategic plan and the Global Fund request being developed presently. Major partners in this intervention include the 3 State Governments, TB REACH of the STOP TB Partnership and UNOPS.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

180 CVs, 55 HWs, 30 lab staff and 12 TB supervisors were trained on TB control using NTP guidelines. 220,204 IDPs were verbally screened, 16,610 (8%) presumptive TB cases were identified and tested with Xpert MTB/Rif out of which 948 (6%) B+ TB cases including 37 Rif resistant cases were detected. This represents 47% of the 2,016 B+ TB cases notified by the 12 LGAs. Additional 147 TB cases including children were clinically diagnosed. 2,025 contacts of B+ TB cases were screened out of which 56 (3%) were found to be B+ TB cases. Of the 1,095 all forms of TB cases detected among IDPs and Host Communities, 1,075 (98%) were enrolled in treatment while 35 of the 37 Rif resistant TB cases were linked to the DR-TB management system of the NTP. Similarly, 215 (1%) of the 22,596 IDPs tested for HIV were positive.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Early and sustained key stakeholder engagement, the use of LGA TB Supervisors as CVs, the creation of a social media platform for all CVs and the CBO staff, the production of identification cards and uniforms for the CVs contributed to the success of the intervention. The door-to-door intervention was more successful than the outreaches; other partners working in the same target population also adopted this strategy based on experiences shared by this project. The project has shown that large-scale ACF interventions among IDPs and other vulnerable populations could improve TB and HIV case detection.

### **ANNEXES**

1. Quarterly Reports submitted to the NTP, 2018.
2. Presentations at the Zonal Quarterly TB Programme Managers Meeting in Bauchi, 2018.
3. Presentation at the Global Fund Technical Review Panel, Abuja, 2018

## 10. SOUTH AFRICA

### 10.1 TITLE OF THE PROGRAMME: CDC Support for TB/HIV Activities in South Africa

#### CONTACT PERSON

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- **Programme is being implemented since:** 2013
- **End date of the programme:** /
- **Responsible parties:** Government, Civil Society, Technical Agency - CDC
- **Population reached: People living with HIV, Miners (especially exposed to silica), People who inject drugs, Migrants (documented and undocumented), refugees or internally displaced populations, Children, Women and girls, Young people/adolescents**
- **Has the programme been evaluated/assessed?** Yes. Programme is internally monitored weekly, monthly, quarterly and annually.
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

Globally, the Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) epidemics are profoundly intertwined, as HIV is the leading risk factor associated with developing active TB, and TB, the leading cause of both morbidity and mortality among HIV infected individuals. This is particularly evident for South Africa, which is home to high numbers of people living with HIV (PLHIV) and is one of the countries with the highest TB incidence globally. Furthermore, presumptive TB cases have been identified as high HIV yield populations. In many settings, HIV prevalence rates among presumptive TB cases are similar to or even exceed rates among key populations.

In 2017, the HIV disease burden was an estimated 7,203,313 PLHIV and according to the South African National Department of Health (NDoH), HIV among TB patients was estimated at between 60% and 70% in 2017. In addition, the South Africa country profile as reported in the World Health Organisation (WHO) 2017 Global Tuberculosis (TB) Report, revealed 237,045 new and relapse TB cases, with a 54% treatment coverage rate. Despite an abundance of scientific evidence, political commitment and clear guidelines in place, TB Preventive Therapy (TPT) implementation among PLHIV has been slow. There is a critical need to improve uptake and scale-up of TPT in South Africa to prevent TB among PLHIV.

## **DESCRIPTION**

The Government of South Africa (SAG) and the United States Government (USG) signed a Partnership Framework (PF) in Support of South Africa's National HIV/AIDS and TB Response (2012/13 – 2016/17), to improve the effectiveness, efficiency, and sustainability of the national HIV and TB response. To achieve this, the SAG and USG, through the USG's PEPFAR (President's Emergency Plan For AIDS Relief) program, have dedicated themselves to improving coordination and cooperation to prevent and mitigate the impact of these epidemics. Implementation is coordinated at all levels: national, provincial, district, and entails collaboration and partnership with non-state actors, as the main Implementing Partner (IP) organisations. The U.S Centers For Disease Control and Prevention (CDC) in South Africa, is one of two USG agencies implementing the PEPFAR Program in South Africa. The three key IPs supporting CDC program implementation at community and facility site levels are TB/HIV Care, The Aurum Health Institute and Health Systems Trust, funded directly through CDC and working in 11 of the 27 high-burden priority districts across the country. These IPs are tasked with the objective of implementing the goals and objectives of the PF's, effected through SA's national strategic health documents (Medium Strategic Framework; Negotiated Service Delivery Agreements; current and successive versions of the National HIV & AIDS and STIs; the TB Strategic Plan; and the National HIV and AIDS and TB Management Policy, among others).

The goals and objectives of the PF include: preventing new HIV and TB infections; increasing life expectancy and improving the quality of life for people living with and affected by HIV and TB; and strengthening the effectiveness of the HIV and TB response system. All IP work-plans and activities are aligned to the annual PEPFAR Country Operational Plans (COP), in turn aligned to the national SAG goals and priorities.

Direct funding and technical assistance to the SAG, includes funding provided to several SAG departments and parastatals. Financial sustainability is maintained through improving the financing of the HIV and TB response by continuous refinements in cost efficiencies of all HIV and TB interventions. The SAG also increases its financial contribution and diversifies its funding bases through greater engagement with the private sector and other development partners.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

The South African NDoH developed guidelines on IPT (Isoniazid Preventive Therapy) among HIV-infected individuals, recommending that all eligible PLHIV on ART be initiated on IPT. Together with infection control policies and active case-finding policies, IPT forms part of WHO's Three I's, and South Africa's core strategy to combat the spread of TB.

IPT is one of the interventions that the WHO and the SA NDoH recommend to prevent progression to active TB disease in PLHIV. The WHO, with a high quality of evidence, strongly recommends that these individuals receive IPT irrespective of their degree of immunosuppression. IPT is implemented through the National Consolidated Guidelines for the Prevention of Mother-to-Child transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults. Intensified efforts are commencing towards IPT scale-up in the country.

To date, CDC program data reported in December 2017, documented 160,138 new and relapse TB cases. Of these 96% new their HIV status. Of the 96% of TB cases with knowledge of HIV status, 63% were HIV positive, and of these, 93% were on ART.

This reflects joint TB/HIV programming, through HIV testing of persons with TB disease, persons with presumptive TB as well as linkage to care for treatment initiation. This is also reflected in the annual public health facility assessments, facilitated through the PEPFAR SIMS (Site Improvement Monitoring System). Of the 115 public health facilities assessed to date in the current 2018 fiscal year, 95% of PLHIV were screened for TB and 77.97% received IPT. In achieving the above, IP efforts at community and facility levels comprise of: community TB

screening at HIV community testing campaigns and door to door household visits; linkage to care and treatment through the use of community linkage officers and facility linkage officers; and adherence and retention strategies, employed through decanting of stable ART patients for medication collection in selected community pick-up points. This decongests normally overcrowded health facilities, thereby creating maximum efficiencies for patients to collect medication.

### **LESSONS LEARNED AND RECOMMENDATIONS**

With the successes reported above, TB remains the leading cause of death among PLHIV. CDC South Africa's current data to date, reveal on average, a 22% TPT (IPT) initiation rate, with a 50% completion rate. This is concerning as it indicates that only 22% of eligible patients are receiving preventive treatment. Furthermore, undiagnosed and untreated TB prevents PLHIV on ART from attaining viral suppression. This points to the need to continue with the following rigorous interventions:

HIV testing among all persons with TB disease and persons with presumptive TB as an entry point to life saving ART. Screening all PLHIV for TB and starting TB treatment immediately for those found to have active disease, as well as giving TPT to all eligible patients to prevent progression of LTBI (Latent TB Infection) to active disease. PITC (Provide Initiated testing and Counselling) and linkage to treatment for presumptive TB patients also requires systematic implementation and monitoring. Piloting of reporting tools for HIV testing and linkage to ART for presumptive TB cases is another critical area to be strengthened. And mentoring of facility level staff on the correct capturing and completion of TB clinical stationery and electronic facility site level data collection systems.

### **ANNEXES**

N/A

## 10.2 TITLE OF THE PROGRAMME: TB and HIV screening and referral project in the greater Johannesburg Metro

### CONTACT PERSON

Name: Yvonee Morgan

Title: Ms.

Organisation: Catholic Healthcare Association of Southern Africa (CATHCA)

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- **Programme is being implemented since:** 2015
- **End date of the programme:** 2019
- **Responsible parties:** Government, Civil Society
- **Population reached:** People living with HIV, Miners (especially exposed to silica), Migrants (documented and undocumented), refugees or internally displaced populations, Men
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

South Africa has around 7.1 million people infected with HIV, of which approximately are co-infected with tuberculosis (TB). 86% know their HIV status and 65% of those are on treatment, while 81% of those on treatment are virally suppressed. This programme is directed towards achieving 90% of those infected who know their status, particularly men, through HTS and TB screening and referral, done in high-prevalence areas such as informal settlements around major metropolises. Faith-based organisations experience a high level of trust from communities; they usually live where they work, and are knowledgeable about their community. People trust them to maintain confidentiality and to understand their circumstances without being judgemental. South Africa has chosen to use lay providers from nongovernmental organisations to supplement and extend their HTS services into underserved communities, and to reduce the case load at local clinics.

### DESCRIPTION

This programme aims to provide communities of people in informal settlements around the City of Johannesburg metropole (population 9.4 million) with HTS and TB screening services and referral to local primary health clinics, to extend the number of those tested, especially men, and to reduce the load on local clinics. CATHCA provides this service under contract to the Gauteng Department of Health (DoH) and manages five local faith-based organisations based in large informal settlements around the city of Johannesburg, four of which are home-based care

providers operating from Catholic parishes and one of which is a privately-funded clinic (funded through the Anglican Church).

It employs a project manager who reports to the CATHCA Director and Finance Officer and who collates and provides data on a monthly basis to CATHCA and to the DoH, using a DoH standardised reporting template. Statistics are collected by age group but not by gender. CATHCA has run this programme since April 2015 and its contract is due to be renewed by the end of May 2018 for a further year. Fifteen lay providers, employed by the five organisations but paid directly by the DoH, carry out HTS and TB screening, and do basic screening for diabetes and hypertension as well. This is because there has been a significant increase in non-communicable diseases in South Africa in past years which has been sidelined by the HIV and TB epidemics.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

The fifteen lay providers screen an average of one thousand people per month, of which 6.7% are referred to government clinics to be put on ARVs or to be tested for TB. Everyone is tested for HIV and screened for TB symptoms, and screening is done for diabetes and hypertension, as well. However, we find that many refuse to go to be tested at the clinic as they 'do not realise how dangerous TB is', as one of the carers said. The percentage testing HIV positive over an eleven-month period in 2017 was 4.90%.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Catholic healthcare organisations; however trained carers are often offered posts in government so there is a continual need for training. Another pillar of faith-based health care is its holistic nature that encompasses not just physical care but emotional and spiritual support too.

Our home-based and community health carers seldom provide just one particular service, such as TB visits or care for the chronically ill. Home-based care should be viewed in the broader sense of palliative care for the chronically-ill (which in South Africa is taken to include those on TB or DR-TB medication and on ARVs as well as those with non-communicable diseases) and the house-bound, as well as acute care for those newly discharged from hospital. Nearly all HBC organisations offer three or more services (food gardens, home visits, support groups, OVC support, etc).

The issue of lay providers being directly paid by the DoH is problematic as this reduces the authority of the project manager and CATHCA and the level of supervision possible, and leads to delays in replacing providers who have left or are underperforming.

### **ANNEXES**

N/A

## 11. TANZANIA

**TITLE OF THE PROGRAMME: Southern focused coalition in support of HIV combined prevention and differentiated service delivery: Coalition to build Momentum, Activism, Solidairty & Strategy Africa (COMPASS)**

### **CONTACT PERSON**

Name: Ms. Joan Chamungu Msuya

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- **Programme is being implemented since:** 2017
- **End date of the programme:** 2020
- **Responsible parties:** Government, Civil Society, UN or other inter-governmental organization, Academic institution
- **Population reached:** People living with HIV, People who inject drugs, Women and girls, Young people/adolescents, Key and vulnerable populations (LGBT)
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** Yes. Tanzania National Strategic Framework on HIV and AIDS

### **BACKGROUND**

First is around community ART. We need health care workers Background: such as expert patients who are out there in the field to be enrolled in providing HIV services, including ART delivery. They understand this role very well. There is a benefit to formalize the volunteer community health care workers and we are urging the government to relax requirements for task-sharing and taskshifting to increase coverage of services and improve retention. Second issue is around HIV related stigma. Stigma in the community remains a big barrier for people to get tested. And we all know testing is the entry point to care and treatment. We are all aware of stigma faced in particular by KVP in accessing health services. Everyone in the health facility needs to be trained on stigma and discrimination reduction. Law enforcement actors also need to be engaged in counter S&D interventions including the TWGs. And we need to monitor the effectiveness of the stigma reduction activities and focus our investments on impactful interventions on S&D reduction. Third issue is around effective connectivity between facilities and community service providers. We have a high TB burden on top of the HIV burden. It becomes of essence that community and facility health systems are talking to one another (bi-directional linkage).



Bi-directional linkage helps in ensuring efficiencies in client case management by making sure that there is effective networking among community and facility service providers. Ideally a facility service person will know about all the services being offered at the facility level while community service provider will know about all the services being offered at the community. Effective communication between these two (community and facility providers), promotes efficiencies: for example instead of the community service provider providing a client escort service; S/he would just call the facility person who would receive the client and ensure that s/he receives the required services at the facility and likewise for the services at the community. This would save much time for both service providers. Social environment is not friendly for marginalized groups still more needed to be done on human rights approach in programming to see no one is left behind. 52.2% of Tanzanians have tested for HIV and 42% viral load suppressed. Tanzania Mainland HIV infection is 5.1 and Tanzania (Mainland and Zanzibar) is 4.7%.

Size estimates for key and vulnerable population is unknown and there is a need for further study to get the exact number. Politically funds for HIV is very little the government is contributing 2% while the rest is from external. There is initiative of domestic resources through AIDS Trust Funds. The program seeks to address the HIV infection for PLHIV, MSM, PWIUD and Data as evidence to policy review advocacy. Reference Country strategy for development cooperation Tanzania 2016 - 2019. and UNAIDS Tanzania report.

## **DESCRIPTION**

The program is done in 3 countries namely Tanzania, Malawi and Zimbabwe.

The objectives are:

- Building power and influence via Africa-focused civil society coalitions
- Using data, information and analytics to advocate for truly Description: comprehensive, effective programs that lead to epidemic control.
- Fostering for Strategic innovations that lead to epidemic control using the “business unusual” approach
- Defining issues and ambitious change agendas: differentiated service delivery, combination prevention, human resources for health, SRHR, key populations and more.

Tanzania Partners are TNW+, NACOPHA CHESA AND TANPUD. the project is managed by AVAC and funded by Melinda Bill Gates through AVAC who are based in US. It has regional partners as follows: COMPASS Africa partners have a range of skills and established modes of work that facilitate both differentiation and collaboration around thematic areas including: differentiated service delivery (Health GAP, ICW EA, MANET/CEDEP); combination prevention (AVAC, ICWEA, CHANGE, MSMGF, ZAN, PZAT); data literacy and using data for advocacy (amfAR, AVAC, Health GAP, MSMGF, PZAT); analysis of power dynamics shaping the epidemic response at institutional and individual level—and of strategies for improving accountability (AVAC, Health GAP, MSMGF, ICWEA, ZAN); community development and issues concerning men who have sex with men and trans-women (CEDEP, MSMGF); support for HIV prevention for women and girls, including female sex workers (AVAC, CHANGE, ICW EA, PZAT). Among these partners is DSDUT which comes with a new set of skills.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

It just started 2018 to end 2020. So far country team participated on COP 2018 processes and inclusion of CSO input on COP2018 was a success story. Meaningful inclusion of CSO in TWG on clinical management of TB/HIV diseases. are virally suppressed.

Tanzania has made significant progress in the fight against the HIV epidemic in recent years, decreasing HIV prevalence rates from 7.0% in 2004 to 5.1% in 2016. In 2015 an estimated 1.4 million people in Tanzania were living with HIV and AIDS, with approximately 91,000 of these 1.4 million being under the age of 15. Sixty percent of those living with HIV were aware of their

status (have ever been tested and received results), and as of August 2016, 49% (690,944 ) were on ART .

There are, however, wide variations in HIV prevalence and uptake of HIV testing and care and treatment services. Women aged 15-49 years are approximately one and a half times more likely to be HIV-positive (6.3%) than men of the same age (3.9%). Although data in recent years shows steady improvement for key and vulnerable populations (KVP) such as men who have sex with men (MSM), people who inject Results, outcomes and impact of the programme: drugs (PWID) and female sex workers (FSW), these populations still experience higher HIV prevalence (22%, 15.5% and 31%, respectively).

Geographic disparities are also present; with some regions varying from 15% estimated prevalence in Njombe, to 2% in Manyara and Tanga. In October 2016, the Government of Tanzania adopted the World Health Organization's (WHO) 'Treat All' recommendations. The recommendations remove limitations on eligibility for ART access for PLHIV, such that anyone infected with HIV should be initiated on ART regardless of CD4 (count or percentage) and WHO clinical staging. The adoption of these recommendations, coupled with the Government of Tanzania's acceptance of the UNAIDS 90-90-90 strategy (90% of PLHIV know their status, 90% of PLHIV who know their status are on ART, and 90% of those on ART are virally suppressed), represents a significant step towards the fight against HIV and AIDS in Tanzania.

However, significant progress still needs to be made in testing and treatment services in order to achieve the 90-90-90 goals. Bridging the gap between a 60% and 90% testing rate, and a 49% and 90% ART access rate will require the Government of Tanzania to carefully examine the challenges, barriers and successes to care and treatment for PLHIV in Tanzania.

Differentiated models of service delivery are needed at each step of the 'treatment cascade' (described below) to meet the challenges posed by these ambitious HIV Service Delivery Model

## **LESSONS LEARNED AND RECOMMENDATIONS**

It is still on going it has participation of PLHIV and key and vulnerable population. Human right approach in program set up.

## **ANNEXES**

National Guidelines for management of HIV 6th edition

## 12. UGANDA

### 12.1 TITLE OF THE PROGRAMME: Use of TB Register to Increase HIV Case Finding in Uganda

#### CONTACT PERSON

Name: Paul Pierre, Sevim Ahmedov

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- **Programme is being implemented since:** January 2016
- **End date of the programme:** June 2016
- **Responsible parties:** Government
- **Population reached:** Children, Women and girls, Young people/adolescents, Presumptive TB Patients
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

The global HIV response is strategically shifting focus towards the remaining clusters of high HIV transmission. Identification of high-burden HIV sub-populations is critical to ensure the epidemic is under control and no longer expanding. HIV testing among TB patients shows some of the highest yields across PEPFAR countries. However, the number of confirmed TB patients that can be tested for HIV is small compared to other testing modalities. Worldwide, the case detection rate of TB has stagnated around 60%. Uganda is a high burden HIV country with an average HIV prevalence of 6% among adults between 15- 49. TB and HIV services have been integrated since 2007 with HIV counseling and testing done routinely at TB clinics. A study analyzed HIV testing rates, the prevalence of HIV among PTPs and linkage of diagnosed PTPs to care across health facilities in Kampala.

#### DESCRIPTION

HIV testing for all confirmed AND presumptive TB patients (PTPs) is a standard of care recommended by WHO and PEPFAR. More than 90% of presumed TB patients who visited 65 TB diagnostic and treatment sites in Kampala between January and June 2016 had HIV testing results in their medical records. Of those tested, 52.9% were positive and 88.3% were linked to HIV care.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Systematic screening of presumptive TB patients resulted in the identification and linkage to care of an additional 40% of HIV infected patients who would have been missed otherwise. The key element of success was the integration of HIV testing into the presumptive TB registers, and the integrated model of delivering TB and HIV services at the facility level. Although the intervention is being implemented on a routine basis in Uganda, it is not systematically monitored and the value of high-yields of HIV testing among this population is not fully accounted. Overall 8,413 (91.3%) out of 9,219 records had HIV testing results. Of those tested, females were 4,455 (52.9%) of the cases. Of the total patients who were tested, 4,449 (52.9%) were positive and of these 3,930 (88.3%) were linked to HIV care. A record with a positive HIV status was more likely to be of a female than a male (OR=1.54, CI: 1.41-1.68; p=0.00). Highest HIV positivity rates were observed among presumptive TB patients aged 35-44 years. Out of the 1,353 presumptive TB patients confirmed with TB, 573 (42.4%) tested positive for HIV as compared to 1,506 (40%) of the 4,076 PTPs where a non-TB diagnosis was made. A total of 3,750 PTPs had their TB status missing in the register, the HIV positivity among these was 70.8%. The prevalence of HIV was double (54%) compared to the prevalence of TB (26%). The proportion of patients confirmed with TB among PTPs (15%) was higher than the 10% estimated by WHO for all forms of TB. The linkage of patients who tested positive for HIV to ART clinics was excellent with >98% of patients starting ART and CPT regardless of their TB status. This performance is a reflection of the capacity of health facility teams in these settings to integrate TB and HIV services effectively. Sustaining this practice is likely to positively impact key indicators such as treatment success rate (TSR) of TB/HIV patients resulting in reduced risk of mortality. The study showed that 42% of children 5-14 years of age presented to health facilities as PTPs were HIV positive. This finding calls for increase in the index of suspicion for HIV and timely action to minimize missed opportunities for HIV diagnosis in children.

## **LESSONS LEARNED AND RECOMMENDATION**

This study demonstrates how systematic testing of presumed TB patients can boost HIV case finding. The specific strategies that were used for testing and linkage to care at these 65 facilities was not discussed. The study reported that 96% of the facilities involved in the study had an HIV implementing partner. This study highlights the feasibility of leveraging TB service delivery systems to promote HIV testing and linkage of diagnosed HIV patients to appropriate care. Systematic testing of presumed TB patients reduces the number of HIV missing cases and offers potential for early HIV diagnosis and treatment, thereby mitigating HIV related morbidity and mortality. Other studies from sub-Saharan Africa and India have also shown high HIV prevalence rates among presumptive TB patients with variation in prevalence according to the epidemiological context. The results show feasibility of implementation of a high-yield HIV testing intervention among presumptive TB patients in Kampala under routine operational practices. This example also shows high levels of linkage of HIV infected patients to ART clinics for care regardless of the patients' TB status. Testing for HIV among presumptive TB patients can be implemented with fidelity and scaled up across PEPFAR countries. This will require increased efforts to strengthen TB/HIV collaboration and integration of TB/HIV services at facility level. High TB screening rates as well as HIV testing can be achieved by optimizing and integrating the work of TB and HIV services providers. This model of intervention not only offsets delays in diagnosis and initiation of treatment for patients affected by either or both diseases, but also ensures efficiency in resource limited setting. The scaling up of systematic screening of TPTs should take into account :

1. Full integration of TB services with HIV and other primary care services
2. Systematic recording of all presumed TB patients at all entry points into the health care system.
3. Regular supervision to ensure all presumptive TB patients are tested for HIV

4. Training of health care providers on HIV testing and counselling
5. Availability of HIV test at TB clinics and other point-of-care

**ANNEXES**

High HIV prevalence among presumptive Tuberculosis patients in an Urban Setting: Lessons from Kampala City- Uganda D. Lukoye<sup>1</sup>; R. Byaruhanga<sup>1</sup>; N Kirirabwa<sup>1</sup>; S. Zalwango<sup>2</sup>; S. D’Jene<sup>3</sup>, S. Birabwa<sup>3</sup>, 4S. Ntudhu, P Suarez<sup>5</sup>;

## 12.2 TITLE OF THE PROGRAMME: Addressing human rights, HIV and TB issues of prisoners in Uganda

### CONTACT PERSON

Name: Dorah K. Musinguzi

Title: Executive Director

Organisation: Uganda Network on Law, Ethics and HIV (UGANET)

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- **Programme is being implemented since:** 2014
- **End date of the programme:** 2015
- **Responsible parties:** Civil Society
- **Population reached:** Prisoners and other populations in closed settings
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

In 2014, the Uganda Network on Law, Ethics and HIV/AIDS (UGANET) received a grant to implement a project aimed at addressing gaps in access HIV and TB services in prisons and strengthen access to justice for prisoners in Kampala Extra region.

### DESCRIPTION

“People should know that the small grant made [prison workers] respond differently and look at human rights and access to justice in a different angle. Also, before we [UGANET] were only focusing on people outside the prison. Now we look at prisons and PLHIV as a priority. There is still a big need and we need to continue working together to address issues.” -Immaculate Owomugisha, UGANET.

During the inception phase, UGANET conducted a needs assessment in the prisons to assess the extent to which prisoners could access HIV and TB related services and access justice in order inform the development of an issues paper, which would form the basis of their activities and advocacy with policy-makers.

### RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

UGANET trained key prison staff on the issues identified in the issues paper. They also trained prisoners on HIV and human rights as well as to work as paralegals. The trained prisoners provided support to their peers, which included making referrals for TB screening and other health services. Following the trainings, UGANET established a network of prisoners who met weekly to address the challenges facing new prisoners living with HIV and TB and to provide paralegal services.

A key outcome of the project was the empowerment of prisoners to claim their rights. For example, following the trainings, prisoners reported feeling comfortable to ask questions to a magistrate or judge about their case, whereas this was not the case before the training. Further, the engagement with prison officials enabled UGANET to access other prisons.

During the implementation of the project, UGANET met with junior and senior prison officers on a quarterly basis to share challenges reported to them and strategise on how to address them.

UGANET's lawyers also provided direct legal support to some prisoners whose notices of appeal were never filed. UGANET has been successful in having several cases, where case files were lost, dismissed and in improving processes within the justice system to ensure cases proceed swiftly and efficiently. For example, since the prison does not have transport to take the notices of appeal to the courts, UGANET has been able to help facilitate this and ensure that these case files are not lost. UGANET and partners also work directly with the Ministry of Justice to address systemic challenges and reduce extensive waiting periods for ministerial order decisions.

### **LESSONS LEARNED AND RECOMMENDATIONS**

UGANET partnered with several NGOs, including the National Forum for People Living with HIV, the Uganda Palliative Care Association and the Network of Public Interest Lawyers to establish a network of organisations who provide psycho-social and other types of support to prisoners. Through the collaboration with the Network of Public Interest Lawyers, UGANET has been successful in addressing the issue of 20- year delays in decisions on ministerial orders which must be issued by the Minister of Justice instead of a doctor. While one judge has ruled in their favour that a doctor should make healthrelated ministerial orders.

This project also allowed UGANET to obtain additional funding from the Open Society Initiative of East Africa to continue addressing access to justice for prisoners.

### **ANNEXES**

The Situation in Uganda Prisons: Access to Justice, T.B and HIV/AIDS.

### 12.3 TITLE OF THE PROGRAMME: Use of TB Presumptive TB Register to Increase HIV Case Finding in Uganda

#### CONTACT PERSON

Name: Paul Pierre, Sevim Ahmedov

Title: Senior TB/HIV Advisor

Organisation: GHFP-II/USAID

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- **Programme is being implemented since:** January 2016
- **End date of the programme:** June 2016
- **Responsible parties:** Government
- **Population reached:** Children, Women and girls, Young people/adolescents, Presumptive TB Patients
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

The global HIV response is strategically shifting focus towards the remaining clusters of high HIV transmission. Identification of high-burden HIV sub-populations is critical to ensure the epidemic is under control and no longer expanding. HIV testing among TB patients shows some of the highest yields across PEPFAR countries. However, the number of confirmed TB patients that can be tested for HIV is small compared to other testing modalities. Worldwide, the case detection rate of TB has stagnated around 60%.

Uganda is a high burden HIV country with an average HIV prevalence of 6% among adults between 15- 49. TB and HIV services have been integrated since 2007 with HIV counseling and testing done routinely at TB clinics. A study analyzed HIV testing rates, the prevalence of HIV among PTPs and linkage of diagnosed PTPs to care across health facilities in Kampala.

#### DESCRIPTION

HIV testing for all confirmed AND presumptive TB patients (PTPs) is a standard of care recommended by WHO and PEPFAR. More than 90% of presumed TB patients who visited 65 TB diagnostic and treatment sites in Kampala between January and June 2016 had HIV testing results in their medical records. Of those tested, 52.9% were positive and 88.3% were linked to HIV care.

#### RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Systematic screening of presumptive TB patients resulted in the identification and linkage to care of an additional 40% of HIV infected patients who would have been missed otherwise. The key element of success was the integration of HIV testing into the presumptive TB registers, and the integrated model of delivering TB and HIV services at the facility level. Although the



intervention is being implemented on a routine basis in Uganda, it is not systematically monitored and the value of high-yields of HIV testing among this population is not fully accounted. Overall 8,413 (91.3%) out of 9,219 records had HIV testing results. Of those tested, females were 4,455 (52.9%) of the cases. Of the total patients who were tested, 4,449 (52.9%) were positive and of these 3,930 (88.3%) were linked to HIV care. A record with a positive HIV status was more likely to be of a female than a male (OR=1.54, CI: 1.41-1.68; p=0.00). Highest HIV positivity rates were observed among presumptive TB patients aged 35-44 years. Out of the 1,353 presumptive TB patients confirmed with TB, 573 (42.4%) tested positive for HIV as compared to 1,506 (40%) of the 4,076 PTPs where a non-TB diagnosis was made. A total of 3,750 PTPs had their TB status missing in the register, the HIV positivity among these was 70.8%. The prevalence of HIV was double (54%) compared to the prevalence of TB (26%). The proportion of patients confirmed with TB among PTPs (15%) was higher than the 10% estimated by WHO for all forms of TB. The linkage of patients who tested positive for HIV to ART clinics was excellent with >98% of patients starting ART and CPT regardless of their TB status. This performance is a reflection of the capacity of health facility teams in these settings to integrate TB and HIV services effectively. Sustaining this practice is likely to positively impact key indicators such as treatment success rate (TSR) of TB/HIV patients resulting in reduced risk of mortality.

The study showed that 42% of children 5-14 years of age presented to health facilities as PTPs were HIV positive. This finding calls for increase in the index of suspicion for HIV and timely action to minimize missed opportunities for HIV diagnosis in children.

## **LESSONS LEARNED AND RECOMMENDATIONS**

This study demonstrates how systematic testing of presumed TB patients can boost HIV case finding. The specific strategies that were used for testing and linkage to care at these 65 facilities was not discussed. The study reported that 96% of the facilities involved in the study had an HIV implementing partner. This study highlights the feasibility of leveraging TB service delivery systems to promote HIV testing and linkage of diagnosed HIV patients to appropriate care. Systematic testing of presumed TB patients reduces the number of HIV missing cases and offers potential for early HIV diagnosis and treatment, thereby mitigating HIV related morbidity and mortality. Other studies from sub-Saharan Africa and India have also shown high HIV prevalence rates among presumptive TB patients with variation in prevalence according to the epidemiological context. The results show feasibility of implementation of a high-yield HIV testing intervention among presumptive TB patients in Kampala under routine operational practices. This example also shows high levels of linkage of HIV infected patients to ART clinics for care regardless of the patients' TB status.

Testing for HIV among presumptive TB patients can be implemented with fidelity and scaled up across PEPFAR countries. This will require increased efforts to strengthen TB/HIV collaboration and integration of TB/HIV services at facility level. High TB screening rates as well as HIV testing can be achieved by optimizing and integrating the work of TB and HIV services providers. This model of intervention not only offsets delays in diagnosis and initiation of treatment for patients affected by either or both diseases, but also ensures efficiency in resource limited setting.

The scaling up of systematic screening of TPTs should take into account :

1. Full integration of TB services with HIV and other primary care services
2. Systematic recording of all presumed TB patients at all entry points into the health care system.
3. Regular supervision to ensure all presumptive TB patients are tested for HIV
4. Training of health care providers on HIV testing and counselling
5. Availability of HIV test at TB clinics and other point-of-care

**ANNEXES**

High HIV prevalence among presumptive Tuberculosis patients in an Urban Setting: Lessons from Kampala City- Uganda D. Lukoye<sup>1</sup>; R. Byaruhanga<sup>1</sup>; N Kirirabwa<sup>1</sup>; S. Zalwango<sup>2</sup>; S. D'Jene<sup>3</sup>, S. Birabwa<sup>3</sup>, 4S. Ntudhu, P Suarez<sup>5</sup>;

## 13. ZAMBIA

### 13.1 TITLE OF THE PROGRAMME:

Building bridges: Inmates leading the fight against TB and HIV in Zambian prisons

#### CONTACT PERSON

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- **Programme is being implemented since:** January 2015
- **End date of the programme:** 2017
- **Responsible parties:** Civil Society
- **Population reached:** Prisoners and other populations in closed settings
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

Zambia are among the top 30 high burden countries in the world for TB (by TB incidence rate) and TB/HIV (in absolute numbers) (Global TB report 2016). Copperbelt province has the highest burden with a prevalence rate of bacteriological confirmed TB at 1211/100 000 population (National Tuberculosis prevalence survey Zambia 2013-2014)

In the African context, prisons are commonly overcrowded with no ventilation, poor nutrition and reduced access to health services. Furthermore, there is often less political will and resources to guarantee human rights and decent living conditions. The prison environment is considered a breeding ground for infections, and it is documented through several studies that the HIV and TB rates in prisons are much higher on the inside than outside (<http://www.who.int/tb/areas-ofwork/population-groups/prisons-facts/en/>).

#### DESCRIPTION

Beginning 2015, IN BUT FREE Prisons Project with support from LHL International initiated a HIV/TB programme called Building Bridges in prisons in Copperbelt Province in Zambia. The main goal of the project is to prevent and control the transmission of HIV and TB in Zambian prisons using a partnership of civil society, the criminal justice system, public health authorities and the lay public.

The primary focus is TB symptom screening at entry to the prison with inmates trained as "peers" as key players. Peers are selected among the inmates and participates in a five days training to become a certified peer. They perform the screening, in collaboration with the TB coordinators/prison officers, but they also have other tasks: spreading information about TB and HIV in their cell, care for the sick and assistance in the nutrition supplement program. Some are

also members of the infection control committees. The peers are incentivized with monthly hygiene packs. Prison officers are also trained, and is given the responsibility from the Zambian Correctional service, to be TB coordinators. The project has also supported their training psychosocial counselors through Ministry of Health, hence they are now offering voluntary counselling and testing for HIV. Coordination of the project is done through a TB Technical Working Group comprising of different stakeholders from the Ministry of Health, the Zambia Prisons Service and In But Free.

The project was between 2015-2017 implemented in eight prisons, covering more than 5,000 prisoners out of the country's prison population of around 20 000. In 2018, the model will be implemented in three additional prisons.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Screening of inmates at entry to prison is a strategy recommended by WHO, and it is a national policy in Zambia. However in this resource poor context, it has not been implement by national authorities. Before implementation of this project, most cases of TB went undetected in the prisons in Copperbelt.

Between July 2015 and December 2017, In But Free have screened 16437 inmates in the eight prisons in Copperbelt province, and 178 cases of TB (1%) have been identified and started on treatment. Early case detection and initiation of treatment is key in infection control as each person with infectious TB is estimated to infect 10-15 others. This is probably higher in overcrowded and unventilated cells. As there previously was no screening and no reliable data about TB in these eight prisons, the program has significantly contributed to safer prisons- both for inmates and staff.

On top of this, more than 600 inmates with TB and/or HIV are each month provided with high energy protein supplements, and their weight is monitored to ensure compliance and improvements. 610 inmates are trained as peers, and 50 prison officers are trained in management of TB and HIV. The peers express a feeling of empowerment, and many are up for early release due to good behavior. The training certificate provides for many an opportunity for employment on the outside. The officers and leadership of the prison have understood the benefits of controlling TB, HIV and other diseases through empowering inmates, better nutrition and infection control, and are expressing an interest to implement the program at a national level.

## **LESSONS LEARNED AND RECOMMENDATIONS**

In But Free has worked on prison health in Zambia since 1995. This long term commitment has earned the credibility and trust of the Zambian Prisons Service, granting the organization full access to all prisons. Regular advocacy meetings with stakeholders and the correctional services have also contributed to put HIV and TB on the agenda, and they now have an "open door policy" towards civil society organizations. To obtain this working environment in a long-term process, and there may be barriers in terms of security matters in many prisons.

The key success factor to the project is the good relationship with the inmates; that they are being treated with respect and given responsibilities and trust. An open dialogue, and to meet the gaps and need they identify, is key. The project have a comprehensive approach, and includes also drama and culture, sports, development of information material, and water and hygiene.

## **ANNEXES**

- [www.inbutfree.org](http://www.inbutfree.org)

### 13.2 TITLE OF THE PROGRAMME:

Experiences of TB Patients and their satisfaction with care provided by Treatment Supporters on the Copperbelt Province of Zambia

#### CONTACT PERSON

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- **Programme is being implemented since:** 1<sup>st</sup> January 2004
- **End date of the programme:** 31<sup>st</sup> December 2017
- **Responsible parties:** Civil Society
- **Population reached:** People living with HIV, Miners (especially exposed to silica), Children, Women and girls, Young people/adolescents, TB patients and Former TB Patients
- **Has the programme been evaluated/assessed?** Yes. Independent Consultant at the end of each three year Contract Greement
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** Yes

#### BACKGROUND

National Context:

Tuberculosis is one of the most important public health challenges in Zambia. The number of TB cases reported each year over the last 15 years has more than tripled as a result of the AIDS epidemic (7). The Ministry of Health (MoH) in Zambia estimates that approximately 50,000 new TB infections are notified annually and of these, 70 per cent of the people are coinfecting with HIV. Deaths attributed to TB were previously estimated at more than 10 000 people per annum. Data compiled in the past five years, however, indicates that deaths attributed to TB have dropped to less than 5000 per annum. The drop in TB related deaths has been credited to strong TB control strategies implemented by the government (7). These strategies include the World Health Organisation recommended strategy 'Stop TB strategy'. Due to a very high patient to staff ratio in the health service, the importance of partnering with the community to provide a high quality of service for the TB patients has been recognised (8). Zambia is one of the countries intergrating the community in the provision of health care for the TB patients. Community involvement in TB care and prevention also provides a chance to communities and civil society organizations, including patients' and activists' groups, to foster their empowerment in matters that strongly affect the common good of a society. Local communities, people who are directly affected by TB and people who have had TB but have been cured should never be seen as mere passive beneficiaries of health services but as partners who can actively join the

fight against the disease. Giving the patients an opportunity to voice their opinions about the care they receive can be seen as part of a broader commitment to public and patient participation in healthcare service planning and delivery (6). Support groups for people with TB have been formed across the country and they help with community sensitisation in order to reduce the disease burden, stigma and promote adherence. Community initiatives have demonstrated that they have the potential to increase cure rates of TB patients (9). Health workers need to link in an intergrated and coordinated way with the community to improve TB control in Zambia. The Ministry of Health has endorsed the intergrated community based DOTS approach as part of the process of strenghtening TB control activities. This approach aims to provide quality intergrated TB services to the people by means of standardized diagnosis, care and community based treatment. The active participation of communities in TB control allows people with TB to be identified and diagnosed more quickly, especially among poor or vulnerable groups who do not normally have access to TB services.

## **DESCRIPTION**

The Copperbelt Health Education Project (CHEP) entered into a collaboration with the Norwegian Heart and Lung Patient Organisation (LHL) to implement a programme that would strengthen community responses to TB and the co-infection of TB/HIV.

CHEP is non-governmental organization founded in 1988 as health Education Project. In 2004 CHEP partnered with Norwegian Heart and Lung patient Organization to implement a TB program.

Goals and Objectives of the CHEP/LHL Programme Development Goal - To prevent further spread of TB and mitigate the impact on individuals and communities in the Copperbelt Province. Programme Objective - People in the project areas access diagnostic and quality treatment and care of TB and HIV/AIDS.

Expected Results

- Treatment supporters are involved in TB/HIV services in all project areas.
- Patient centred TB booklets are being recognised and being used throughout the TB services in Zambia.
- TB patients can better control their health and life due to increased knowledge and improved relation with the health care professionals.

The patients were mobilized and supported to participate in a community DOTS program. Through on site mentoring 30 groups are registered and linked to the local health facilities. TB groups were trained in DOTS/ART in order to enhance client patient satisfaction.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

- Patient satisfaction with care provided by Treatment Supporters was high. About 249/253 (98%) of the respondents mentioned that they were happy with services provided by treatment supporters and that they motivated them to take drugs every day and to complete treatment.
- Increased Motivating factors to patient adherence to treatment
- Use of Teaching Aids such as the TB Booklets increased level of interaction between care provider and patients.
- Having community based treatment supporters increased compliance to treatment and compliance to referrals.

## **LESSONS LEARNED AND RECOMMENDATIONS**

RECOMMENDATIONS:

Immediate:

- I. Organise refresher trainings for treatment supporters as a motivation.
- II. Consider improving the distribution mechanism of the booklets to health centres in order for patients have access to these resources.

- III. III. Conduct regular monitoring visits to health centres in order to know what is going on in the programme.
- IV. IV. Strengthen the community based support group by offering them more awareness programmes to facilitate patient mobilisation.
- V. V. Provide transport logistics to rural treatment supporters to enable them enhance their case detection and patient follow up.
- VI. VI. Organise training workshops for all DOTS Corner Staff to orient them on TB services. VII. Establish health forums with TB patients in their respective health centres.

Mid-Term

- I. I. Conduct research to understand how a health system in government health centres impact on CHEP programming.
- II. II. Consider expanding services to other health facilities yearning for treatment supporters.
- III. III. Consider increasing the TB Booklets coverage sites.
- IV. IV. Consider consolidating the five booklets into one booklet for easy storage by patients.
- V. V. Promote and sustain linkages and interactions between CHEP and District Health Offices (DHOs). We believe that if these recommendations were to be followed vigorously, the low levels of knowledge recorded in this study will be reduced considerably in the next few years. The need for treatment supporters and TB booklets in the health facilities will certainly increase the treatment outcomes. The support of all stakeholders will be cardinal in reversing this picture.

**ANNEXES**

N/A

## 14. ZIMBABWE

**TITLE OF THE PROGRAMME: Total Control of Epidemic (TCE) & HIV index-case testing**

### **CONTACT PERSON**

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- **Programme is being implemented since:** 2014
- **End date of the programme:** /
- **Responsible parties:** Civil Society
- **Population reached:** People living with HIV, Miners (especially exposed to silica), Migrants (documented and undocumented) refugees or internally displaced populations, Children, Young people/adolescents, Female Sex Workers, Truckers
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** Yes. Total control of Epidemic (TCE) & HIV index-case testing

### **BACKGROUND**

The most challenging and primary part of 90-90-90 strategy for AIDS elimination is bringing people under HIV testing and counselling to detect at least 90% of the country's HIV load. Stigma, lack of privacy and long distances to the health-facilities are key barriers to HIV testing. Organizations under the umbrella of Humana Federation have overcome these barriers by introducing HTC in the high-burden Sub-Saharan countries.

### **DESCRIPTION**

HTC was introduced in Mozambique, Namibia, South Africa and Zambia under two different situations. Firstly, under TCE (Total Control of Epidemic) strategy the Field Officers (FOs) of Humana member organizations of those countries visited every household of well-defined geographic areas and offered HTC along with HIV education, condom promotion, stigma reduction and TB screening. In the second situation the Humana FOs visited households of index HIV cases who were recently registered for ART in local health-facilities. They screened household members and sexual partners of those index cases with HTC and provided other services at their doorsteps. They further assisted the newly detected HIV-infected cases to initiate and adhere to ART and to ATT as well if found to be co-infected.



## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Between 2015-17 the Humana FOs tested 2,180,574 people and distributed 67,964,949 condoms in four countries. Country-wise positivity rates - Mozambique 6 to 7%, Namibia 3 to 4%, South Africa 6 to 9% and Zambia 3 to 9%. Out of total 121,458 newly infected HIV cases detected through HTC during this period in four countries 112,108 (92%) were put on ART and provided community-based adherence support. Additionally, 1,213,657 people were screened for TB during HTC sessions, 45,781 symptomatic out of these were tested and 9,331 TB cases were detected. During the same period the Humana FOs enrolled 95,974 HIV-infected pregnant women under PMTCT. In Mozambique usage of specialized mobile apps further helped the Humana FOs to monitor and enhance viral suppression and successful completion of TB treatment among their enrolled patients.

## **LESSONS LEARNED AND RECOMMENDATIONS**

Humana experiences demonstrated that HTC is highly effective for expanding the scope of HIV testing. It additionally creates opportunities for other essential services within the supportive and stigma-free environment of the households.

## **ANNEXES**

<http://www.humana.org/what-we-do/healthcare>

## II. ASIAN STATES

## 15. CAMBODIA

**TITLE OF THE PROGRAMME: Active case finding in elderly and other vulnerable communities of Cambodia**

### **CONTACT PERSON**

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- **Programme is being implemented since:** 2013
- **End date of the programme:** 2015
- **Responsible parties:** Civil Society
- **Population reached:** Elderly
- **Has the programme been evaluated/assessed?** Yes. TB Reach
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### **BACKGROUND**

Cambodia still has one of the highest tuberculosis (TB) prevalence rates in the world. People aged 55 years and over account for an estimated 50% of the country's TB burden, yet this group has a low notification rate owing to specific barriers in accessing health services."

### **DESCRIPTION**

One-off active case finding (ACF) days were organized at 75 government health facilities in four operational districts. The diagnostic capacity of health facilities was temporarily upgraded by deploying mobile GeneXpert and x-ray systems. Village health support groups screened community members and made referrals to ensure high testing volumes. Though people aged 55 and over were targeted, any community member with a cough was encouraged to receive a Xpert MTB/RIF test and chest xray. Treatment was started at health facilities and was supported with funding from the initiative. ACF yield and official National TB Program data were analysed to assess the impact of activities on notification and treatment outcomes.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

2,068 individuals submitted sputum for Xpert MTB/RIF testing, resulting in the identification of 329 (15.4%) bacteriologically positive TB patients and 893 people with All Forms of TB. In the ACF quarters, new bacteriologically-positive notifications increased +119.2% for all ages and +262.7% for people aged 55 and over compared with expected notifications. Though the roving ACF days visited each health facility for just one day, treatment initiation was above trend three

full quarters postintervention. Treatment success rates remained stable or improved in all operational districts.

### **LESSONS LEARNED AND RECOMMENDATIONS**

When combined with community mobilization and use of new tools, a series of roving, one-off ACF days at government health facilities were able to increase TB diagnosis, treatment initiation and treatment outcomes in a key population with high TB prevalence. Targeted ACF interventions such as this could be used to reduce a backlog of untreated, prevalent TB.

### **ANNEXES**

TB REACH Team

## 16. CHINA (People's Republic)

### TITLE OF THE PROGRAMME: Total Control of the Epidemic (TCE)

#### CONTACT PERSON

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- **Programme is being implemented since:** 1<sup>st</sup> May 2014
- **End date of the programme:** 30<sup>th</sup> June 2017
- **Responsible parties:** Government, Civil Society, Academic Institution
- **Population reached:** People living with HIV, People who inject drugs, First nations/indigenous peoples, Children, Women and Girls, Young people/adolescents
- **Has the programme been evaluated/assessed?** Yes. The assessment of the programme which consisted of 3 phases was executed via social survey methodology. And two academic institutes participated in the whole survey process. West China School of Public Health, Sichuan University designed the baseline research. In July, 2014, at the early beginning of programme phase 1, 1000 local villagers in Yuexi County were randomly selected for pre-test questionnaires. A report in terms of baseline analysis was issued afterwards Yunnan Health and Development Research Association ('YHDRA') planned the post-test survey of the programme and later on produced a project assessment report for programme has been evaluated phase 3. In June 2017, at the end of phase 3, 426 randomly selected local villagers received post-test questionnaire survey and 23 key persons were semi-structured interviewed. And such results were comparatively analyzed with the pre-test data (the theory hypothesis was though the baseline was conducted 3 years before the phase 3 project started, there was no distinguished HIV/AIDS control & prevention intervention in the phase 3 area and the communities remained a backwater during the period, therefore, the earlier baseline can be valid).
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

Liangshan Prefecture is located in the southwest part of Sichuan province, with an area of 60,400 square kilometers and 17 counties (1 district, 15 counties and 1 autonomous county) in total in the prefecture. Yuexi County is one of 17 counties in Liangshan Prefecture with an area

of 2,256 square kilometers, and there are 4 urban districts and 40 towns/townships with 298 administrative villages in this county with a total population of 346,000 at the end of 2013 of which Yi ethnic population covers 77.06% of the total. As for economy, yearly GDP reached RMB3,471 million in 2013. As for public health resource, there were 2.18 health professionals for each 1,000 population on average, which is far away from 5.26 for provincial average. (Source: YHDRA) Liangshan Yi Autonomous Prefecture of Sichuan Province is one of the 3 Central Government designated HIV/AIDS focus areas and has the highest HIV/AIDS infection rate due to its location along the golden triangle drug trafficking route bringing drugs to China's inland and coastal areas and the specific local minority culture which is based on shamanism and rejects notions of bacteria and virus as basis for infectious diseases. During the early phases, the main route of transmission was needle sharing in injected drug user, but now sexual transmission is accounting for an increasing proportion of new infections. In recent years, over 90% of infected people are Yi minority youth. Until December of 2015, there were accumulated 4,493 HIV/AIDS cases with 3,667 cases still alive in Yuexi County with the first HIV/AIDS case reported in 1996. The cases were reported mainly in villages of 40 townships, only 20 cases were reported from the county capital. 1,860 PLHIV are enrolled into ARV treatment and 1,500 actually join the treatment. There was an increase of 13.5% of HIV new infection comparing with HIV/AIDS reported cases in 2014. (Source Yuexi Public Health Bureau) The hospital delivery rate in 2011 was 41% and 54% in 2012. According to the interview in Maternity and Child Care Hospital (MCH) on Jan. 15, 2016, the rate increased to 84% but still 16% of mothers deliver at home in 2015. The number of MCH staff is not enough to reach all women. Meanwhile, about 4,000 pregnant women take physical examination every year, which accounts for 65% of total pregnancies. (Source: Yuexi Maternal and Child Hospital) Yuexi County is the top 3 county with HIV prevalence increasing in Sichuan Province, even in the whole country. Accumulated the main transmission channel was IDU (injection drug use) with 80% of total cases, some for sex transmission and fewer cases for MTCT (mother-to-child transmission).

## **DESCRIPTION "**

### **Objective:**

Firstly, the programme in Yuexi County aimed to increase HIV/AIDS awareness, decrease stigma and discrimination, mobilize for HIV testing, provide basic counseling for both HIV risk reduction planning and sexual behavior change, conduct Home Based HIV tests, mobilize for ARV uptake and provide emotional support for children and adults affected by HIV and other related diseases. Secondly, the project team also paid attention to capacity building of village & township level clinic staff, women leaders and Passionates. Furthermore, HPP China team intended to demonstrate the advantages of TCE model to the government and then facilitated the policy change.

### **How it works:**

Initially, the Project Leader recruited 8 local young people as the project Field Officers and then provided training. Afterwards, the 8 Field Officers who became the main force executed daily one-on-one & door-to-door visits to all resident villagers with health education, mobilization and voluntary home-based counseling and rapid HIV testing (HPP is the first one provided rapid testing to villagers in Liangshan Prefecture), etc. Except for above activities, the project management team also conducted training, meeting and discussion with local clinic staff, women leaders and Passionates. And during the whole programme, HPP China team always invited the county and Prefecture level health bureaus to visit the project site, provided regular reports and arrange seminars with the bureaus.

**Geographic reach:**

The whole programme covered 6 townships in Yuexi County, which is Zhongsuo, Shugu, Naituo, Datun, Matuo and Darui.

**Focus:**

The focus people included PLHIV, sexually active population, pregnant women, adolescents, local clinic staff, women leaders and Passionates.

**Finance:**

From 2014-5-1 to 2015-6-30, the programme phase 1 was financed by World Bank and the grant size is USD99,702. From 2015-10-1 to 2016-9-30, the programme phase 2 was financed by AIDS Healthcare Foundation (AHF) and the grant size is USD19,660. From 2016-4-7 to 2017-6-30, the programme phase 3 was financed by China Association for the Prevention and Control of STD and AIDS (CASA) who has the government background and the grant size is RMB570,000 (Approximately USD89,600).

**Major partner:**

The main local partners were the county level public health bureau and Women Federation.

**Sustainability:**

The whole programme in Yuexi ended in June, 2017. However, thanks to the programme, from 2017-9-13, HPP started a fresh project in Liangshan Prefecture and a new policy was issued by The people's Government of Liangshan Prefecture which was a milestone for both HPP TCE model and Liangshan Prefecture HIV/AIDS prevention & control (see detail descriptions in next section, "Results, outcomes and impact of the programme").

**RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

During the whole programme, 45,026 villagers in the 6 townships in Yuexi County were educated via House to house visit. And 8,363 villagers received HIV/AIDS knowledge through 522 group training sessions. In addition, 15,899 villagers received rapid testing and 79 HIV+ case were identified.

According to the evaluation of programme phase 3 by YHDRA, the percentage of the population who could correctly answer at least 6 questions out of total 8 questions related on HIV/AIDS knowledge increased from 48.9% to 83.6%, a 71% increase.

The whole programme in Yuexi ended in June, 2017, however, the reason why CASAPC (a government organized NGO) financed the programme phase 3 was to explore what the government could learn from the HPP TCE model and how the Field Officer approach could be implemented in the whole of Liangshan. During the phase 3, CASAPC fully spotted the values of TCE model which relies on and works among the communities through village based HIV prevention worker, a grassroots work, that the government was not familiar with. Therefore, CASAPC coordinated several meetings and discussions among HPP, Prefecture level bureaus and other related organizations to invent a similar community model for the Prefecture government to fight with HIV/AIDS. Eventually, in the middle of 2017, a government version of the TCE model, called "1+M+N" model was agreed by all parties and started to be carried out in Liangshan Prefecture. "1" stands for 1 Township Communist Party Committee HIV prevention Party Secretary (appointed among officials from either county or prefecture level) leading the fight against HIV in the township (usually 8-20,000 people), "M" stands for 1 Township clinic leader and "N" stands for a varying number of village based 'HIV prevention officers' (= TCE's Field Officers), in average 7-8 full timers per 1 township. The whole concept is to hire "N" to conduct daily house to house visits and community trainings among villages and "1" & "M" play the roles of Project Managers and Project Leaders. And in order to implement the model effectively, in September, 2017, Liangshan Association for the Prevention and Control of STD

and AIDS (LSAA) hired HPP to provide training services to “1”, “M” and “N” in the 20 most HIV prevalent townships and the services included group training course for new-hire “N”, practice training in HPP Yuexi training camp for “N” and on-site instructions to “1”, “M” and “N”. Later on 2018-3-8, The people's Government of Liangshan Prefecture issued an official policy document (' red head letter') in terms of operation procedures of the “1+M+N” model to all level health bureaus in Liangshan, which means such model became a new HIV/AIDS prevention and control policy.

## **LESSONS LEARNED AND RECOMMENDATIONS**

What factors helped success of the programme:

1. the non-hierarchical setup of the project team, where the project leader as head among equals constantly mobilized, empowered and trained the front line workers and himself constantly worked in the villages walking foot by foot to door to door
2. that the project leader himself was a national of the target national ethnic minority, spoke their language and had the same cultural background, but was trained outside the traditional settings in Africa and worked in an international environment of an international NGO
3. the personal engagement and communication skills of the local village health workers with one of them being selected as 'model health worker' by the government
4. the institutional set-up where the leading Chinese central level NGO (= Chinese Association for STD and AIDS Control, composed and lead by former senior officials of the China CDC) coordinated the local public health bureau and created the institutional 'open space' for HPP to deliver its methodology
5. The systematic and output oriented implementing methodology of the project with daily, weekly and monthly output goals to reach and internal control mechanism
6. The good team work and cooperation between the local health workers, project leader and the local hospital Administrators

What were the biggest challenges:

1. the long and remote muddy roads to walk
2. 5 month of blizzards and snow
3. the drinking culture of poverty populations
4. low salary and scarce funding
5. early identification of pregnant women, as girls themselves often did not know their pregnancy status for many months
6. cultural taboos around sex and pregnancy
7. low level of literacy and high level of animistic spiritualism
8. wrong perception of drug use and HIV/AIDS

What recommendations could be made to programmes in other settings:

1. work with full time community health workers, who have no other job to do while in the project
2. select health workers based on recommendations of both community and local authorities and the implementation team should have the final say on who should be the local health worker
3. engage program managers from the target minority
4. Do thorough initial training of the community health workers, and on top do continuous monthly trainings and M&E in order to constantly increase the quality of the work
5. Digitalize project indicators (process and results and impact) and reporting in order to have current data and be able to adapt the program to the reality of each sub area

## **ANNEXES**

Case story, YHDRA evaluation, Government policy document (in Chinese only), Photos



## 17. INDIA

### 17.1 TITLE OF THE PROGRAMME:

Community led early detection and management of HIV-TB co-infection among People living with HIV

#### CONTACT PERSON

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- **Programme is being implemented since:** April 2013
- **End date of the programme:** March 2021
- **Responsible parties:** Government, Civil Society, Community based organization of people living with HIV and key populations
- **Population reached:** People living with HIV, People who inject drugs, Children, Young people/adolescents, Transgender, sex workers, men having sex with men (MSM)
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

TB disease is the commonest opportunistic infection among HIV-infected individuals. Further it is also known that TB being a major public health problem in India accounts for 20-25% of deaths among PLHIV. It is known that nationally about 5% TB patients registered under the Revised National Tuberculosis Control Programme (RNTCP) also have HIV infection. In high prevalent states and districts, positivity among TB patients is more than 10% and is as high as 40% in selected high burden districts of India. TB kills an estimated 480,000 Indians every year and more than 1,400 every day. India also has more than a million 'missing' cases every year that are not notified and most remain either undiagnosed or unaccountably and inadequately diagnosed and treated in the private sector. India HIV/AIDS Alliance (Alliance India) is implementing the largest national care and support program in close coordination with central TB division, NACO and TB/HIV affected communities in order to support the national HIV TB co-infection programme across India.

#### DESCRIPTION

Supported by Global Fund, since April 2013 onwards, Vihaan's Care and Support Centres (CSCs) in India provides expanded and holistic care and support services for People Living with HIV (PLHIV) through a community led model. Community-based outreach is the backbone of CSC, serving as a comprehensive approach to provide support for retention in treatment, adherence, positive living, referrals to other health services, linkages to social welfare schemes,

and strengthening enabling environment for PLHIV. There are 350 CSCs implemented by PLHIV networks, community-based organizations, and NonGovernment Organizations. Tuberculosis (TB) and HIV services were integrated in CSC services to address dual infection till Dec 2017. The programme is being continued from Jan 2018 till March 2021. The HIV – TB component through an integrated approach into the CSC's services were scaled up from Oct 2015 onwards. Tuberculosis screening among PLHIV based on four symptom screening, linkage to ART for those diagnosed with TB, counselling for treatment adherence of HIV-TB co-infected clients, referral and contacts screening for TB were the activities integrated to CSC services. Trainings were conducted for all CSC staff and monitoring indicators were defined. The HIV-TB component of the Vihaan programme aims to achieve the following objectives:

- Increase the screening among PLHIV and early detection of TB
- Immediate ART initiation of all PLHIV detected TB
- Improve and sustain treatment adherence of HIV-TB coinfecting clients.

In order to achieve the above mentioned objectives, various HIVTB collaborative activities at National level such as training of Sub –Recipients (SR) partners of the programme, World TB Day observation in close coordination with NACO and CTD. The trained SR staff across India further carry out at the state level in close coordination with the State AIDS Control Societies and State TB Programme Officials which further enables the district team to carry out the following activities by the CSC staff:

- ICF for TB for new clients enrolled under Vihaan programme
- ICF for TB for existing clients • Follow-up of PLHIV with TB for ATT
- Follow up for linkages with social protection services by Govt. of India like direct cash scheme for nutrition support and travel support for MDR TB patients
- Follow up for Isoniazid preventive therapy for all registered PLHIV under the program
- As per new policy updates all PLHIV who are having TB symptoms needs to diagnosed by CBNAAT (gene expert testing at district hospital, mainly at ART centres)
- All PLHIV who are found TB positive need to initiate
- Support Group Meeting on TB related issues at CSC and field
- Other TB prevention activities:
  - a) Immediate ART initiation for TB cases
  - b) Follow up for each registered PLHIV through IT based application called Empower
  - c) Referral of family members for TB testing
  - d) TB referral services for key populations
  - e) TB referral services for children
  - f) TB referral for antenatal women living with HIV

Vihaan programme also uses IT based (eMpower Tablet application) client monitoring system which prioritise HIV-TB coinfecting PLHIV for follow up services like counselling on TB treatment adherence, contact tracing and further referral to TB facilities if any of the family members are found TB symptomatic.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

As on March 2018 we have screened 11,09,516 which is 89% of the total PLHIV (12,48,815 enrolled under Vihaan programme which is 98% of the total P:LHIV registered at ART on active care across India). Of the total screened on the basis of 4 TB symptoms as per WHO recommendation, 1,60,466 (14.46%) PLHIV were found symptomatic of atleast one or more symptom, and those all have been referred for TB testing at the ART centres which is the Government's treatment facility centre for PLHIV where TB testing is also carried out. Of the total tested for TB, 11,020 ( 6.87%) have been found TB positive. 9,949 (90.28%) linked with TB treatment.

## **LESSONS LEARNED AND RECOMMENDATIONS**

1. The findings of intervention suggests that community based care and support centres involvement in TB/HIV are effective to enhance early TB detection and linkage to TB treatment also. Thus it complements the national HIV-TB activities.
2. Community led HIV-TB treatment literacy and treatment adherence supports is effective in retaining the patient in HIV-TB care and thus enhance treatment success rate.
3. Involvement of HIV-TB co-infected community in all HIV-TB collaborative activities at all levels is the backbone of the success of the programme.
4. Robust coordination between HIV and TB programme workforces at all levels, proactive involvement in planning, implementation and monitoring of the HIV-TB collaborative activities adopting the existing collaborative forums enhances the early detection of TB symptomatic cases, linkage to treatment and completion of treatment.

## **ANNEXES**

N/A

## 17.2 TITLE OF THE PROGRAMME:

Community-based TB screening among HIV High-risk group population – Experience from India

### CONTACT PERSON

Name: Dr Sunil D Khaparde

Title: Deputy Director General (Tuberculosis)

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- **Programme is being implemented since:** 2017
- **End date of the programme:** /
- **Responsible parties:** Government
- **Population reached:** People living with HIV, People who inject drugs, Migrants (documented and undocumented) refugees or internally displaced populations, Female Sex workers, Men who have sex with men, Transgender, Truckers
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

The National AIDS Control Program in India has identified high-risk group (HRG) population for HIV including Injectable Drug Users, Female Sex workers, Male having sex with male, Transgender, migrant and trucker are at higher risk of development of Tuberculosis on account of their behavioural and biological factors. Screening for TB is an ongoing activity for the population availing services under the programme. The Revised National Tuberculosis Control Program (RNTCP) adopted systematic community-based tuberculosis (TB) screening/ active case finding (ACF) strategy among NACP identified High risk group (HRG) for HIV in urban & rural areas of the country, for reaching the unreached, especially those not availing services under the programme. Three phases of the campaign were carried out in 2017, with 1st, 2nd and 3rd phase completed in January, July and December 2017 respectively.

### DESCRIPTION

In order to carry out the activity, joint planning between the RNTCP and NACP was carried out. NACP facilities providing services to the HRG were identified in the selected districts including District AIDS Prevention and Control Unit (DAPCUs) – a management structure and Targeted Intervention sites – service delivery site with services being provided by affected community members/peers. The healthcare workers from these facilities were made part of the team doing the community-based TB screening to ensure acceptability among the HRG. The population in all the above HRG settings were mapped prior to the activity. The teams of healthcare workers visited the HRG area/hotspot and screened the population for any 1 of the following symptoms – persistent cough or fever for  $\geq 2$  weeks, significant weight loss, presence of blood in sputum in

past 1 month, chest pain in last 1 month and history of antiTB treatment. The sputum sample of symptomatics identified were collected by the teams on the same day and transported for TB testing through Gene Xpert/Microscopy. In addition, Chest X Ray was offered as and when necessary for those not confirmed by above modality. The TB healthcare worker then ensured that the TB cases identified are initiated on treatment within 2 days of diagnosis and patient continues treatment within the at the nearest TI site/health care facility. The data obtained from this activity was analysed at the national level to understand the performance.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Among the nearly 311 districts identified for the activity, DAPCUs were identified in 126 districts and TI sites in 232 districts. Coordinated effort between the healthcare worker of RNTCP and NACP resulted in mapping nearly 0.7 million HRG population and screening for TB symptoms. Following the screening, nearly 9,900 TB symptomatics were identified, who were then linked for TB testing through Gene Xpert/microscopy. As a result of this activity nearly 324 additional TB cases were diagnosed and put on treatment.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Community based TB screening among HRG population is feasible and results in additional yield of TB cases. The programme has decided to scale up the intervention across all districts in India. Community-based dual screening for TB and HIV is being explored under the programme.

### **ANNEXES**

Table 1: State-wise performance of community based TB screening among HIV High risk group population, India-2017(<https://drive.google.com/file/d/1t2IPLTcCpYsS1nVJ1GuLA9MVMo4DikUt/view?usp=sharing>)

### 17.3 TITLE OF THE PROGRAMME:

Gender differences in coverage of TB treatment and preventive service among PLHIV in India

#### CONTACT PERSON

Name: Dr Sunil D Khaparde

Title: Deputy Director General (Tuberculosis)

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- **Programme is being implemented since:** 2016
- **End date of the programme:** /
- **Responsible parties:** Government
- **Population reached:** People living with HIV, Women and girls
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

Although globally men have a higher risk of contracting and dying from TB than women, TB can pose a significant burden among women especially during the reproductive years and pregnancy and affecting nearly 3 million adult women globally. The National Strategic Plan for TB Elimination in India 2017-25 articulates a gender-responsive approach to TB.

#### DESCRIPTION

One of the first steps towards gender-sensitive programming is availability of gender-disaggregated data at all levels and analysis of the data for providing inputs to the national programme. The recording systems of Revised National TB Control Programme (RNTCP) and National AIDS Control Programme (NACP) enable capturing the gender of the patient including the third-gender and data is available at all levels. Secondary data available under the National programme for patients either diagnosed with Tuberculosis or initiated on TB preventive therapy during the period April 2017 to March 2018 was extracted and gender-wise analysis was carried out to look at differences at National and State levels.

#### RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

With regards to People Living with HIV (PLHIV) diagnosed with TB, at the National level, only 2% of the female PLHIV were diagnosed as compared to 5% among male PLHIV. State-wise differences were also observed with Haryana showing huge gender difference of 5%, while smaller states showed 1% difference and the HIV high-burden states showed an average 3% difference. With regards to People Living with HIV (PLHIV) initiated on TB preventive therapy, at the National level, only 17% of the female PLHIV were initiated as compared to almost 19% among male PLHIV. State-wise differences were also observed with Haryana showing huge

gender difference of 5%, while smaller states showed nil differences and the HIV high-burden states showed only average 1% difference.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Gender is a key issue which needs to be addressed to identify the missing TB cases and thereby eliminate TB by 2025 in India. One of the reasons for underdiagnosis and sub-optimal initiation of IPT among female PLHIV may be suboptimal access to healthcare services, especially when both the spouses are HIV infected and husband usually comes to the health facility to collect the medication, even for his wife, thereby reducing opportunities for identifying TB cases or initiating on IPT.

### **ANNEX**

Table 1: State-wise gender differences in PLHIV diagnosed with TB, India - 2017  
([https://drive.google.com/file/d/1AanXI\\_ni2pkGQSMLO7zArv6OWZ0yOTBW/view?usp=sharing](https://drive.google.com/file/d/1AanXI_ni2pkGQSMLO7zArv6OWZ0yOTBW/view?usp=sharing))

Table 2: State-wise gender differences in PLHIV initiated on Isoniazid preventive therapy (IPT), India - 2017 (<https://drive.google.com/file/d/1G1mS1b8EjL91ZHjbh6EsGcpBcm9zVFCk/view?usp=sharing>)

## 17.4 TITLE OF THE PROGRAMME: Enhanced TB case finding among people living with HIV

### CONTACT PERSON

Name: Dr Sunil D Khaparde

Title: Deputy Director General (Tuberculosis)

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- **Programme is being implemented since:** 2016
- **End date of the programme:** /
- **Responsible parties:** Government
- **Population reached:** People living with HIV
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

India has a high burden of both tuberculosis (TB) and HIV. TB continues to remain as the most common opportunistic infection among People living with HIV. To mitigate the effect of the dual burden of HIV and TB co-infection, the National AIDS Control Programme (NACP) and the Revised National TB Control Programme (RNTCP) of the Government of India have been, since 2001, undertaking joint collaborative efforts as per the National Framework for Joint HIV-TB Collaborative Activities. The TB-HIV collaborative activities between the Revised National Tuberculosis Control Programme (RNTCP) and National AIDS Control Programme (NACP) started in 2001. The National Framework for Joint TBHIV Collaborative activities was developed in 2007 and has been updated in 2013 based on experiential learning and scientific evidence.

### DESCRIPTION

The joint initiative aims to provide single window services for management of HIV-TB co-infections at ART centers so as to improve access to HIV-TB care and ensure seamless services to PLHIV. As part of the single window approach, the following initiatives have been identified for smooth implementation, i) Intensive case finding (ICF) for TB in HIV care setting with 4-symptom (4S) screening for TB and fast-tracking of all PLHIV with presumptive TB; ii) prioritization of rapid molecular Cartridge Based Nucleic Acid Amplification Test (CBNAAT) for all PLHIV with presumptive TB to ensure early diagnosis of TB and to identify Rifampicin resistance; iii) provision of daily ATT with fixed dose combination; Innovative drug intake tracking mechanism using missed call at a toll free number on the FDCs strips iv) provision of IPT for prevention of TB in PLHIV; and v) Airborne Infection control at HIV care settings. Intensified case finding (ICF) involves systematic screening for active TB among high-risk populations at each visit to a health facility. All PLHIV should be regularly screened for four symptoms—current cough of any duration, fever of any duration, weight loss and night sweats



during every contact with a health care provider in the ART center. Similarly, children living with HIV (CLHIV) who have one or more of the following four symptoms—poor weight gain, fever of any duration, cough of any duration, or history of contact with a TB patient—should be evaluated for TB.

CBNAAT is the preferred diagnostic technique for TB testing in PLHIV when compared to smear microscopy. In addition to diagnosing TB, there is also the need to test for drug resistance so as to provide the most effective treatment to curb the progress of drug-resistance TB (DR-TB) in patients and also to reduce risk of transmission in the community.

The Standards for TB Care in India (STCI) recommend daily anti-TB treatment (ATT) instead of the current intermittent regimen. The patient would be given the daily regimen in dosage depending on body weight (weight bands). IPT has been recommended as part of a comprehensive HIV and AIDS care strategy by the World Health Organization (WHO). Isoniazid has been given to PLHIV as a part of the TB preventive therapy that protect against progression of latent TB infection to active disease (against endogenous reactivation).

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Single window approach has given an opportunity for enhanced diagnosis of TB among the PLHIV which in turn resulted in slight increase in proportion of the Diagnosed TB among People living with HIV i.e 7% to 8% Single window delivery approach has been implemented across the country in Oct 2016.

Figure 1 describes number of Presumptive TB cases referred from ART center for TB diagnosis and absolute number of PLHIV diagnosed with TB. It shows the gradual rise in Number of Diagnosed Tb cases among People living HIV. Figure 2 depicts proportion of Diagnosed TB cases before and after implementation of Single window services in year 2016 & 2017 and number of PLHIV referred for TB diagnosis.

## **LESSONS LEARNED AND RECOMMENDATIONS**

Single window approach has been implemented with joint efforts from NACO and RNTCP for enhanced diagnosis and treatment. One-year implementation of single window services has improved the quality of Presumptive TB referrals for TB diagnosis. Though there is no much change in the absolute number of referrals proportion of Diagnosed TB patients has improved slightly around 1%. To achieve the full impact of Single window services for enhanced TB diagnosis among PLHIV needs to supportive supervision and intensive monitoring and evaluation is essential.

## **ANNEXES**

Fig 1: Trend of PLHIV diagnosed with TB, Jan 16 - Dec 17

(<https://drive.google.com/file/d/1xINMXPe9h8gHHF0bsRHlxI3oE0mlye2/view?usp=sharing>) Fig 2: Total number of PLHIV referred for TB Diagnosis & Proportion of Diagnosed TB cases among PLHIV in 2016 vs 2017

(<https://drive.google.com/file/d/1yxvhq3Bjth6Ljt9xKNbcmrNYgH4Ms8og/view?usp=sharing>)

### 17.5 TITLE OF THE PROGRAMME:

Benefits of Information Communication Technology based TB treatment adherence among TB-HIV co-infected patients

#### CONTACT PERSON

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Title: Deputy Director General (Tuberculosis)

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- **Programme is being implemented since:** 2015
- **End date of the programme:** /
- **Responsible parties:** Government
- **Population reached:** People living with HIV
- **Has the programme been evaluated/assessed?** Yes
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

Tuberculosis (TB) is the leading cause of morbidity and mortality among People Living with HIV (PLHIV). All the TB-HIV co-infected patients were offered services separately under both the National program with TB treatment decentralized to near patient's residence and HIV treatment centralized to specialized Anti-Retroviral therapy (ART) centres. In order to enhance access of services to the patients and improve outcomes, the Ministry of Health decided to implement single window delivery of TB and HIV services from ART centres itself from 2016. This included an array services - TB treatment, preventive therapy, ICT enabled adherence mechanism, pharmacovigilance and Airborne Infection control.

#### DESCRIPTION

Under the 99DOTS initiative, the TB drugs are packed into envelopes with a hidden toll-free number, which becomes visible once the patient removes the tablet from the strip. The patient is advised to call the number visible on the envelope, after consuming the drug, which is captured in the digital treatment adherence calendar of the patient. This adherence information is available to the health care providers caring for the patient. In case of patient not taking the drug and subsequently not calling on the toll-free number within prescribed times, a notification is sent to the health worker caring for the patient to follow up and counsel in case of non-adherence. The health worker performs the home visit and subsequently updates the digital treatment adherence calendar by marking manual doses. The initiative was piloted among 30 ART centres in high-burden HIV settings in 2015 and subsequently scaled up across the country in 2016. We analysed data from 2015 to 2nd Quarter 2017 (2Q 17) on performance of the ICT tool in measuring adherence and predicting treatment outcomes. Adherence is

calculated as number of calls made by the patient and number of manual doses marked by the health worker against the total number of doses prescribed to the patient.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

The average adherence through 99DOTS has been steadily increasing over the years from 62% in 2015 to 73% in 1Q-2Q 17 (Table 1). State-wise variation was seen in average treatment adherence with states implementing the activity like Andhra Pradesh, Tamil Nadu and Telangana showing a better overall performance (Table 1). The higher is the average adherence of the patient, better is the treatment outcome (Table 2).

### **LESSONS LEARNED AND RECOMMENDATIONS**

Adherent patients can take independent custody of their drugs and confirm consumption without physical observation, which simultaneously reduces the burden on providers. Program managers gain real-time information on adherence, enabling customized and efficient patient supervision and support. 99DOTS empowers patients, providers and support health system efficacy and efficiency. It enables daily monitoring without daily observation. It enables prioritization of patient for field visit by the health workers and identifies patient at risk of loss to follow up and hence intense counselling requirement.

### **ANNEXES**

Table 1: State-wise performance in treatment adherence through 99DOTS in India among TB-HIV co-infected patient, 2015 to 1Q-2Q17

([https://drive.google.com/file/d/1qyspX3cFEyAhViMvclBBXXMUhZFref4\\_/view?usp=sharing](https://drive.google.com/file/d/1qyspX3cFEyAhViMvclBBXXMUhZFref4_/view?usp=sharing))

Table 2: Treatment adherence through 99DOTS and treatment outcomes among TB-HIV co-infected patient in India, 2015 to 1Q-2Q17 (<https://drive.google.com/file/d/1-GyKTPtfejR83PSfh9qhBVi2XDQTIR1/view?usp=sharing>)

## 17.6 TITLE OF THE PROGRAMME: TB Preventive therapy among People Living with HIV in India

### CONTACT PERSON

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- **Programme is being implemented since:** 2016
- **End date of the programme:** /
- **Responsible parties:** Government
- **Population reached:** People living with HIV
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

TB is the leading cause of morbidity and mortality among People Living with HIV. The WHO recommends Isoniazid Preventive therapy to reduce the burden of TB in PLHIV. The Government of India launched the initiative in all the ART centres on 01st December 2016.

### DESCRIPTION

This initiative is a coordinated effort between the Revised National TB control program (RNTCP) and National AIDS Control Program (NACP). The RNTCP is responsible for procurement and supply chain management, Description: while NACP is responsible for patient management. The drugs are procured centrally and supplied to the states, districts and Anti-retroviral treatment centres (ARTc) as per requirement. The drugs are dispensed by the 535 ARTc situated in 33 States/UTs following screening of patient, assessing eligibility and counselling of the patient. The patient receives a 6-month course of IPT with adults and children receiving Tab Isoniazid 300mg and Tab Isoniazid 100 mg respectively along with Tab. Pyridoxine supplementation. The patient visits the ARTc every month for follow-up and is provided with a monthly refill. Thus, the activity is implemented through coordination between the two programs at all levels – National, State, District and facility level. Analysis of the secondary data available at the National level was undertaken to determine the coverage of the initiative, state-wise variations and monthly trend in initiation of IPT among PLHIV.

### RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

As on March 2018, nearly 328,102 People Living with HIV (PLHIV) in 418 ARTc across all States/UTs had initiated PLHIV on IPT. Nearly two-thirds of the states started implementing the activity within 1st quarter of launch of the intervention, with almost all the states implementing by the end of 1 year (Figure 1). The month-wise trend in the number of PLHIV initiated on IPT

shows variation on account of various factors - supply of Tab Isoniazid and hence availability in ARTc, policy decision in July 2017 to use Tab Pyridoxine 40 mg in place of Tab Pyridoxine 50 mg due to non-availability of the same in the local market (Figure 1). The state-wise status of implementation of the initiative shows a gap in coverage of eligible PLHIV with IPT ranging from 0% to as high as 93%, with most states with high burden of PLHIV showing large gaps in coverage including Andhra Pradesh, Bihar, Gujarat, Maharashtra and Telangana (Figure 2).

### **LESSONS LEARNED AND RECOMMENDATIONS**

The rate of initiation of PLHIV on IPT has been sub-optimal due to information gaps in the new initiative even though nation-wide capacity building of all ARTc were carried out, non-availability of Tab Pyridoxine for supplementation, especially dosages as per the national guidelines. To address this, virtual learning sessions were held to build capacity of ARTc in delivering IPT, monitoring of the activity was intensified across all levels, states were provided with flexibility to procure Tab Pyridoxine in dosages available in local market. In order hasten coverage of PLHIV on IPT, regular capacity building activity needs to be in-built into the programme along with supportive supervision and continuous availability of drugs may be ensured.

### **ANNEXES**

Fig 1: Month-wise trend in initiation of IPT among PLHIV and coverage of states with IPT intervention, Dec 16 – Mar 18

(<https://drive.google.com/file/d/1DZ62PkDi0IHeu0u6jDiqfNcK1SdMjhr/view?usp=sharing>) Fig

2: State-wise status of coverage of IPT among PLHIV along with gap in coverage of eligible PLHIV as on Mar 2018

(<https://drive.google.com/file/d/1ThsRa8FvBUeEEfKB7F4S5K9u7eo36n/view?usp=sharing>)

## 17.7 TITLE OF THE PROGRAMME: Standard of TB care at BEST

### CONTACT PERSON

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- **Programme is being implemented since:** 2017
- **End date of the programme:** ongoing
- **Responsible parties:** Government, UN or other inter-governmental organization
- **Population reached:** Workers of transport and electricity department of Mumbai
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

Mumbai is the financial capital of India and like most indiscriminately expanding urban spaces, the island city faces serious health issues, fuelled by a general squalor, punishing pollution and the stresses of everyday existence. Of the various diseases that mar people's lives, tuberculosis, or TB, is among the top of the heap. There were 38,667 cases of TB in 2015, and 42,115 in 2016, according to the Brihan-Mumbai Municipal Corporation (BMC) data released in 2016. The number of patients suffering from drug-resistant tuberculosis in the city increased by 21 per cent between 2015-16. There were 3,608 patients with multi-drug-resistant (MDR) TB in 2015, and 4,374 in 2016. And, although the number of extreme drug resistant (XDR) cases remained stagnant at 556 in 2016, the XDR-TB numbers had increased sharply by over 60 per cent between 2014 and 2015. (Source: 'Drug-resistant TB cases in Mumbai up 21% in 2015-16', Times of India, March 24, 2017. Retrieved 2018-03-14, from <https://timesofindia.indiatimes.com/city/mumbai/drug-resistanttb-cases-in-mumbai-up-21-in-2015-16/articleshow/57799772.cms>)

TB is one of the biggest public health challenges before Mumbai today. The National Strategic Plan (NSP) for Tuberculosis Elimination, 2017-2025, underlines the need for new approaches and special efforts to address TB among vulnerable and disadvantaged groups. As TB afflicts the productive 15-54 age group and is known to be aggravated in certain specific working conditions, reaching out to the vast workforce with 'preventive and promotive action' has been articulated in the National Health Policy 2017.

The Brihanmumbai Electric Supply and Transport (BEST), a statutory Undertaking of Mumbai Municipal Corporation, India's oldest civic body, is the lifeline of Mumbai's road public transportation service, reaching out to three million commuters daily, apart from supplying electricity to 10.55 lakh consumers in the island city. It's comprehensive TB and HIV programme is among the most effective employer driven health interventions in the country. Operational

since 1945, BEST, has more than 40,000 employees, including 39,326 men and 1,139 women. It also employs 840 casual labourers on a contractual basis in the electric supply division.

## **DESCRIPTION**

A majority of the BEST workers are deployed in the field, multiplying their risk of exposure to TB – 27,000 drivers and conductors ply buses across the city, while the electricity supply staff works on the streets and goes into homes for distribution of bills, many of them congested chawls and slum areas, the hotbed of infection.

BEST addresses TB as per Revised National Tuberculosis Control Program (RNTCP) guidelines, under the aegis of the Medical Department. The programme is executed through 26 in-house depot dispensaries; a team of depot medical officers, pharmacists, medical attendants and on-call specialist consultants; and the Mumbai Central Bus Depot Dispensary and Investigation Centre, where testing facilities are available. For medication, patients are linked with their local DOTS centre for expert care. This is done under a 2012 MoU with the Brihanmumbai Municipal Corporation (BMC) and the Mumbai District TB Control Society that promises free treatment and hospitalization services for employees and their family members. Simultaneously, there is continuous follow-up, assistance and Description: support provided from the Undertaking.

For an initial diagnosis and treatment, BEST has in-house facility at the depot dispensary. Drugs are purchased via open tender system or through the Pradhan Mantri Bhartiya Jan Aushadhi Kendra (generic medicine stores under government initiative). For accurate, specialised tests and suitable treatment an arrangement has been made with the Mumbai District TB Control Society. The empanelled hospitals either provide patients hospitalization free of cost or at a subsidized rate. In case of payment, the Undertaking provides an advance once the BEST medical officer in-charge has visited the patient at the facility for assessment. The Undertaking also has an annual budgetary provision for leave with full pay, provided to TB patients, as per Service Regulations.

Prevention activities, early detection, notification, appropriate treatment, special benefits, and treatment follow-up, make up the standards of TB care in BEST.

Prevention: The medical department has identified five main triggers of secondary immunodeficiency among BEST employees around which the TB prevention strategies are based. These are: stress, protein energy malnutrition (PEM), tobacco addiction, diabetes and HIV. Regular recreational activities are organised by the BEST Arts & Sports Club whilst yoga and stress management camps are held in collaboration with KEM Hospital. High-protein diet is available at concessional rates at the depot, workshop and mobile canteens run by BEST. As nearly 40 per cent of the employees are addicted to tobacco, mainly the smokeless products, the Undertaking has set up an in-house de-addiction centre with assistance from KEM Hospital. Regular counselling is also available at the Mumbai Central Bus Depot Dispensary and Investigation Centre and at KEM Hospital's Psychiatry Department. These initiatives, apart from diabetes control programme and a spirited implementation of the HIV Workplace Policy, make the prevention strategy at BEST. Notably, to deal with Drug Resistant (DR)-TB, the distribution of Quinolone drugs has been restricted at all depot dispensaries.

Detection: Extensive awareness generation, rigorous screening and treatment literacy for patients and medical personnel provide for a robust detection mechanism.

- Awareness is created through display of IEC material shared by the Mumbai District TB Control Society in buses, bus shelters, electricity poles, depots and dispensaries, as well as at staff quarters; interactive health talks is another form of outreach. Besides these, every year, on BEST Foundation Day, August 7, a health skit, covering wellness issues, including TB, is staged by the Arts Club and informative articles on TB find space in the in-house magazine, BEST Varta.

- Mandatory TB screening happens during the pre-employment health examination, the periodic medical check-up or during the walk-ins for treatment of diseases such as hypertension, diabetes or cancer and HIV, at the depot dispensary. Screening is done through an x-ray, microbial examination by a WHO accredited laboratory, sonography, HRCT scans, bronchoscopy or any other required specialised test. It is also a routine practice to send the sputum sample for DST (Drug Sensitivity Testing) to detect DR-TB at the earliest.
- Continuous medical education (CME) is organised periodically for medical officers, pharmacists and technicians with the assistance of the Mumbai District TB Control Society. For patients, treatment literacy is extended via the pharmacist-cumcoordinator at the depot, who counsels them and their family members on what to expect during treatment and why adherence is paramount for cure.

Notification: Diagnosed TB cases are immediately notified to the Municipal Corporation of Greater Mumbai (MCGM). Notification either happens from the depot dispensary or when the patient is referred to his/her linked DOTS centre.

Treatment protocol and benefits: TB treatment is free and facilities are available in-house or at a DOTS centre near home. Those fighting the HIV-TB co-infection can avail of single window service at the Mumbai Central Depot Dispensary and Investigation Centre. In case a patient needs to be hospitalised, s/he can get admitted free of charge at the BMC's Group of Tuberculosis (TB) Hospitals, Sewri; apart from all MCMGadministered medical college hospitals and Sarvodaya Hospital.

Treatment adherence: To ensure that employees are motivated to seek and complete treatment, and colleagues are supportive in this endeavour, BEST has provisioned for extraordinary benefits. Employees are sanctioned leave with pay for up to one year, depending upon the years of service; there is also leave without pay for up to three years, which ensures job security. Furthermore, in case an employee develops physical disability post treatment (as in the case of TB of the spine or brain), s/he is entitled to a suitable alternate assignment even as the original salary is maintained. There is an in-house Disability Board that deliberates on such cases.

A monthly three-tier follow-up system has been devised to ensure defaulters are called out right away. The first follow-up is at the DOTS centre, the second at the depot dispensary and the final one at the Mumbai Central Bus Depot Dispensary and Investigation Centre, where the patient has a consult with the pulmonologist. Once treatment summaries have been studied, the patient's special leave is extended as per need. In case the patient skips any one of these levels, his/her extra-ordinary benefits are withdrawn till the original treatment regime is undertaken.

Counselling is another factor that plays an important part in optimum treatment outcome and adherence. Sessions are held not only at the time of commencement of treatment but while it's on-going, too. If required, the spouse and other family members are asked to be part of the process.

To manage the difficult side-effects of TB medication, which has a significant bearing on treatment adherence, consultations from specialists like a pulmonologist, cardiologist and ophthalmologist are available. Moreover, if a patient is experiencing serious drug reactions then treatment is re-planned.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

The TB programme has produced good results over the last few years:

- The drug defaulter cases have reduced by 100 per cent.
- Hospitalization cases have reduced by 95 per cent.
- Number of deaths due to TB has reduced by 90 per cent.
- Over the last three years, BEST has continuously shown a cure rate of 95 per cent.



- If the average sickness absenteeism due to TB in 2012 was one-year-plus it has now reduced to six to eight months.

### **LESSONS LEARNED AND RECOMMENDATIONS**

- Integrating TB response with other health initiatives paves the way for a far-reaching impact.
- Management support to workplace-based social/health interventions ensures sustainability in the long run.
- Employee-centric policies, which promise job security, offer reasonable accommodation, and contribute to a destigmatised workspace, encourage workers to seek timely counselling and treatment.
- Effective linkages with the national, state and local TB frameworks and action plans for collaboration – technical and treatment – allows for the development and provisioning of effective treatment opportunities.
- Sensitive, caring co-workers greatly lend to creating a stressfree work atmosphere, which enables sick employees to deal positively with their illness and get back on the job fast and fullyfit.
- Access to treatment at workplace presents a seamless opportunity to tackle the disease.
- Astute advocacy strategies and peer education play a vital role in arming employees with the knowledge to not only safeguard themselves but also enjoy a productive life as a result of opportune diagnosis and treatment.

### **Strategies for the Future:**

- Information and messages on TB will be a part of the curriculum for the scheduled annual training, which is mandatory for drivers, conductors and other garage staff at BEST. Due to the enforcement of the National Workplace Policy on HIV/AIDS, so far, HIV has been addressed through this module. From 2018, there will be a session on TB as well.
- TB survivors who are enjoying an active life post treatment will be given centre-stage as 'brand ambassadors'. Sharing stories and experiences on a public forum will transform them into ideal role models for TB response.
- The Medical Department is working on a proposal to extend extra-ordinary paid leave from 12 to 18 months for MDR- and XDR-TB patients due to the lengthy duration and difficult nature of treatment. Alternately, there are discussions on capping leave with pay depending upon the type of TB diagnosed.

### **ANNEXES**

2015 2016 2017 TOTAL TB CASES 135 146 130 New cases 79 70 60 Old cases 56 76 70 TB patients under treatment for diabetes 39 35 41 TB patients under treatment for HIV 14 14 13 Tobacco Chewers 40% 30% 20% No. of TB patients Hospitalized 03 03 01 Drug defaulters 02 01 00 Death 06 04 01

## 17.8 TITLE OF THE PROGRAMME:

Active Case Finding Campaign of Tuberculosis with People who Inject Drugs in New Delhi, India

### CONTACT PERSON

Name: Chinmay Modi

Title:

Organisation: National Coalition of People Living with HIV in India (NCPI+)

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- **Programme is being implemented since:** 1<sup>st</sup> July 2017
- **End date of the programme:** 15<sup>th</sup> July 2017
- **Responsible parties:** Government, Community based Organization
- **Population reached:** People living with HIV, People who inject drugs
- **Has the programme been evaluated/assessed?** Yes. The Pilot of the program was evaluated by State TB Division (Government). The Operational Research Committee evaluated the pilot study of the program by discussing the outcomes and the reliability.
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

Active Case Finding campaign (ACF) is an activity with the primary objective of detecting active TB cases at the early stage with an objective of reaching the unreached population at the high-risk area. It was carried out in brothel based sex worker in march 2017 as they are at high risk of getting exposed with HIV and TB.

The overall prevalence of HIV/AIDS in India has come down but the prevalence rate among different groups shows that HIV is concentrated among High Risk groups (HRGs). The prevalence rate amongst Transgender is 8.82%, IDUs (7.14%), MSM (4.43%) and FSWs (2.67%) (Annual HIV/AIDS report 2015). India is categories among high burden country by WHO. ([http://www.who.int/tb/publications/global\\_report/high\\_tb\\_burdencountrylists2016-2020.pdf](http://www.who.int/tb/publications/global_report/high_tb_burdencountrylists2016-2020.pdf)) Since there is high prevalence risk of HIV among key population and many of them do not aware of their HIV status, around 10.5 lakh people are in active care of HIV Treatment in India as on March 2017 and in the state of Delhi there are 26188 on active care. The newly diagnosis cases of HIV were 1,74,125 in 2016. The total new cases referred to ART centers the cases diagnosis from TB patient are among highest as 87009 (TB program data 2016) which is account for almost 50%, therefore National Coalition of people Living with HIV in India with the help of Delhi State AIDS control society and RNTCP done a active case finding campaign among brothel based sex worker in march 2017 and made a linkage with community to TB program.

National Coalition of People Living with HIV in India (NCPI+) is a national body of People Living with HIV (PLHIV), affected individuals and organisations which works with the aim to increase active, transparent and constructive participation of PLHIV. We also focus on health activist to strengthen care, support and treatment response of the country by improving the quality of life of individuals and families to control HIV. Our mission is to improve quality of life of people living with HIV in society by providing a sense of belonging to people living with HIV and their families for full active participation in society and reduce further HIV transmission.

## **DESCRIPTION**

Objectives of ACF campaign for People Who Use Injecting Drugs (PWID)

- Early suspect of TB • Early diagnosis
- Treatment preparedness
- Link to Treatment and Care

The prevalence rate of HIV among people who use drugs are very high 21.8% (IBBS 2016) among all key population and in Delhi which makes PWID community as most vulnerable in all key population. The living condition of PWID community is also making them more vulnerable as most of them are residing on some odd places i.e. park, street, temple/gurudwara etc. Many of them do not have any means to earn their livelihood and proper food. They are dependent on free food distribution from temple/ Gurudwara. Taking all this into account NCPI+ along with TI partners of DSACS in collaboration with RNTCP department designed and implemented an “Active Case Finding” campaign to raise TB awareness, early diagnosis and link to treatment with treatment preparedness at Jamuna Bazar and Connaught Place, New Delhi, from 01st July 2017 to 15th July 2017 at the hotspot area of New Delhi.

Methodology adopted:

The geographic location has identified for the ACF campaign i.e. Jamuna Bazar and Hanuman Mandir and team from the TI - DSACS are identified to carry out the Active Case Finding Campaign. The Targeted intervention projects and OST centers are taken on board. Training and Orientation is done through Delhi RNTCP department.

A questioned tool was prepared and door to door screening for TB was carried out in given area where the clients are screened and the symptomatic cases are referred for sputum examination and x rays. Proper IEC materials, Focus Group Meeting/Session/Support Group Meetings are organized for sensitization and TB awareness. People are screened based on 4's symptoms questioned tool. All the symptomatic cases are referred to facilities for diagnosis. Those who are found TB positive will be counseled for treatment preparedness. Regular follow up is done during treatment and all the positive cases are received comprehensive and holistic care and support after getting linked.

Targeted Population:

Person who Inject drugs in the area of Delhi of Jamuna Bazar, Hanuman Mandir, CP of New Delhi

Estimated number of population:

With the help of targeted intervention team various hotspot areas are identified of people who inject drugs, the mapping of area is carried from OST center and 2 TI projects which is approximately 1500. This population registered are at the high risk of getting TB as well as HIV.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Outcome:

The campaign was carried out during 1st July 2017 to 15th July 2017 at the identified area and total number of people received ACF services are 369. The details are mentioned in the below table.

**Results:**

Number of People received ACF intervention : 369 Total number of client found 4's

Symptomatic of TB and referred to New Delhi TB centers : 315

Total people tested for TB (sputum, X-ray and CBNAAT) : 196 Number of people diagnosed with TB and initiated the treatment : 24 Total Patient kept under observation for further diagnosis : 08

Active case campaign for PWID Community Phase-2 (Operational research) People who Inject Drug (IDUs) are one of the High Risk Group population considered to be the drivers of concentrated HIV and TB epidemic in India.

The outcome of the first phase of ACF campaign among PWID's is very alarming as we found over 12% positivity, which is very high among all high risk population of TB, this positivity suggested the more TB intervention is needed among this community.

**Geography:**

The next phase of the IDU active case finding campaign is proposed and will be carried out in the Jamuna Bazar and Hanuman mandir with the remaining population of Inject Drug User and estimated population is 1350 with two targeted intervention project and one OST centers .

Estimation population of PWID

The proposed operational research of the active case finding for PWID will be cover around 1500 community members Jamuna bazar and Hanuman Mandir

**LESSONS LEARNED AND RECOMMENDATIONS**

Learning from Phase-1

- Retention of PWID is major challenges in connection with screening, diagnosis and till treatment completion
- Reporting of Extra Pulmonary to be notified separately
- Quality of TB screening has to monitor regularly and filtered clients to be sent to DOTS center
- Selection of NGO and sensitization of staff is required
- To involve district TB officers of the respective area and strengthen the partnership with them

**Monitoring and Evaluation:**

Monitoring:

NCPI Plus directly implemented operational research pilot in collaboration with Delhi RNTCP. Monitoring of the project activities is done on the daily basis and report is provided to RNTCP, Delhi unit as per agreed format and targets specified. Some of the monitoring indicators are given below

1. The number of districts project activities initiated
2. Number of individual provided capacity building trainings on Community based operational research of TB
3. Number of district where the baseline mapping for the project to be done
4. Number of TB cases screening for TB based on 4'S verbal screening
5. Number of suspected cases referred to facilities for diagnosis

Evaluation:

The project will undertake a baseline mapping and end line evaluation study to understand the impact of the intervention, which will shed light to the some pertinent issues such as

1. In the current state of affair how to establish linkages with HRG community to RTNCP program?
2. Why is there are gap between number of the individuals in needs and identified to the ones accessing them

Final Deliverables of the Project:

1. A comprehensive report with recommendations on the current status that elaborates the inhibiting with regards to access to TB services
2. A community based outreach plan with defined linkages strategy of HRG with TB program
3. Estimated 1500 people of PWID community is the target for screening for TB and all suspected cases are link to facilities for further diagnosis

**ANNEXES**

The operational Research Proposal has been submitted to State TB division for taking it further to cover the overall population in the identified hotspot area along with the financial provision to it and it has been approved for 6 months.

## 17.9 TITLE OF THE PROGRAMME:

Single Window Services for management of HIV-TB co-infected patients

### CONTACT PERSON

Name: Reshu Agarwal

Title: Public Health Specialist

Organisation: CDC India

Address: CDC India

Tel: 911124198649

Email: [mdx6@cdc.gov](mailto:mdx6@cdc.gov)

- **Programme is being implemented since:** 2016
- **End date of the programme:** /
- **Responsible parties:** Government
- **Population reached:** People living with HIV, TB patients
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** Yes. Guidelines on Prevention and Management of TB in PLHIV at ART Centres, December 2016, NACO & RNTCP

### BACKGROUND

India has second highest burden of HIV /TB cases in World . HIV prevalence among incident TB patients is estimated to be There are an estimated 87,000 persons living with HIV that have HIV-associated TB occurring annually, but less than 50% diagnosed . The mortality in HIV-TB coinfectd patients is very high, with an estimated annual 12,000 deaths. Addressing burden of these two diseases has been the priority for national HIV and TB programmes.

### DESCRIPTION

Government of India rolled out single window services for prevention, early detection, and prompt management of both HIV at ART Centres. These services consist of i) Enhanced TB case-finding among people living with HIV, with 4-symptom (4S screening for TB and fast-tracking of all PLHIV with presumptive TB; ii) prioritization of rapid molecular Cartridge Based Nu Acid Amplification Test (Xpert) for all PLHIV with presumptive TB to ensure early diagnosis of TB and to identify rifampicin resistance; iii) provision of daily ATT through ART Centres; iv) use of ICT-based tools for adherence monitoring ; and v) pr of TPT for prevention of TB in PLHIV.

This initiative is being implemented by the Indian National AIDS Control Programme in coordination with the revised nation control programme. All 539 ART centres across the country are providing these integrated HIV-TB services. CDC provided technical support for the roll-out this initiative.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

This initiative is expected to enhance early TB case detection, reduce linkage loss, improve adherence and retention in care also reduce TB burden and TB deaths among people living with HIV.

## **LESSONS LEARNED AND RECOMMENDATIONS**

This initiative has been successful because of the strong collaborative mechanisms between the national HIV and TB prog at national as well as sub-national levels. Some of the challenges have been a knowledge gap among ART staff, TB and H programme managers regarding HIV-TB related programmatic and technical issues to be located in the other programme, logistics for drugs and diagnostics.

## **ANNEXES**

<https://tbcindia.gov.in/WriteReadData/l892s/8466816483Guidelines%20on%20Prevention%20and%20Management08Dec>

### 17.10 TITLE OF THE PROGRAMME:

Active Case Finding Campaign of Tuberculosis with People Who Inject Drugs in New Delhi, India

#### CONTACT PERSON

Name: Chinmay Modi

Title:

Organisation: 204A, First Floor, Sant Nagar, East of Kailash, near Sanatan Dharam Temple, New Delhi 110065

Tel: +91 8690584549

Email: [chinmaymodi13@gmail.com](mailto:chinmaymodi13@gmail.com)

- **Programme is being implemented since:** 1 January 2017
- **End date of the programme:** 15 July 2017
- **Responsible parties:** Government, Community Based Organization
- **Population reached:** People living with HIV, People who inject drugs
- **Has the programme been evaluated/assessed?** Yes. The Pilot of the program was evaluated by State TB Division (Government). The Operational Research Committee evaluated the pilot study of the program by discussing the outcomes and the reliability.
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

Active Case Finding campaign (ACF) is an activity with the primary objective of detecting active TB cases at the early stage with an objective of reaching the unreached population at the high-risk area. It was carried out in brothel based sex worker in March 2017 as they are at high risk of getting exposed with HIV and TB.

The overall prevalence of HIV/AIDS in India has come down but the prevalence rate among different groups shows that HIV is concentrated among High Risk groups (HRGs). The prevalence rate amongst Transgender is 8.82%, IDUs (7.14%), MSM (4.43%) and FSWs (2.67%) (Annual HIV/AIDS report 2015). India is categorized among high burden country by WHO.

([http://www.who.int/tb/publications/global\\_report/high\\_tb\\_burden/countrylists2016-2020.pdf](http://www.who.int/tb/publications/global_report/high_tb_burden/countrylists2016-2020.pdf))

Since there is high prevalence risk of HIV among key population and many of them do not aware of their HIV status, around 10.5 lakh people are in active care of HIV Treatment in India as on March 2017 and in the state of Delhi there are 26188 on active care. The newly diagnosis cases of HIV were 1,74,125 in 2016. The total new cases referred to ART centers the cases diagnosis from TB patient are among highest as 87009 (TB program data 2016) which is account for almost 50%, therefore National Coalition of people Living with HIV in India with the help of Delhi State AIDS control society and RNTCP done a active case finding campaign among brothel based sex worker in March 2017 and made a linkage with community to TB program



National Coalition of People Living with HIV in India (NCPI+) is a national body of People Living with HIV (PLHIV), affected individuals and organisations which works with the aim to increase active, transparent and constructive participation of PLHIV. We also focus on health activist to strengthen care, support and treatment response of the country by improving the quality of life of individuals and families to control HIV. Our mission is to improve quality of life of people living with HIV in society by providing a sense of belonging to people living with HIV and their families for full active participation in society and reduce further HIV transmission.

## **DESCRIPTION**

Objectives of ACF campaign for People Who Use Injecting Drugs (PWID):

- Early suspect of TB
- Early diagnosis
- Treatment preparedness
- Link to Treatment and Care

The prevalence rate of HIV among people who use drugs are very high 21.8% (IBBS 2016) among all key population and in Delhi which makes PWID community as most vulnerable in all key population. The living condition of PWID community is also making them more vulnerable as most of them are residing on some odd places i.e. park, street, temple/gurudwara etc. Many of them do not have any means to earn their livelihood and proper food. They are dependent on free food distribution from temple/ Gurudwara. Taking all this into account NCPI+ along with TI partners of DSACS in collaboration with RNTCP department designed and implemented an “Active Case Finding” campaign to raise TB awareness, early diagnosis and link to treatment with treatment preparedness at Jamuna Bazar and Connaught Place, New Delhi, from 01st July 2017 to 15th July 2017 at the hotspot area of New Delhi.

Methodology adopted:

The geographic location has identified for the ACF campaign i.e. Jamuna Bazar and Hanuman Mandir and team from the TI - DSACS are identified to carry out the Active Case Finding Campaign. The Targeted intervention projects and OST centers are taken on board. Training and Orientation is done through Delhi RNTCP department.

A questioned tool was prepared and door to door screening for TB was carried out in given area where the clients are screened and the symptomatic cases are referred for sputum examination and x rays. Proper IEC materials, Focus Group Meeting/Session/Support Group Meetings are organized for sensitization and TB awareness. People are screened based on 4's symptoms questioned tool. All the symptomatic cases are referred to facilities for diagnosis. Those who are found TB positive will be counseled for treatment preparedness. Regular follow up is done during treatment and all the positive cases are received comprehensive and holistic care and support after getting linked.

Targeted Population:

Person who Inject drugs in the area of Delhi of Jamuna Bazar, Hanuman Mandir, CP of New Delhi

Estimated number of population:

With the help of targeted intervention team various hotspot areas are identified of people who inject drugs, the mapping of area is carried from OST center and 2 TI projects which is approximately 1500. This population registered are at the high risk of getting TB as well as HIV.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

### **Outcome:**

The campaign was carried out during 1st July 2017 to 15th July 2017 at the identified area and total number of people received ACF services are 369. The details are mentioned in the below table:

### **Results**

Number of People received ACF intervention : 369

Total number of client found 4's Symptomatic of TB and referred to New Delhi TB centers : 315

Total people tested for TB (sputum, X-ray and CBNAAT) : 196

Number of people diagnosed with TB and initiated the treatment : 24

Total Patient kept under observation for further diagnosis : 08

Active case campaign for PWID Community Phase-2 (Operational research) People who Inject Drug (IDUs) are one of the High Risk Group population considered to be the drivers of concentrated HIV and TB epidemic in India.

The outcome of the first phase of ACF campaign among PWID's is very alarming as we found over 12% positivity, which is very high among all high risk population of TB, this positivity suggested the more TB intervention is needed among this community.

### **Geography:**

The next phase of the IDU active case finding campaign is proposed and will be carried out in the Jamuna Bazar and Hanuman mandir with the remaining population of Inject Drug User and estimated population is 1350 with two targeted intervention project and one OST centers .

### **Estimation population of PWID:**

The proposed operational research of the active case finding for PWID will be cover around 1500 community members Jamuna bazar and Hanuman Mandir

## **LESSONS LEARNED AND RECOMMENDATIONS**

### **Learning from Phase-1**

- Retention of PWID is major challenges in connection with screening, diagnosis and till treatment completion
- Reporting of Extra Pulmonary to be notified separately
- Quality of of TB screening has to monitor regularly and filtered clients to be sent to DOTS center
- Selection of NGO and sensitization of staff is required
- To involve district TB officers of the respective area and strengthen the partnership with them

### **Monitoring and Evaluation:**

#### **Monitoring**

NCPI Plus directly implemented operational research pilot in collaboration with Delhi RNTCP. Monitoring of the project activities is done on the daily basis and report is provided to RNTCP, Delhi unit as per agreed format and targets specified. Some of the monitoring indicators are given below

1. The number of districts project activities initiated
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5. Number of suspected cases referred to facilities for diagnosis

**Evaluation:**

The project will undertake a baseline mapping and end line evaluation study to understand the impact of the intervention, which will shed light to the some pertinent issues such as

1. In the current state of affair how to establish linkages with HRG community to RTNCP program?
2. Why is there are gap between number of the individuals in needs and identified to the ones accessing them

**Final Deliverables of the Project:**

1. A comprehensive report with recommendations on the current status that elaborates the inhibiting with regards to access to TB serves
2. A community based out reach plan with defined linkages strategy of HRG with TB program
3. Estimated 1500 people of PWID community is the target for screening for TB and all suspected cases are link to facilities for further diagnosis

**ANNEXES**

The operational Research Proposal has been submitted to State TB division for taking it further to cover the overall population in the identified hotspot area along with the financial provision to it and it has been approved for 6 months

## 18.INDONESIA

### 18.1 TITLE OF THE PROGRAMME:

Acceleration of District-level TB/HIV service coverage: Lessons Learned from Tulung gung District, East Java Province and Jayapura Municipality, Papua Province, Indonesia

### CONTACT PERSON

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- **Programme is being implemented since:** 2017
- **End date of the programme:** /
- **Responsible parties:** Government, FHI360, KNCV-USAID Challenge TB
- **Population reached:** People living with HIV, TB patients
- **Has the programme been evaluated/assessed?** Yes. This programme was jointly assessed and evaluated by the Ministry Health Office, District Health Office and USAID Challenge TB project to see the improvement of TB/HIV services, particularly regarding the main indicators of TB/HIV such as TB patients knowing their HIV status and ART coverage among TB/HIV patients. Outcome was assessed using site level data from national reports.
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

For a G20, Upper Middle Income country, Indonesia lags behind significantly in HIV, TB, maternal and child health with serious problems with stunting. These issues have been flagged as national priorities. The Government of Indonesia is fully committed to achieving the SDGs and Universal Health Coverage by 2030. Indonesia has a high burden of people living with HIV, estimated at 630,000 people, with around only 15% ART coverage. TB and MDR-TB also remains challenging – Indonesia has the second highest TB burden after India. In 2016, Indonesia managed to treat 360,500 TB patients out of the estimated one million new cases per year.

To address TB and HIV co-infection all TB patients should be offered HIV testing, however only 14% of all TB patients knew their HIV status in 2016. With significant difficulties to scale up access and patient follow-up, the Ministry of Health together with Challenge TB project piloted

special technical assistance program in two high TB and high HIV prevalence sites: (i) Tulung Agung (East Java Province) and Jayapura (Papua Province).

Source of data: National TB and AIDS programme data, 2015- 2017

### **DESCRIPTION**

Provincial and district TB coordinators from the sub-national health office collaborated on advocacy, strategy development, and resource mobilization. The process included endorsement of HIV testing policy, ensuring testing access, capacity building, strengthening M&E, and establishing instant messaging group. The team adopted the MoH national policy to provide One-Stop-Service for both TB and HIV patients ensuring the HIV services are available in TB clinics - including testing, strengthening ART referral systems, ensuring test kit availability and training on PITC and laboratory testing. The District Health Offices also monitored TB/HIV activities and mentored under-performing facilities, including quarterly data checks, strengthening staff capacity, engaging communities and developing referral systems for ART initiation. Additional supports were also provided to conduct on-the-job training, supportive monitoring visits, and monthly feedback meetings. USAID Challenge TB project provided the technical support to this pilot program.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

TB/HIV performance significantly improved during the pilot program. In Tulung Agung the number of TB patients knowing their HIV status increased from 32% (282/872) in 2015 to 65% (657/1013) in 2016 and continued to increase to 89% (931/1043) in 2017. TB patients with HIV initiated and remained on ART also increased from 23% (7/31) in 2015 to 73% (53/73) in 2017. By 2017, all TB facilities in Tulung Agung were able to provide HIV testing (a 72% increase from only 11/40 centres in 2015).

In Jayapura, the number of TB patients knowing their HIV status increased from 46% in 2016 to 74% in 2017. ART coverage among TB patients with HIV also increased from 52% to 73% in the same period.

The key to improving performance in these two sites was the intensive collaboration between TB and HIV teams, close monitoring of program implementation and most importantly the buy-in and commitment to provide One-Stop-Services for TB and HIV by ensuring availability of HIV testing in all service centres, health commodities and accountability in achieving results.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Along with provincial and district health offices commitment to work together to implement One-Stop-Services for TB and HIV, an important factor that helped to achieve these impressive results is the involvement of civil society partners including people living with HIV and key populations. Experienced patients of HIV and TB provided additional support such as giving information to new TB patients on importance of getting early HIV tests and accompanying patients to initiate ARV. The technical assistance program also focused on strengthening knowledge and skills of doctors to enable them to more confidently address both TB and HIV, thus offering HIV tests to TB patients and initiating ARV treatment faster.

### **ANNEXES**

The abstracts of this pilot program have been submitted to the 49th UNION World Conference on Lung Health and the 22nd International AIDS Conference (IAS 2018).

## 18.2 TITLE OF THE PROGRAMME: Home-Based Pediatric Palliative Care Service for Children Living with HIV AIDS

### CONTACT PERSON

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- **Programme is being implemented since:** 2006
- **End date of the programme:** /
- **Responsible parties:** Civil Society
- **Population reached:** People living with HIV, Children, Women and girls, Young people/adolescents
- **Has the programme been evaluated/assessed?** Yes. The program is evaluated on a regular basis by our faculty of international palliative care experts through clinical audit and field supervisions, including a clinical audit by Singapore International Foundation-led palliative care doctors from Singapore in 2011-2012.
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

An estimated 620,000 people are living with HIV AIDS in Indonesia, 14,000 of whom are children under the age of 14.(\*1) Tuberculosis (TB), candidiasis, and diarrhoea are the most common opportunistic infections, with TB being the leading cause of death.(\*2)

The Indonesian Government has taken major strides to improve the health of its population, introducing universal health insurance (JKN) in stages since 2014. The Ministry of Health has also granted free access to antiretroviral drugs (ARV), TB medications, and most treatments for HIV-related opportunistic infections. However, many still don't get the treatment they need for reasons such as:

-Complex and overburdened healthcare system

With JKN in place, many more Indonesians are able to access healthcare services. While this means that more people are receiving the care they need, it also places a great burden to a system in which there is already a decreasing number of healthcare professionals (2 doctors and 13.8 nurses for every 10,000 people in 2015(\*3), compared to 3 doctors and 20 nurses in 2011(\*4)). This results in extremely long queues and waiting time for patients, making going to hospital an incredibly demanding task both physically and mentally.

-Lack of collaboration and care evaluation by medical professionals

There is a significant difference in care planning and collaboration between district (secondary) and national referral (tertiary) hospitals. In district hospitals where subspecialist pediatricians are not available, treatments for HIV and opportunistic infections are handled solely by the pediatrician. While this simplify the interaction between patient, caregiver, and healthcare

provider, often the pediatricians don't possess the necessary skills, expertise, and experience to deal with multiple and complex opportunistic infections. Treatment for infections such as tuberculosis may be stopped after the regimen has been completed according to the existing protocol, but without the necessary diagnostics and evaluations to confirm the success of treatment and elimination of infection.

In contrast, HIV-positive patients with lung tuberculosis at national referral hospitals would be referred by their immunologist to the pulmonologist(s), skilled in treating severe cases of tuberculosis. However, a risk to patient care can occur when the different doctors involved do not communicate and coordinate with each other, resulting in suboptimal quality of care and failure of treatment.

-Lack of health education for patient and family-

Patients and families often do not receive clear explanation and instructions regarding the benefits and proper administration of ARV and TB medications. This leads to patients and/or caregivers being noncompliant, missing doses because they do not understand that the medications need to be taken every day at the same time, or skipping doses because they feel the drugs do not make much difference to their health.

(\*1) UNAIDS 2016 (<http://www.unaids.org/en/regionscountries/countries/indonesia>)

(\*2) "The cases with opportunistic infections among HIV patients in Indonesia 2011" BMC Infectious Diseases 2014 14(Suppl 2):P45

(<https://bmcinfectdis.biomedcentral.com/articles/10.1186/1471-2334-14-S2-P45>)

(\*3) World Health Statistics 2015

([http://www.who.int/gho/publications/world\\_health\\_statistics/2015/en/](http://www.who.int/gho/publications/world_health_statistics/2015/en/))

(\*4) World Health Statistics 2011

([http://www.who.int/gho/publications/world\\_health\\_statistics/2011/en/](http://www.who.int/gho/publications/world_health_statistics/2011/en/))

## DESCRIPTION

Rachel House is a not-for-profit organisation providing home-based palliative care - a specialised medical care that provides pain and symptom management, emotional, and social support for people living with serious illnesses, so that they can live pain-free and with optimal quality of life. Our service is targeted at children living with life-threatening illnesses, such as cancer and HIV AIDS, from the most marginalised communities in Jakarta. Besides ensuring that pain and symptoms are managed through regular home visits and patient education, our team of nurses works as an advocate for the patients and their families, communicating and coordinating with patients' primary physicians and other healthcare providers to address complex issues associated with their illness.

We work closely with national referral and district hospitals in Jakarta, including Cipto Mangunkusumo National Referral Hospital, Sulianti Saroso Infectious Disease Hospital, and Koja District Hospital, as well as primary care clinics (puskesmas) in Jakarta's poorest areas, including North and East Jakarta. Our nursing team receive patient referrals from doctors and nurses in these partner hospitals. Through regular meetings and phone calls, Rachel House nurses ensure that all healthcare professionals involved are updated on the latest patient's condition and working collaboratively to carry out a coherent and appropriate treatment plan. In the case of children living with HIV AIDS and pulmonary tuberculosis, our nurses would work with a range of physicians including pediatricians, immunologists, and pulmonologists to make sure that patients are receiving and adhering to the appropriate ARV and TB regimens.

The program and organisation is funded by donations made by individuals, corporations, and grant-providers. A mix of fundraising efforts ranging from crowd-funding, online campaign, CSR partnership, and grant proposal applications are conducted every year to ensure financial sustainability.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Out of 236 children living with HIV in Jakarta who were admitted into Rachel House's home-based palliative care service, 131 were discharged under stable condition i.e. compliant to treatment and free from opportunistic infections. Of these, one particular case stood out to exemplify the positive impact of collaboration and palliative care approach on management of HIV and pulmonary tuberculosis.

### **THE CASE OF AHMAD\***

#### **-Admission to Rachel House**

Ahmad was 8 years old when he was admitted to Rachel House's service. He has been diagnosed with HIV and opportunistic infections including lung tuberculosis and severe oral candidiasis. In January 2017, Ahmad's primary physician and pediatric immunologist at a national referral (tertiary) hospital referred him to Rachel House, with the following goals of care: a) compliance to ARV and TB medications, b) improved nutrition with a target body weight of 22 kg, and c) all opportunistic infections and symptoms managed.

Prior to admission, Ahmad had been malnourished, weighing only 14 kg (far from the ideal weight of 24 kg), which made him weak and unable to perform daily activities, including walking. He had very low appetite and food intake, and had been using a nasogastric tube (NGT) for over a year, which Ahmad found very uncomfortable and in turn worsened his appetite and intake. He had been experiencing multiple and recurrent issues such as diarrhea, high fever, and pruritic papular eruption (PPE), leading to several hospitalisations in the past couple of years.

Ahmad had not been able to maintain compliance to both his ARV and TB medications for two years. Upon assessment, Rachel House nurse found that having been taking ARV since the age of one, Ahmad had started to grow tired of the medications and therefore, been missing or skipping doses - leading to a deterioration of his condition. We also discovered that Ahmad's mother (who was also diagnosed with HIV) had recently died after being severely ill for the past year. Ahmad's grandmother, who then assumed the role primary caregiver, was both untrained to correctly administer medications and was occupied with caring for Ahmed's mother – additional factors that contributed to Ahmad's noncompliance.

#### **Collaborative Care between Rachel House's Home-Based Palliative Care Nurse and Ahmad's Hospital-Based Physicians**

In the hospital, Ahmad's case is handled by a pediatric immunologist as well as a team of pulmonologists. Ahmad's HIV treatment is prescribed by the immunologist, while his TB treatment is managed by the pulmonologists. Both his ARV and TB treatments were closely and regularly monitored, with Ahmad being scheduled for weekly doctor appointments (otherwise known as "control visits") at first, gradually reduced to biweekly and monthly control visits as he showed improvement in both health and compliance.

As the hospital was a teaching and a tertiary hospital, it was very common for patients like Ahmad to see different doctors on his regular visits to the pulmonary outpatient clinic. There was a risk for Ahmad's TB treatment being incoherent, contradictory, or otherwise ineffective if there was no clear communication and leadership among the hospital team. However, Ahmad's immunologist, acting as the primary physicians, supervised Ahmad's overall care and kept close tabs on all of his medications, including his TB medications.

At home, Ahmad and his grandmother are visited by a Rachel House nurse every week. During these visits, the homecare nurse educated Ahmad and his grandmother on Ahmad's illness and medications. She provided clear and comprehensive information on ARV and TB medications: how they work, why they are important, how and when they should be taken, as well as potential side effects and how to manage them. The nurse closely monitored Ahmad's symptoms and adherence to treatment at home, updating any changes in condition to Ahmad's primary physician through regular texts, phone calls, and face-to-face meetings. Existing symptoms as well as new ones were managed at home by the nurse, in consultation with the



primary physician and in collaboration with the newly-educated and empowered patient and caregiver.

Mindful of Ahmad's discomfort with the nasogastric tube and his wish to have it removed, the nurse negotiated with him on ways to improve and ensure his nutrition as well as medication compliance if and after the tube had been removed. The nurse also advocated to the primary physician for the removal of the tube, explaining how this would benefit the patient's morale and ultimately, achieve the desired goals of care.

Ahmad was discharged from Rachel House's service 9 months after his first admission. During the time, we managed to encourage him to adhere strictly to the antiretroviral treatment regime, convinced him to complete his TB treatment and improved his nutritional intake. As a result, the lung tuberculosis was successfully treated, his immunity was stabilised, and his weight increased. He regained his functional abilities and resumed school.

\* Patient's name has been changed to protect identity.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Tuberculosis remains the biggest cause of death for people living with HIV AIDS in Indonesia, despite antiretroviral and TB therapy being accessible to all Indonesians under the universal health insurance. Lack of clinical expertise, interdisciplinary collaboration, and disempowered patient and family are all contributing factors to failure of treatment that causes pain and suffering to many.

The case above illustrated how those challenges need to be tackled on many fronts, to ensure the successful management of the patient's HIV infection as well as pulmonary tuberculosis.

1. The pulmonologists in Ahmad's case provided their expertise by prescribing treatment that would be appropriate for a long-term lung tuberculosis case with a history of noncompliance.

2. The immunologist served as an excellent primary physician, making sure to check and evaluate Ahmad's current treatment regimens on every hospital visit, including medications prescribed by the pulmonologists, ensuring that all treatments were accurate and complementary to each other.

3. The home-based palliative care nurse was essential to manage symptoms at home, monitor changes, and feed the updated information to the primary physician, allowing the physician to evaluate treatment and adjust it according to patient's current Lessons learned and recommendations: condition and needs. The homecare nurse also empowered patient and caregiver by educating them on their illness and treatment as well as involving them in the decision-making process of their care - resulting in significant improvement in adherence to treatment and consequently, health and quality of life.

There is much to be done to ensure that other children living with HIV can enjoy the same level of care and quality of life. Training on the treatment, monitoring, and evaluation protocols of various HIV-related opportunistic infections must be improved for all medical professionals who might be involved in providing care for patients living with HIV. This is important especially for medical professionals practicing at district hospitals, where subspecialist expertise is not available and a pediatrician is tasked to handle most if not all the symptoms and infections associated with HIV AIDS. Practices and systems that improve communication among doctors, hospitals, and institutions must be implemented to ensure that patient receives appropriate, coherent, and effective care.

In addition, community-based health services need to be strengthened and connected with their counterparts in primary care as well as hospital facilities. A community-based healthcare team is key to ensuring continuous support is available for patients and families at home, providing both medical and psychosocial support to enhance the success of the treatment and promote quality of life. The availability of a strong and supportive community network of care providers can reduce patient visits and utilisation of hospital services, reducing the burden on the hospital system and making it available to serve those with acute care needs. All of the above efforts

combined will create an integrated, collaborative, patient-centered healthcare service that would help end tuberculosis and AIDS, allowing patients to live with dignity and without pain.

**ANNEXES**

- (1) UNAIDS 2016 (<http://www.unaids.org/en/regionscountries/countries/indonesia>)
- (2) "The cases with opportunistic infections among HIV patients in Indonesia 2011" BMC Infectious Diseases 2014 14(Suppl 2):P45  
(<https://bmcinfectdis.biomedcentral.com/articles/10.1186/1471-2334-14-S2-P45>)
- (3) World Health Statistics 2015  
([http://www.who.int/gho/publications/world\\_health\\_statistics/2015/en/](http://www.who.int/gho/publications/world_health_statistics/2015/en/))
- (4) World Health Statistics 2011  
([http://www.who.int/gho/publications/world\\_health\\_statistics/2011/en/](http://www.who.int/gho/publications/world_health_statistics/2011/en/))

## 19. IRAN

### TITLE OF THE PROGRAMME: TB/HIV Co-infection Control Programme

#### CONTACT PERSON

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- **Programme is being implemented since:** 2009
- **End date of the programme:** Ongoing
- **Responsible parties:** Government, Civil Society, Private sector, UN or other inter-governmental organization, Academic Institution
- **Population reached:** People living with HIV, People who inject drugs, Prisoners and other population in closed settings, Migrants (documented and undocumented) refugees or internally displaced populations, Children, Women and girls, Young people/adolescents, TB patients
- **Has the programme been evaluated/assessed?** Yes. The program is evaluated by MoH; process and output evaluation
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** Yes. Primary Health Care Programme

#### BACKGROUND

Islamic Republic of Iran – an upper mid income country in MENA- benefits from a nation-wide Primary Health Care (PHC) system where disease control is one of its prominent pillars. With low prevalence HIV (0.05%) and TB (14/100,000) epidemics national strategic plans of two diseases aim to control both with well-defined and matched objectives including addressing HIV/TB co infection in each programme. All HIV prevention, care and treatment services are delivered in more than 240 triangular clinics (TCs), inside and outside the prisons, free of charge. TB care and treatment services are integrated in the primary health system. All needed TB services -including but not limited to anti TB medication using DOTS approach, screening people who are in close contact with the source patients and post treatment follow of patients- are provided in the closest center to the patient's place of residence, free of charge. Two especial softwares are available for registration and reporting of HIV and TB. TB and HIV data are collected at local level to be compiled and cross-matched later at provincial and national levels.

Iran's HIV care and treatment cascade in Iran:

As demonstrated in the above diagram, the main two gaps in HIV care are insufficient case finding and linkage to care. Active linkage to care means referring to the TCs at least once during the past 12 months. Based on the national protocol, all PLWH who refer to TCs should be evaluated for TB. Latent TB and TB case finding services are provided regularly in TCs for PLWH.

Based on intensified case finding approach for TB screening, if a patient has any symptoms of fever, cough, night sweats, and weight loss, s/he will immediately enter the path of diagnosis for TB, such as sputum smear and culture, conduct of necessary imaging, etc. This approach is done routinely in triangular clinics for all PLWH. It is noted that the initiation of INH prophylaxis is done only in case of suspected latent TB infection including PPD/IGRA positive cases, old fibrotic lesion in pulmonary radiography and recent contact with TB case, and ruled out active tuberculosis, in the absence of previous prophylaxis or treatment of tuberculosis.

INH prophylaxis is provided to eligible PLWH in TCs but anti TB medication are provided after diagnosis confirmation in TB centers. Since August 2017 'test and treat' policy is included in the national HIV Care and Treatment protocol.

ART coverage in PLWH who regularly refer to TCs.

By the end of 2017, more that 85% of diagnosed and linked PLWH received ART. Trend of TB case finding among PLWH (HIV/TB co infection) in Iran.

## **DESCRIPTION "**

According to National HIV Strategic Plan (2015-2019), below objectives were considered for HIV/TB coinfection:

- At least 90% of tuberculosis patients receive regular training, counseling and testing for HIV.
- At least 95% of tuberculosis patients who have a positive initial test receive counselling and confirmatory tests. • TB status of 100% of PLWH is assessed annually.
- At least 90% of PLWH who are eligible for TB prophylaxis have received standard INH prophylaxis.
- 75% of the patients with TB/HIV co-infection are identified and received appropriate therapy for both diseases.
- Provide facilities and equipment for molecular detection of TB in at least 15 regions in the country

Since 2016, for increasing access to HTS (HIV Testing Services) and case finding, provider initiated counseling and testing (PITC) was integrated in almost all of comprehensive health services centers and Health Posts throughout the country. Several training courses (using TOT approach) were conducted throughout the country and rapid test kits provided, especially for at risk population in marginalized regions. PITC is going to be also provided in all harm reduction services.

In line with increasing access to HIV testing, PITC is also provided for TB cases in TB centers. After a positive initial HIV test, TB individuals are referred to triangular clinics for confirmatory test. HIV test was done for almost 80% of diagnosed TB cases at the end of 2016. Improving data registration system of TCs provides us with accurate and easy- to- access data on HIV care and treatment, including HIV/TB co infection. TB and HIV data can be potentially cross-matched at provincial and national levels for improving monitoring and follow up of common cases, however this needs more coordination between two units at national level. Different training courses on TB and HIV for various groups of care providers have been organized including:

- General physicians who are working in TCs o 231 general physicians have been trained as "AIDS therapists", during five-day workshops, and joined web based "AIDS therapists network"
- PITC workshops (includes TB education and symptomatic TB case finding) for several health care providers throughout the country. Many Health Care Workers (HCW) who are working in several units of comprehensive health services centers and health posts have been trained and

provide counseling and if required HIV testing to the clients. o Tuberculosis education is part of HCW training course By the end of 2017, more that 75.2% of referred PLWH to TCs were evaluated for TB/latent TB and received appropriate services/care.

Simultaneous TB and HIV therapy in co-infected cases:

Simultaneous anti TB therapy and ART is very important and is one of the emphasized points of training courses. Contact tracing and screening household for TB and HIV are part of the TB/HIV care and treatment protocol. This activity is done by TCs' personnel and also staff of TB centers. Strengthening capacity of molecular diagnosis of TB among PLWH is another important national objective. In this connection 10 Gen Xpert machines are working in collaboration with the national AIDS programme. 13 regional laboratories have appropriate equipment for Real time PCR throughout the country and help for patients' monitoring and EID. Five point of care machines (POC) provide EID services especially for hard to reach areas.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Following, definition of objectives with related targets set for 2017 and our achievement are reported:

- By 2019, at least 90% of tuberculosis patients receive regular training, counseling and testing for HIV. Milestone for 2017 is 50%

In 2017, 80% of TB patients were counseled and tested for HIV

- By 2019, At least 95% of tuberculosis patients who have a positive initial test receive counselling and confirmatory tests. Milestone for 2017 is 80%

In 2017 Milestone was achieved

- By 2019, TB status of 100% of PLWH is assessed annually. Milestone for 2017 is 75%

In 2017, 75.2% of diagnosed and actively linked patients to TCs have been evaluated for TB disease.

- By 2019, At least 90% of PLWH who are eligible for TB prophylaxis have received standard INH prophylaxis. Milestone for 2017 is 70%

In 2017, 53.6% of known eligible PLWH received INH prophylaxis

- By 2019, 75% of the patients with TB/HIV co-infection are identified and received appropriate therapy for both diseases. Milestone for 2017 is 65%

In 2017, 95.1% of known eligible PLWH received INH prophylaxis

- By 2019, Provide facilities and equipment for molecular detection of TB in at least 15 regions in country (target sets for 2019)

In 2017, 10 Gen Xpert machines are working in collaboration with the national HIV

## **LESSONS LEARNED AND RECOMMENDATIONS**

We should have a comprehensive approach. Appropriate infrastructure (human resource, equipment, inter-department communication) is necessary for delivering the best services. Updating care and treatment guidelines, training HCWs, scaling up registration and reporting system and software, coordination between TB and HIV departments and providing diagnostic facilities for both TB and HIV are the main activities that led to our significant achievements.

Main challenges:

- Insufficient HIV case finding
- Insufficient linkage to care among diagnosed PLWH
- Insufficient coverage of latent TB prophylaxis

Gaps:

Education:

- More emphasis on INH prophylaxis and its registration in training programmes of physicians
- Inter-department communication: More interdepartmental coordination for better use of collected data on monitoring and follow up of co-infected patients. The cause of death is recorded, but it is not very accurate. Postmortem studies and verbal autopsy are needed. Sustainable livelihood and support services for tuberculosis patients
- Joint national strategies for TB/HIV/Hepatitis are needed.

Recommendation:

- Development and implementation joint national strategies for TB/HIV/Hepatitis
- Strengthening use of peer groups (among PLWH) for increasing linkage of diagnosed PLWH to care and also TB contact tracing

**ANNEXES**

Death rate in the year of TB diagnosis in TB/HIV co infected patients

### **III. EASTERN EUROPEAN STATES**

## 20. BELARUS

**TITLE OF THE PROGRAMME: State Programme 'Tuberculosis' for the years 2016-2020**

### **CONTACT PERSON**

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- **Programme is being implemented since:** 2013
- **End date of the programme:** /
- **Responsible parties:** Government
- **Population reached:** People living with HIV
- **Has the programme been evaluated/assessed?** Yes. The programme has been evaluated by Green Light Committee for the WHO European Region in the year 2018.
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** Yes. National Programme

### **BACKGROUND**

Regulatory act: the order of the Ministry of Health of the Republic of Belarus dated 08.10.2013 № 1034 "Approval of the Instruction on tuberculosis care providing procedure to patients with HIV infection"

### **DESCRIPTION**

Cooperation of HIV and TB programmes in Belarus

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

The Instruction on tuberculosis care providing procedure to patients with HIV infection has been developed. Within the framework of the Instruction: clinical algorithm for tuberculosis detection in HIV-infected individuals has been developed for infectious diseases doctors; the algorithm for tuberculosis diagnosis in HIV-infected patients using fast methods has been determined; the algorithm for HIV testing in patients with tuberculosis and people suspected to have tuberculosis has been streamlined; 98% of patients have been tested in the year 2016; the approaches to ART prescribing in patients with HIV-associated tuberculosis have been revised; 83% of patients received ART in the year 2016; co-trimoxazole prevention in patients with HIV-associated tuberculosis has been implemented; 100% of patients were covered by co-trimoxazole preventive treatment; the indications and contraindications to isoniazid prevention in HIV-infected persons have been revised; the mechanism for data exchange between infectious disease doctors, epidemiologists and phthisiatricians using TB and HIV registers has been developed.



## **LESSONS LEARNED AND RECOMMENDATIONS**

Advantages:

- ART coverage;
- co-trimoxazole prevention coverage;
- isoniazid preventive treatment;
- TB Register has been published in “Best Practices” of WHO European region;
- interaction of TB and HIV registers.

Existing problems:

- isoniazid prevention frequency;
- use of rapid HIV tests in patients with tuberculosis.

Preparation of new Instruction on tuberculosis care providing procedure to patients with HIV infection.

## **ANNEXES**

Green Light Committee for the WHO European Region Technical assistance mission report, Republic of Belarus, 22–26 January 2018

## 21. UKRAINE

### 21.1 TITLE OF THE PROGRAMME: Early TB detection among most at-risk population

#### CONTACT PERSON

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- **Programme is being implemented since:** 2013
- **End date of the programme:** /
- **Responsible parties:** Civil Society
- **Population reached:** People who inject drugs, Homeless people, Ex-prisoners, Roma population
- **Has the programme been evaluated/assessed?** Yes. The programme has been evaluated by TB program manager of Alliance
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

As per WHO assessment 20-25% of TB cases are not detected in Ukraine annually (WHO country profiles for 2013-2016) creating a reservoir of TB infection and contributing towards the TB epidemic. There was assumed that non-detected cases were concentrated in MARPs who have limited access to health care services.

#### DESCRIPTION

Project aimed at reaching MARPs groups, it started in 2013 and covered clients of harm reduction program (PWID); starting from 2015 project additionally covers special risk groups for TB: homeless people, ex-prisoners, Roma population. 79 field NGOs supported by Alliance implemented the project in all regions of Ukraine (except temporary occupied Crimea). Activities included: screening questionnaire and referral to health care institutions for further examining of those who were screening-positive. Patients with diagnosed TB are referred to TB clinics and enrolled on treatment. All health care institutions were informed about the project, roadmaps were developed for the clients of NGOs to improve the access to health care services in both primary health care centers and TB clinics.

#### RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Patients' roadmap allows to extend and facilitate the access to TB diagnostics for risk groups representatives. Community NGOs can be the link between risk groups and health care

institutions. Within the project about 580 thousand of risk groups' representatives were screened for TB symptoms and 2614 new TB cases were detected (see the table below)

	2013	2014	2015	2016	2017
Covered with screening	55 549	38 720	159 513	160 591	165 700
Screening-positive	12 305	6 123	17 850	17 547	14 732
Examined in HC institutions	5 698	5 214	14 699	13 958	12 375
Diagnosed TB	626 (11%)	510 (10%)	563 (4%)	529 (3.8%)	386 (3.1%)

### **LESSONS LEARNED AND RECOMMENDATIONS**

During the first two years of the project implementation more than 90 thousand of PWID were screened for TB symptoms, the total number and rate of TB in PWID increased from 702 (2.3% of all TB cases) in 2012 to 1789 (7.0%) in 2014. Starting from 2015 the total number of TB cases decreasing every year - 650 in 2016. The same happens with other risk groups. This means that the audience of risk groups does not expand any more. To overcome this and make NGOs attract new clients to TB screening result based financing (RBF) approach (bonuses for each detected TB case) was applied in community NGO that works with Roma population. As a result in 2017 the number of diagnosed TB in Roma increased by 42%: 74 new TB cases among 4477 screened Roma in 2017 in comparison with 52 new TB cases among 4553 screened in 2016. Starting from 2018 RBF approach is being applied in the work with all risk groups.

### **ANNEXES**

Poster presentation at Union World Conference on Lung Health in October 2016, Liverpool, UK

## 21.2 TITLE OF THE PROGRAMME: Providing access to new anti-tuberculosis medicine

### CONTACT PERSON

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- **Programme is being implemented since:** 2016
- **End date of the programme:** /
- **Responsible parties:** Civil Society
- **Population reached:** People who inject drugs, Prisoners and other populations in closed settings, Migrants (documented and undocumented), Refugees or internally displaced populations, Women and girls, Young people/adolescents
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

In 2014, for the first time Ukraine entered the top five countries with the highest rate of multidrug-resistant TB. In recent years, there has been an increase in the number of cases of multidrug-resistant TB from 3 442 cases in 2009 to 7 778 cases in 2016. Among multidrug-resistant TB cases, the major concern is that there is an increase in cases with extended drug resistance TB which is difficult to find a regimen of treatment for, and the patients often die, especially vulnerable patients with co-infection TB / HIV. New medicine to treat drug-resistant forms of TB, including TB with extended drug resistance, can be used to improve the situation.

### DESCRIPTION

To ensure the access of patients with TB in Ukraine to new anti-TB medicine, in June 2016, the CO "All-Ukrainian Network of People Living with HIV" (the Network) initiated the negotiation process on registration of medicine with the Janssen company – the manufacturer of new anti-TB medicine Bedaquiline; and in 2017 – with the `Otsuka Pharmaceutical Co., Ltd` company – the manufacturer of Delamanid. The negotiation process was complicated since the rights to distribution of Bedaquiline and Delamanid in Ukraine were owned by Russian companies. By the reason of Russia's military aggression against Ukraine, on April 03 2017, the Ministry of Health of Ukraine send a letter to the Cabinet of Ministers of Ukraine on the prohibition of distribution and registration of medicines manufactured by the Russian companies. Therefore, during negotiations on registration of medicines, it was necessary to change the Russian distribution companies in Ukraine with companies that are not of Russian origin. Along with this,

the Network initiated a process of including Delamanid and Bedaquiline into the nomenclature list of medicines for public procurement.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

As a result of protracted negotiations, personal meetings and meetings at EECA CAB, in a letter dated 22.02.2018, the manufacturer of Bedaquiline, the Janssen company, informed about the substitution of the Russian distributor Pharmstandard with Janssen (the Ukrainian office) and the preparation of documents for registration of Bedaquiline in Ukraine. In March 2018, the Janssen company filed for registration of Bedaquiline in the Ministry of Health of Ukraine. As a result of negotiations, the manufacturer of Delamanid, Otsuka Pharmaceutical Co., Ltd., in a letter dated 10.01.2018, informed about substitution of the Russian distributor the RPharm company with the German company R-Pharm Germany GmbH and the preparation of documents for the registration of Delamanid in Ukraine. In April 2018, the documents for the registration of Delamanid were filed in the Ministry of Health of Ukraine.

Also, the Network has achieved remarkable results in a parallel process: Delamanid and Bedaquiline are included in the nomenclature list of medicines for procurement for the state budget funds in 2018.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Due to persistent activities of the Network in Ukraine, in the nearest future new anti-TB medicines will be available for treatment of resistant TB forms. The state bureaucratic system is very clumsy, that is why no one should wait for the state institutions to begin negotiations on the registration of new antiTB medicines, new diagnostic methods, etc. Patients' organizations should take the initiative. It is necessary to conduct negotiations with manufacturers / suppliers and the state structures simultaneously, only in this case it is possible to quickly introduce innovations for effective control over TB.

### **ANNEXES**

Additional materials will be provided upon request

### 21.3 TITLE OF THE PROGRAMME:

Development and implementation of an optimal model of outpatient treatment and social support for TB patients and patients with co-infection TB/HIV in Ukraine to improve the results of treatment of drug-sensitive TB

#### CONTACT PERSON

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- **Programme is being implemented since:** 2017
- **End date of the programme:** 2020
- **Responsible parties:** Civil Society
- **Population reached:** People living with HIV, People who inject drugs, Prisoners and other populations in closed settings, Migrants (documented and undocumented), Refugees or internally displaced populations, Women and girls, Young people/adolescents
- **Has the programme been evaluated/assessed?** Yes. The Global Fund to Fight AIDS, Tuberculosis and Malaria, PwC audit.
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** Yes. The Order of the Cabinet of Ministers dated March 22, 2017, No. 248-p Strategy for ensuring a sustainable response to the TB epidemic, including chemoresistance, and HIV / AIDS for the period up to 2020, and approval of a plan of measures for its implementation.

#### BACKGROUND

In 1995, the World Health Organization declared the TB epidemic in Ukraine for the first time. The peak incidence occurred in 2005 (84.5 cases per 100 000 population). Since 2006, a slow decline in the incidence rate has been observed. According to the state statistics in 2016, the incidence of TB in Ukraine is 67.6 cases per 100 000 population. Although, there is a positive tendency, the 74% treatment effectiveness index remains low (data as of 2016).

#### DESCRIPTION

In 2017, the Network implemented a project aimed at development of a sustainable model for providing outpatient care to TB patients under the supervision of a DOT provider, priority was given to patients with a risk of treatment drop out. The model included participation of various providers of DOT services: patients' organizations, social workers and primary health care. The main principles used to help TB patients: a comprehensive patient-centered approach that

provides social and medical services, daily delivery and consumption of anti-TB medicines under supervision of a DOT service provider, as well as funding aimed at treatment outcomes. A comprehensive patient-centered approach envisaged individual approach to every client for solving social and psychological issues, renewing documents, rehabilitation, employment assistance, legal assistance, moneyed assistance, and integration of health services, especially for patients with coinfection TB / HIV.

The funds were utilized to achieve the result providing bonus payments (motivation) for providers of DOT-services (social workers, nurses, family doctors). Motivation was provided in two stages: during treatment (for continuous treatment of TB patients) and at the end of treatment in case of successful result confirmed by laboratory tests. The patients were also motivated based on the results of treatment with food packages in three stages: during treatment, in case of completion of treatment and after laboratory confirmation of successful treatment.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

The results of the project: 21 patients' organizations involved in 17 regions of Ukraine. Comprehensive approach to provision of assistance covered 2 712 patients with drug-sensitive TB, 652 of them being with co-infection TB / HIV (24% of the total). The effectiveness of treatment of patients with sensitive TB reached 96%.

### **LESSONS LEARNED AND RECOMMENDATIONS**

The patient-centered approach in TB treatment in outpatient settings has proved its effectiveness. In 2018 – 2020, it is planned to continue the project: to increase coverage of patients to 12 000 and to engage patients with drug-resistant TB.

### **ANNEXES**

Additional materials will be provided upon request

## 21.4 TITLE OF THE PROGRAMME: Support and institutional development of TB communities

### CONTACT PERSON

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- **Programme is being implemented since:** 2018
- **End date of the programme:** 2019
- **Responsible parties:** Civil Society
- **Population reached:** People living with HIV, People who inject drugs, Prisoners and other populations in closed settings, Migrants (documented and undocumented), Refugees or internally displaced populations, Women and girls, Young people/adolescents
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** Yes. The Order of the Cabinet of Ministers of Ukraine dated March 22, 2017 No. 248-p Strategy for ensuring a sustainable response to the TB epidemic, including chemoresistance and HIV / AIDS, for the period up to 2020, and approval of a plan of measures for plan its implementation

### BACKGROUND

In 1993, the WHO declared TB a global problem. Every year, almost half a million people die of this disease, the vast majority of them are residents of developing countries. The WHO program envisages the end of TB until 2035. Although, in recent years, the prevalence of TB in Ukraine has declined, but so far Ukraine is still among countries with high prevalence of TB and its drug-resistant forms. In 2014, Ukraine entered the top five countries with the highest level of multidrug-resistant TB.

Over the past 15 years, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) has provided Ukraine with financial support for implementing TB control programs. The state in its turn took the responsibility to ensure the transition to financing of TB programs at the expense of the state budget, reflected in the Strategy No. 248-r of the Cabinet of Ministers of Ukraine of March 22 2017, providing a sustainable response to TB epidemic, including chemo-resistant, and HIV / AIDS for the period until 2020.

The communities of people affected by the epidemic and active public organizations working in the sphere of TB control are important driving force in overcoming the TB epidemic in Ukraine. They best of all understand and know the existing needs and barriers. Therefore, in order to change the situation for the better, they should be involved in the processes of planning and implementing policies in overcoming TB in Ukraine. Moreover, we have a positive experience – we have founded a community of people living with HIV in Ukraine.



In Ukraine, there have been many attempts to mobilize people affected by TB epidemic. In our opinion, the main shortcoming of this activity was the vertical principle of mobilization of TB community, which provided for implementation of the strategy of individual leaders without sufficient horizontal communications at regional level with a community and their needs. Therefore, in the framework of the project, the efforts will be aimed at support and development of the TB community capacity, involving patients' organizations and TB community leaders in the development of national and regional policies in the sphere of TB control, promoting the best world models of prevention and treatment, and ensuring the sustainability of programs for local budgets.

## **DESCRIPTION**

In January 2018, the Network together with the charitable organization "Light of Hope" started active mobilization of the community to overcome the TB epidemic in Ukraine. As of now, the community development strategy is primarily aimed at strengthening the advocacy capacity and skills of TB community leaders, so that their impact on local and national TB policies can be increased. In order to involve a representative of the TB community in advisory bodies and groups on reforming the health system at the national level, an appropriate package of documents has been submitted for admission of one of the most significant and recognizable leaders of the TB community into the National Council for TB and HIV / AIDS. Among health workers, TB community leaders in the regions are working to reduce stigma and discrimination of TB patients and populations vulnerable to TB. In order to ensure the sustainability of services, which are so far provided using the funds of international donors, TB community leaders are working to change the staff schedule of healthcare facilities and to introduce the position of social workers who manage patients at the outpatient stage of treatment.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

Currently the TB community consists of more than 500 members. The organization TBPEOPLEUKRAINE is registered, its representatives being in 24 regions of the country. Leaders of TB community in the regions are included in the consultative and advisory bodies of local self-government; they are engaged in the analysis of local policies and the expediency of utilization of the budget funds. They also provide assistance to TB patients during the inpatient and outpatient stages of treatment. A wide information company has been launched with the aim to promote patient-centered models for treatment of all forms of TB according to the best international practices, as well as to develop TB community in Ukraine. In most regions, social services procurement is already being implemented or planned to be for management of TB patients at the expense of local budgets.

## **LESSONS LEARNED AND RECOMMENDATIONS**

The joint TB community has become a catalyst for changes in overcoming the TB epidemic in Ukraine. Activities of the TB community will be implemented until the complete defeat of TB in Ukraine.

## **ANNEXES**

Additional materials will be provided upon request

## 21.5 TITLE OF THE PROGRAMME:

Result based financing (RBF) for DOT provision for TB patients at ambulatory phase

### CONTACT PERSON

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- **Programme is being implemented since:** 1<sup>st</sup> January 2017
- **End date of the programme:** 31<sup>st</sup> December 2017
- **Responsible parties:** NGO
- **Population reached:** Patients with diagnosed TB or DR-TB
- **Has the programme been evaluated/assessed?** Yes. Program Staff
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

While there are no significant regulatory obstacles in Ukraine to the transition to outpatient TB care model, there are certain obstacles to introduction of outpatient TB care: TB treatment facilities do not have the sufficient number of visiting nurses to provide observed treatment to all patients, and primary health care facilities are mostly not involved into the treatment process, despite the fact that it is part of their functions. Considering that it is easier to organize observed treatment in inpatient units, patients are often admitted to hospitals without sufficient indications or are kept in inpatient facilities longer than needed, which leads to increase in the cost of patient treatment and causes hospital-associated transmission of drug-resistant TB forms. One of the reasons of such situation is lack of motivation among health care workers and heads of primary health care facilities to organize and conduct TB treatment.

### DESCRIPTION

This pilot project stipulated new way of financing observed outpatient treatment. Implementing health care facilities (HCF) got payment for every patient who received treatment in outpatient settings (payment for services). The set indicators contributed to increased treatment success rate (completion of treatment with the results "cured" or "treatment completed") and to efforts to form adherence to treatment among patients (the higher the adherence of a patient to treatment, the fewer money is spent to retain such patient in care). Additional incentives (payment for results) were paid to HCFs for performance of indicators; within certain boundaries, HCFs were able to decide how to spend money at their own discretion. 14 rayons (regions) of Odesska oblast took part in the project. Before the start of the project all of them had poor treatment results of both susceptible and drug resistant TB and high rates of treatment

interruption (up to 43% in DR-TB and up to 14% in susceptible TB patients). Goals of the pilot project:

- introduce RBF model to organize the process of observed TB treatment of patients at the outpatient stage and study its efficiency;
- increase the number of TB patients who receive TB treatment in outpatient settings;
- help HCFs to get prepared to work within different financial models (payment for performance)

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

482 patients were enrolled on DOT during the 2017 (422 with susceptible TB and 60 with DR-TB). One rayon (Izmail-city) could not organize DOT and refused to participate. Since the project lasted only one year, we can assess treatment results only of 1st and 2nd cohorts 2017 (susceptible TB) - 93% of treatment success. Project demonstrated that PHC Centers are able to provide DOT to TB/DR-TB patients, but they need preliminary training and motivation. RBF approach is good motivation for PHC Centers. Bringing medical care closer to the patients allowed reducing costs for patients' support twice in comparison with another all-Ukrainian project, and achieving better treatment results.

### **LESSONS LEARNED AND RECOMMENDATIONS**

Project demonstrated that PHC Centers are able to provide DOT to TB/DR-TB patients, but they need preliminary training and motivation. RBF approach is good motivation for PHC Centers. Bringing medical care closer to the patients allowed reducing costs for patients' support twice in comparison with another all Ukrainian project, and achieving better treatment results.

### **ANNEXES**

Printed article in Ukrainian scientific and practical specialized journal "TB. Lung diseases. HIV-infection". #1(32) 2018

## **IV. LATIN AMERICAN AND CARIBBEAN STATES**

## 22. GUYANA

### TITLE OF THE PROGRAMME: TB/HIV Collaborative Programme

#### CONTACT PERSON

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- **Programme is being implemented since:** 2002
- **End date of the programme:** /
- **Responsible parties:** Government
- **Population reached:** People living with HIV
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

Guyana has a population of approximately 747,884 (2012 population census) with a land mass of 215,000 km<sup>2</sup> extending along the north-eastern coast of South America. It is the only English speaking country in South America and is bordered by Suriname, Brazil and Venezuela, as shown in figure 1 below.

Figure 1: Map of Guyana There are 10 Administrative regions (1-10) in Guyana, with general primary health care service and delivery available in each region. The country is further divided into coastland and hinterland regions where most of the population (89.1) is concentrated in the coastal areas (regions 3, 4, 5 and 6). (Guyana AIDS Response Progress Report 2015) Regions # 4 has the largest population by geography as compared to the other 9 administrative regions with the main Chest clinic and HIV Care and Treatment Site. Each site has its own independent service that caters for people residing in and around its environs. Tuberculosis (TB) is a contagious disease caused by the bacteria Mycobacterium Tuberculosis. When a person with TB coughs, sings, sneezes, speaks or spits, the TB bacteria are expelled into the air. The goal as recommended in 2016, is to end the global TB epidemic by implementing the End TB Strategy. Adopted by the World Health Assembly in May 2014 and with targets linked to the newly adopted SDGs, the strategy serves as a blueprint for countries to reduce the number of TB deaths by 90% by 2030 (compared with 2015 levels), cut incidence by 80% and ensure that no family is burdened with catastrophic costs due to TB Global TB report, 2015, WHO (Global Tuberculosis Report 2015).

The HIV epidemic has increased the burden of TB globally, especially in populations where the prevalence of TB infection is high among young adults. In Guyana, according to the 2016 WHO Global report, in 2015, 85% of 668 TB patients knew their HIV status, 25% of them were HIV-

positive, and 78% were on ART. TB is one of the most commonly occurring opportunistic infections among HIV-infected persons in Guyana. HIV is the most powerful factor known to increase the risk of progression from TB infection to TB disease and to death; for a person dually infected with HIV and M. Tuberculosis, the lifetime risk of developing TB is about 50%. Guyana has adopted the WHO recommended TB/HIV collaborative activities which comprises of three major components (1. Establish and strengthen the mechanisms for delivering integrated TB and HIV services; 2. Reduce the burden of TB in people living with HIV and initiate early antiretroviral therapy and; 3 Reduce the burden of HIV in patients with presumptive and diagnosed TB) with support from the Government of Guyana, the Global Fund, Center for Disease Control, UNAIDS etc., since it requires financial, technical support and other resources to provide services from diagnosis to treatment and patient support.

### **DESCRIPTION:**

The overarching objective of the National Tuberculosis Programme is to decrease the morbidity and mortality associated with Tuberculosis in Guyana, with a Mission statement being: To reduce the incidence and prevalence of tuberculosis and to mitigate its impact through a multisectoral response that provides high quality and equitable prevention, treatment and support Services. Description: In 1994 the Government of Guyana (GoG) through the Ministry of Public Health (MoPH), recognized the need to revamped the National Tuberculosis Programme (NTP) based on recommendations from WHO/PAHO and the World Health Resolution of 1993, declaring TB a global emergency. The Ministry initiated this process by reviewing the existing functions of the NTP and establishing a structure to reform the national TB control services.

Units within the NTP:

- TB/HIV - TB Care and Prevention
- Laboratory Detection and Diagnosis - Health Systems Strengthening
- DR /MDR-TB
- Administrative
- Basic Management Units (BMUs)

Features of the NTP:

1. Coordination: The National tuberculosis Programme (NTP) unit within the Ministry of Public Health (MoPH) Department of Disease Control is guided by a National Tuberculosis Strategic Plan. Central and regional supervision at all levels of the NTP is carried out and on a daily/monthly/quarterly basis or as necessary. Additionally, the procurement and supply of drugs, diagnostic materials and equipment is done through the materials management unit (MMU) of the MoPH.
2. Surveillance, Monitoring and Evaluation (M&E): Standardized surveillance tools available at established TB clinics to facilitate accurate recording and reporting of information, also epidemiologic surveillance of TB and TB/ HIV co-infection at all Basic Management unit (BMUs), including the prisons. Facilitates operational research and other analytic TB studies.
3. Clinical Management: The Guyana TB Manual, 2015 is made available at all levels and across public and private sectors of the health system to guide physicians and other health care workers in TB and TB/HIV care and management. A nationwide network of microscopy and radiological services, both at the central and primary health care level provides quality and timely services to the general public. Care and treatment services for TB and HIV/TB cases within the public health system are available with appropriate and unique services, with priority for Directly Observed treatment (DOT), administered by TB Field outreach workers/ volunteers.
4. Training: Training programme covering all aspects of TB prevention, screening, diagnosis, care, treatment and support. Mentorship and case presentations for new physicians/nurses are ongoing.

Activities within the NTP:

- Early case detection across the health system
- Provision of TB treatment in accordance with the National TB Manual- Guyana, 2015
- Staff training on all aspects of screening, diagnosis and clinical management of TB and TB/HIV
- Health information, education and communication on TB - TB laboratory services and other supportive diagnostic testing
- TB care and management
- Contact tracing and investigation
- Lost to follow-up tracking of patients
- Recording and reporting for surveillance and M&E
- Enabling environment for support (support groups, enabler support etc.)
- TB/HIV collaboration
- RR MDR-TB management
- Prison collaboration
- Research

Direct spending on tuberculosis interventions through the Ministry of Public Health includes human resources and infrastructure, laboratory and diagnostic resources, training and prevention initiatives. There has been constant increase of Government of Guyana (GoG) financing of the programme over the past years. The NTP has already taken steps to ensure that the expansion of efforts realized through the Global Fund Programme throughout the years will be sustained by the GoG once funds have decreased. As shown in figure 2 below, the highest number of TB cases remains in region 4, contributing to approximately 60% of all TB cases in the country. However, region 1 reported the highest incidence per 10 000 population, over the past years. The demographics of the disease have also remained relatively unchanged over the past few years, where males continue to be more affected: an almost 2:1 ratio, and the age groups most affected being 25 – 54 years.

### **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME:**

HIV is a strong risk factor for developing TB disease in those with latent TB infection, as a mandate all People living with PLHIV, whenever they receive care, should be regularly screened for TB disease using the algorithm at every visit to a health facility. Below figure shows the TB/HIV co-infection data from 2011 to 2017 which demonstrates that over 90% of the new TB cases were tested for HIV through the years, with over 20% co-infection rate. The sero-prevalence in TB cases remains constant. HIV testing in TB cases continues to be one of the NTP's best practices since the implementation of the WHO collaborative activities.

Figure 3: TB/HIV co infection, HIV sero prevalence in TB cases, and proportion of TB cases tested for HIV, 2011-2017. (NTP report 2017)

Figure 4: TB key populations, 2010-2017 (NTP report 2017) As shown above in figure 4, TB/HIV co-infection among the key population still poses a major challenge for the management of TB for the NTP. With sero-prevalence rates of also over 20% each year; this group of patients continues to receive comprehensive care at the chest clinics.

Figure 5: Treatment outcomes, percentage of TB/HIV cases, 2010-2016 (NTP report 2017) As shown in figure 5 above, TB/HIV cases successfully treated fluctuates over the years; however the death rate decreased significantly with 7% in 2016 as compared to 19 % in 2012. This can be mainly attributed to the improved collaboration within the National AIDS Programme Secretariat (NAPS) and NTP in the area of management and care, offering enabler support, DOT/HAART and support groups.

## **LESSONS LEARNED AND RECOMMENDATIONS:**

### Lessons learned:

- The increased collaborative efforts between NAPS and the NTP coupled with the roll out of the 90, 90, 90 initiative should further decrease the TB/HIV co infection rate.
- Shorter second line TB regimen for the RR MDR-TB cases, so as to promote adherence, decrease pill burden and early treatment outcome.
- Inclusive of more community TB and HIV services, with emphases on prevention through sensitization and outreaches.
- Social protection and enablers for the patients with difficult circumstances hence, aimed at meeting the 0% of catastrophic cost due to tuberculosis. Recommendation
- Strengthen the TB/HIV collaborative activities, focusing on the WHO 12 points initiative
- Governments commitment for improved services through timely and adequate supply of drugs, equipment and medical supplies
- Inclusiveness of more civil society organizations (CSOs) to bridge the gaps in areas that have not been reached fully, promoting equality of service delivery.
- Health system strengthening
- implementation of the TB electronic register to enhance TB case surveillance and reporting.
- Research, especially in the key population group so as the embrace and implement best practice initiatives and lobby for improved care, management and support.

## **ANNEXES**

N/A



## 23. HAITI

### TITLE OF THE PROGRAMME: HIV/AIDS Tuberculosis Assistance for Prisoners of Haiti

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- **Programme is being implemented since:** 2009
- **End date of the programme:** /
- **Responsible parties:** Civil Society
- **Population reached:** Prisoners and other populations in closed settings
- **Has the programme been evaluated/assessed?** Yes. It was evaluated by USAID with the Site Improvement through Monitoring Systems (SIMS). SIMS data aims to increase the impact of PEPFAR programs on the HIV epidemic through standardized monitoring of the quality of PEPFAR support at the site level.
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

Haiti remains the country with the highest incidence in the Americas (nearly 15,582 cases detected in 2016) with an estimated incidence at 200 for 100000 for general population and 100 for 10000 in prisons. Health through Walls, a non-governmental organization with unique expertise and experience in prison health, has implemented the goals and objectives that will reduce and control contagious disease among this vulnerable population. Health through Walls has conducted medical examinations and created medical files for each prisoner and during medical blitz realized in other prisons. Hard and electronical medical files have been created and medical exams have been conducted by medical doctors including psychiatric consultation, and symptom screening for infectious and chronic diseases. Since 2009, Health through Walls (HtW) has worked in prison settings in Haiti, its program provides treatment and care to prisoners infected with HIV/AIDS and Tuberculosis to 17 prisons and 4 clinics. HtW with collaboration with AIDS Healthcare Foundation (AHF), has an external Clinique in Port-au-Prince for the families of affected prisoners, Klink Solidarite and 3 mobile clinic, North, South and Artibonite.

HIV prevalence inside Haiti's prison system is 4.3 percent, which is high compared to the national average of 2 percent. Haiti counts around 11780 prisoners in 17 prisons out of which 340 are women. This prevalence can vary though between 4-14 percent depending on the

prison. The lack of proper preventive and clinical services, together with overcrowded conditions, results in prisoners being four times more likely to develop TB and other opportunistic infections associated with HIV than the general population. The high transmission of disease within prisons, and failure to adequately manage them, creates risks for prisoners and prison staff, and poses a public health threat to the communities in which they live and return to. Prison personnel are often the first to recognize potential disease risks or illnesses among prisoners. Therefore, the education of prison personnel on the signs and symptoms of disease, and the appropriate actions to take, can significantly improve the health of prisoners and staff. When disease prevention, screening, care, treatment, and behavior change activities are implemented within prisons, the benefits of those activities can be farreaching, impacting families and communities beyond the prison walls.

Currently HtW implements interventions in 11 prisons (around 11190 inmates) with a fixed staff and an infrastructure ensuring adequate care. These screening activities for tuberculosis, HIV and syphilis will be done daily in the prison with a fixed staff. For satellite prisons such as Jacmel, Carrefour, Petit-Goave, Mirebalais, Aquin they will benefit a weekly visit according to a scheduled agenda. Interventions in the communities through the 3 mobile clinics are done daily in a predefined area; so that this target is visited at least twice a month.

## **DESCRIPTION**

USAID/Haiti's PEPFAR funded Health through Walls' activities contribute significantly to improving health outcomes in Haiti through the provision of life-saving care and treatment services. But to close the gap and achieve epidemic control in Haiti, activities must continue to target those most-at-risk of contracting and spreading HIV, including prisoners, who are a high-risk, priority population. In addition, index case testing or partner testing, which includes contacting and testing all sexual partners, family members, and relevant contacts of HIV positive prisoners, is an effective strategy for case finding, particularly among children. The primary objective of our program is to provide HIV and related health care services within the Haiti prisons for preventing, identifying, diagnosing, and treating HIV/AIDS and related opportunistic infections. Our program activities will provide essential health awareness and education on HIV/AIDS and TB prevention, care, and treatment to prisoners at the targeted sites, and mitigate the impact of these diseases in the broader population by reaching HIV positive prisoners' family members with HIV and related services. Our activity will also expand index case testing within supported sites.

In light of reduced overall PEPFAR funding levels in Haiti, it is essential that we identify efficiencies to expand services to more prisoners, their family members, and sexual partners. With the support of AIDS Healthcare Foundation (AHF) Health through Walls employ innovative service delivery models – including roving clinical teams to provide services in multiple prisons and scaling up the use of mobile units to conduct index case.

Our three main objectives of the program are:

Objective 1: Provide quality HIV prevention, testing, and treatment services for prisoners, including TB prevention and screening. HtW provide comprehensive health examinations, including voluntary HIV/AIDS counseling and testing and TB screening, for all inmates within the selected prisons and satellite sites and schedule follow up visits as necessary. Clinical personnel create a medical file for each prisoner, which is converted into an electronic format and integrated within the Ministère de la Santé Publique et de la Population (MSPP) national health information system (SISNU). Using a mobile, digital x-ray machine, we conduct TB screening when possible, organize systemic screenings of each prisoner, and arrange follow-up care. Prisoners who test positive for HIV receive an integrated package of antiretroviral (ARV) treatment and palliative care and we provided TB screening and isoniazid preventive therapy (IPT) as appropriate. ARV and TB treatment protocols will follow MSPP and PEPFAR guidance

and guidelines. HtW ensure fast tracking and sequestration plans for all TB suspected cases at supported sites and conduct test verification on positive TB digital x-ray results by bacilloscopic or GeneXpert. HtW liaise closely with the Global Fund to ensure all TB confirmed cases receive appropriate medical care and treatment. Inmates will be monitored at appropriate intervals to ensure clinical stability and adherence to treatment and will be screened and treated for opportunistic infections as necessary. Upon their release from prison, the HtW Discharge Planner will work together with HIV positive prisoners receiving ARV and active TB cases to connect them to appropriate medical services within their community and confirm to the extent possible former prisoners' adherence to treatment and follow-up services. Linkages will be established with Klinik Solidarite or private and public health centers.

Objective 2: Provide HIV prevention, testing and treatment services to HIV-positive prisoners' sexual partners, families, and within communities where large numbers of HIV positive individuals are identified. HtW expand index case testing of sexual partners and family members of HIV positive and TB-confirmed prisoners according to the MSPP policies and protocols. Prisoners testing positive are counseled on the importance of testing and linking to treatment and encouraged to provide contact information for their family members and sexual partners. We then contact these individuals and (without disclosing the status of the positive prisoner) arrange to provide their contacts with a free health exam that includes voluntary HIV counseling and testing services via outpatient services at Klinik Solidarite or mobile units. Positive partners and/or family members will receive ARV treatment from Klinik Solidarite and the mobile units. We also support outpatient testing and treatment services to released HIV positive and TB co-infected prisoners via Klinik Solidarite and the mobile units. In addition, we provide prevention messaging and blitz testing in communities where large numbers of people infected by HIV and TB are identified through index case testing and other means. For those HIV positive prisoners, partners, and family members who receive treatment via Klinik Solidarite or mobile units, HtW is responsible for monitoring adherence to treatment services and outcomes, including viral suppression.

Objective 3: Improve the knowledge and skill level of prison healthcare personnel, security personnel, and prisoners in the prevention, diagnosis, and treatment of HIV, TB, and opportunistic infections. Within all supported prisons HtW implement peer education programs carried out on a weekly basis to address the knowledge, attitudes, and practices underlying the transmission of HIV and TB. Prison peer educators trained to coordinate group sensitization sessions that generate demand for HIV testing services and increase prisoners' understanding and awareness of these diseases. Peer educators is closely monitored to ensure correct dissemination of information. We also work closely with the Direction de L'Administration Pénitentiaire (DAP), the United Nations, and other partners on an ad hoc basis to conduct training for prison personnel on policies and procedures pertaining to health care delivery and personnel safety within the prison. We also provide in-service and/or refresher training to health workers in HIV and TB prevention (including IPT) and treatment according to national protocols, will train lab personnel in HIV rapid testing, GeneXpert, viral load testing, etc. Finally, we work closely with USAID, Global Funds, AIDS Healthcare Foundation and other partners to respond to any outbreaks that may jeopardize the lives of the prisoners.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

HIV Prevalence in prisons (programme data): 3.2% 6083 prisoners have been tested for HIV out of which 860 were found positive. The estimated number of PLHIV in prisons is 1402. 2753 prisoners were screened for TB out of 385 had TB and 54 co-infected HIV/TB. All patients have been treated for TB. The programme has a cohort of 860 HIV patients which represents 61% of the 1st 90. 840 HIV positive inmates are on ARV and this represents 97% for the second 90 and 580 had a viral load suppressed 69% of the 3rd 90.

## **LESSONS LEARNED AND RECOMMENDATIONS**

The HtW model, which includes 1) health blitz, 2) peer education, 3) testing and screening, and 4) care management and follow-up, provides a unique opportunity to strengthen the healthcare infrastructure within prisons in resource poor countries that do not have rigorous healthcare systems.

A “health blitz” provides an opportunity to serve 100% of an incarcerated population within a prison and is an effective model to create medical records and gather critical baseline clinical information on patients. The “health blitz” model can also greatly increase testing rates that routinely identifies undiagnosed HIV positive individuals within prisons. HtW has been able to improve the treatment protocols for individuals living with HIV in prison including case monitoring and support, initiation of ARV, nutritional support, TB prophylaxis therapy, and/or treatments for STIs and document positive clinical outcomes (based on viral load and/or CD4 measurements).

By utilizing a peer-based health education program within the prisons, HtW has documented that peer education is feasible and has a positive impact on reducing stigma and increasing testing uptake within these prisons. It takes time and patience to develop relationships with prison authorities in order to win support and gain access to prisons within resource poor countries. In this context, HtW has successfully developed working relationships with necessary key correctional authorities in order to gain and maintain access to the prisons they serve. They receive requests from other countries to expand the model.

HtW has developed a very collaborative approach toward prevention and care in prisons they serve that includes relationships with important local NGOs and healthcare providers. This is also valuable in discharge planning.

By hiring and training in-country staff, HtW is further creating a sustainable model of prevention, testing and care delivery in prisons in resource poor countries.

Information and Technology systems within prisons of resource poor countries can be lagging or non-existent, thereby creating barriers to identifying clients for services and tracking their progress. Care Management assists this process.

Community follow-up after incarceration can be one of the biggest challenges in continuity of care and is especially difficult in resource poor countries, yet HtW has results as good as, or better, than high income countries.

The results obtained in this fight are fairly encouraging because the figures are constantly decreasing in Haiti and is convinced that the global commitment to eliminate TB by 2050 is achievable, while being aware of the challenge in Haiti to reduce the percentage of deaths that is too high, which is now 5%.

Some challenges:

- Poor Nutrition: Sometimes they feed the inmates once day, and some of them with no food and they are not able to take their medication as they are hungry.
- poor ventilation, overcrowded cell
- Poor Sanitation • Follow-up of patients after release or Contact Tracing
- Lack of Medication
- Limited Fund

## **ANNEXES**

Graphics sent separately to illustrate Results, outcomes and impact of the programme

## **V. WESTERN EUROPEAN AND OTHER STATES**

## 24. NETHERLANDS

### TITLE OF THE PROGRAMME: HIV/AIDS Tuberculosis Assistance for Prisoners of Haiti

#### CONTACT PERSON

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- **Programme is being implemented since:** 2016
- **End date of the programme:** /
- **Responsible parties:** Government, Civil Society, Private sector, Academic institution
- **Population reached:** People living with HIV, Healthcare professional working in the field of Tuberculosis and HIV
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

The epidemics of tuberculosis (TB) and human immunodeficiency virus (HIV) are closely linked, as HIV infection is the main risk factor for progression from latent TB infection (LTBI) to active TB disease. Globally, 11% of the 10.4 million new TB cases in 2016 were HIV-infected, and 22% of the 1.7 million TB deaths were among HIV-infected patients (1). Both the absolute number and the proportion of HIV-infected TB patients are however declining in the world due to successful HIV prevention programmes, and increased access to antiretroviral therapy. In the Netherlands, the number of TB patients declined from 1800 in 1994 to 787 in 2017, when the lowest number was recorded since notification became mandatory in the 1950s. Since 1993, HIV co-infection has been a variable in the Netherlands Tuberculosis Register (NTR). Figure 1 shows that during the 1990s on average 59 HIV-co-infected TB patients were notified, which declined to an average of 23 per year in the last five years. The proportion of HIV-co-infected TB patients decreased from 3.9% in the 1990s to 2.8% in the last five years. The World Health Organization (WHO) recommends collaborative TB/HIV activities to establish and strengthen the mechanisms for delivering integrated TB and HIV services; reduce the burden of TB in people living with HIV and initiate early antiretroviral therapy; and reduce the burden of HIV in patients with presumptive and diagnosed TB (2)

## DESCRIPTION

A TB/HIV Platform was started in the Netherlands on 1/12/2016 (World AIDS Day) with 16 interested clinicians and public health professionals working in TB and HIV control. The objectives for the Platform were defined as: i) to share knowledge on both diseases; ii) to discuss management of TB/HIV patients; iii) to improve collaboration between professionals working in TB and HIV clinics and programmes; iv) to systematically collect data for operational research (3). In 2017, another physical meeting and a teleconference were organized.

## RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The Dutch TB/HIV Platform in its terms of reference, objectives and composition addressed coordination, planning, monitoring and evaluation of TB/HIV activities as recommended by WHO. Furthermore, three topics researched by the TB/HIV Platform participants were discussed during the three meetings, i.e. :

- HIV-co-infected TB patients. The proportion co-infected TB patients was 3.1% among all notified patients and 5.6% among those with a known HIV status in 2011-2015. Patient records of 123 TB/HIV patients were studied, of which 66 (54%) patients had been diagnosed with HIV more than 1 month before the TB diagnosis, while the others were diagnosed with both TB and HIV during the present disease episode (4). Among the patients with known HIV infection, 29 (44%) had been diagnosed with HIV more than 5 years before the TB diagnosis, 46 (70%) were on antiretroviral therapy, and 14 (21%) had a history of previous TB treatment (4). We are now investigating how TB can be better prevented in patients with known HIV infection (see also next paragraphs).
- HIV testing of TB patients. The proportion of TB patients with known HIV status in the NTR increased from 20% in 2006, but levelled off to around 50-60% in 2013-2015, despite the National TB Control Plan and national guidelines recommending routine HIV testing (5-6). Due to a study improving HIV data entry in the NTR, the proportion of TB patients with a known HIV status in 2015 increased to 73.2% (7) and was sustained in 2016 when reporting institutions were reminded about HIV data incompleteness of TB patients.
- Latent tuberculosis infection (LTBI) screening of HIV-positive persons. This has been a controversy in the Netherlands. The Dutch TB/HIV guideline was amended after research showed that clinicians did not agree with the recommendation to screen all newly diagnosed HIV-positive individuals for LTBI. The current recommendation is to only screen HIV-positive individuals from high TB-incidence countries or with known exposure to TB (5). Currently, in several hospitals the new guideline is implemented, and supported by research to be informed about the yield of LTBI screening and document good practices and challenges.

Table 2 provides an overview of the key indicators collected in the National TB Register and in the Dutch HIV Monitoring Register, enabling the country to monitor the WHO recommended TB/HIV collaborative activities.

### References:

1. Global Tuberculosis Report 2017. Geneva: World Health Organization; 2017.
2. WHO Policy on Collaborative TB/HIV Activities: Guidelines for National Programmes and Other Stakeholders. Geneva: World Health Organization; 2012.
3. de Vries G, van den Hof S, Op de Coul E, van Crevel R. Closing the gap in surveillance of tuberculosis and HIV coinfection, and the need for clinician-public health alliances. *Eur Respir J*. 2018;51(3).
4. de Vries G, van Crevel R, Erkens C, Gavric A, Mensen M. Tuberculose en hiv in Nederland. *Tegen de Tuberculose*. 2017;113(1):3-6.
5. CPT-Richtlijn Tuberculose-HIV. Den Haag: KNCV Tuberculosefonds; 2016.  
<https://www.kncvtbc.org/kb/3-14-richtlijn-tuberculose-hiv/>.

6. National Tuberculosis Control Plan 2011-2015. Bilthoven: RIVM; 2010.
7. Arnoldussen M, Schimmel H, Op de Coul E, van den Hof S, de Vries G. Tuberculosis patients with unknown HIV status in the Netherlands: analysing underreporting and lack of testing. *Eur Respir J.* 2017;50(5).

#### **LESSONS LEARNED AND RECOMMENDATIONS**

TB/HIV collaborative activities can effectively be implemented in a country where both diseases are not very prevalent. Key is that surveillance systems are in place to monitor both diseases, including the WHO-recommended indicators, and that a platform is available to discuss optimization of treatment and efforts to further reduce both diseases.

#### **ANNEXES**

N/A



## VI. MULTIPLE COUNTRIES

## 25. KAZAKHSTAN, NIGERIA AND PHILIPPINES

### TITLE OF THE PROGRAMME: Improved TB Care and Outcomes for PLHIV and at risk of acquiring HIV in Southern Africa

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- **Programme is being implemented since:** 2016
- **End date of the programme:** 2019
- **Responsible parties:** Government, Civil Society, Private sector
- **Population reached:** People living with HIV, People who inject drugs, Prisoners and other populations in closed settings, Migrants (documented and undocumented), Refugees of internally displaced populations, Children, Women and girls, Young people/adolescents, MSM and transgender & the urban poor
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

The 'Improved TB/HIV prevention & care - Building models for the future' (BMF) project is working to improve TB and HIV prevention and care in line with the Global End TB Strategy and its call for a "paradigm shift" in order to end TB by 2030, the Fast-Track Ending AIDS by 2030 Strategy, and the Sustainable Development Goals.

TB remains the leading cause of death for people living with HIV (PLHIV). Of the globally 36.7 million PLHIV, approximately 47% do not have access to treatment, and 30% do not know their status. For many of them developing TB disease might be the first indication of having contracted HIV. The World Health Organization estimates that approximately 4 million persons with TB are "missed" by programs worldwide. Country experience shows that in many cases up to 70% of these "missing persons with TB" are in contact with health service providers (informal or formal; public or private) who are not formally linked to the national programs, and thus are neither reporting, nor being quality assured, and might or might not be aware of the need to offer TB and/or HIV services to their clients.

Barriers to accessing affordable quality care are multi-layered and complex. Ensuring availability, physical proximity, and subsidized or free provision of actual services, while important components, are often only a small contributor to the solution. Many vulnerable and at risk populations struggle with additional overwhelming barriers such as transportation costs,

necessary significant time investments (= loss-of-income), stigma, discrimination, legal (e.g. undocumented migrants, drug users, etc.), trust, and similar. It is important to understand the “who” are we missing and the “why” are we missing them within this particular group-in-need in order to adequately and effectively remove access barriers. This is why a multi-disciplinary and holistic approach beyond the pure bio-medical/ clinical, psychosocial or socio-economic, etc. must be employed.

## **DESCRIPTION**

Funded by the Dutch Ministry of Foreign Affairs (DGIS), KNCV in collaboration with AFEW International, Hivos and PharmAccess International, launched the BMF project to safeguard and optimize investments through the Global Fund (GF) mechanism and their underlying development principles, such as “access for all” to affordable, adequate, quality care, and gender equality and empowerment, reduction of stigma and discrimination.

The design and interventions focus on system related barriers to quality care in the non-governmental and private health care delivery sectors, and removing human rights and gender related barriers to TB and HIV care and prevention. The aim is to ensure access to affordable quality care for vulnerable and marginalized key affected populations. The models recognize the gaps as well as the opportunities in service provision and the important role a multi-partner approach can play in providing comprehensive client centred approaches to TB/HIV care. A tailored ‘engaging all providers’ approach is used to engage these actors and create replicable and sustainable partnership models. The unique partnership of the project coalition combines and amplifies diverse skills and experience of dedicated TB, HIV, human rights and quality systems experts to optimally address the complex needs and challenges faced by key affected populations and service providers in their respective contexts. The project design also draws on the individual partners’ complimentary skills, in-country presence, established local partnership networks and capacities as a catalyst for change.

KNCV Tuberculosis Foundation is the world’s leading TB expert organization. Established in 1903, KNCV delivers evidence for policy and technical assistance for impact in TB care and prevention worldwide. KNCV has a presence in all 3 project countries. AFEW International provides technical support to and strengthens the capacity of local NGOs and CSOs to improve health care. AFEW is focusing on Central Asia and supports the Kazakhstan component.

HIVOS is an international humanist organization working to end discrimination, inequality, abuse of power and the unsustainable use of our planet’s resources. The project draws on HIVOS’ work with vulnerable and marginalized KAPs in the Philippines. PharmAccess is an international organization with a digital agenda dedicated to connecting more people in sub-Saharan Africa to better healthcare. For this project, the PharmAccess work on the international accredited SafeCare model and its potential for linking quality standards and accreditation to private sector engagement and ultimately health insurance reimbursement, were chosen as entry point in Nigeria.

The project works with non-public sector actors to introduce and strengthen comprehensive TB and HIV service provision (e.g. screening, diagnosis, and care) and improve treatment adherence and outcomes in an inclusive manner that meets the requirements of international best practices, National Programs and Donors (e.g. Global Fund’s new funding model (NFM)) alike. Through country-informed and tailored models, Private Health Care Providers (PHCPs), Civil Society Organizations (CSOs), and patients’ organisations in Kazakhstan, Nigeria and the Philippines are engaged to attain and align with government endorsed service provision, adopt client-centred TB/HIV service standards and National HMIS reporting, while both CSOs and service users monitor the quality of services with an eye towards the reduction of stigma and discrimination. In Kazakhstan an integrated TB/HIV care network model encourages strong collaboration between the government, civil societies, private sector and international organizations and aims at supporting implementation of the reforms related to strengthening

public/non-public sector partnerships. The model operates at three levels: (1) supporting the mechanisms and legal framework of collaboration between public and private sectors; (2) establishing and strengthening a network of NGOs providing a full range of patient centred activities from prevention & care to advocacy, including legal consultations for patients from vulnerable and key affected populations; and (3) reducing stigma and discrimination, and raising awareness by providing legal support and empowering patients to use photography to show the human face behind the diseases and utilise results to actively engage in critical dialogue with health care providers and policy makers.

The Philippines Partnerships Model, focuses on establishing public-private partnerships between the Philippine Department of Health (DOH) (including city health officials) and different nonpublic sector organizations currently providing TB and HIV services, such as: private clinics, health facilities, and civil society organizations working with, and advocating for the rights of, key affected populations in Metro Manila. The interventions within the model, are designed to: (1) improve quality of care, case finding, and treatment success for TB and HIV in the nonpublic sector from a human rights perspective in accordance with the healthcare protocols and strategies of the Philippine government; (2) facilitate meaningful engagement of civil society and key populations in decision-making and monitoring of TB and HIV services; (3) ensure the long-term financial sustainability of the national response against TB and HIV, by piloting a result-based accreditation and incentive scheme. This is based on the Philippine Health Insurance Corporation, or “PhilHealth”, the public health insurance system with the goal that DOH-certified non-public sector facilities become "one-stopshops" for patient centred TB and HIV care and achieve full accreditation and integration into the PhilHealth reimbursement system. If the pilot proves successful, the Philippine DOH intends to fund and roll-out the model countrywide.

The Nigeria model employs dual but integrated tools (ISTC (1) and SafeCare (2) ) to assess and improve quality of TB/HIV services in the private health sector in Lagos. The aim of the interventions is to demonstrate that the private sector provides affordable, safe, and high quality TB/HIV care, and strengthens the impact of the national and State TB program when actively engaged and supported by the public sector. The model is being developed through: (1) quality measurement and stepwise improvement to ensure quality of service provision in participating private (non-public) healthcare facilities, (2) stimulating increased case finding and increasing access to services, (3) strengthen engagement between public and private sector, and (4) close collaboration with Challenge TB (USAID’s flagship TB project), NTP, and Lagos State Tuberculosis and Leprosy Program (LSTBLP). The model leverages this combined partner expertise to translate into the building blocks of sustainable health systems, exploring health financing options and business approaches, to improve access to quality TB/HIV services in the private sector. The tools and methodology are used to assure quality at the most integral level of implementation and closest to the patient i.e. at health facilities.

Strengthening the integration of TB and HIV care in collaboration with the non-public sector can vastly improve effectiveness of the government’s efforts addressing both diseases. While each model is country-specific and ‘stand-alone’, the partnership between the four international NGOs as well as local civil society and NGOs engaged at the country-level, unites to create a strong voice for key populations and those most at risk for TB and HIV. For example, the collaborative network strongly emphasizes information sharing and encourages learning across models of quality enhancement and countries. In addition, care is taken within and across each model to replicate best practices and lessons learned towards scale-up and across countries as well as integration of feedback mechanisms to share NGO and community perspectives to inform GF processes as well as policy development and governance at national and global level.

1. ISTC – International standards for Tuberculosis Care:  
[http://www.who.int/tb/publications/ISTC\\_3rdEd.pdf](http://www.who.int/tb/publications/ISTC_3rdEd.pdf)

2. SafeCare aims to support basic healthcare providers in resource-restricted settings to go through stepwise structured improvement programs, to deliver safe and quality-secured care to their patients, according internationally recognized standards. <http://www.safe-care.org>

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

In Kazakhstan, partners facilitated the development of a legal framework that allows private health care facilities to provide TB care under the state funded Guaranteed Volume of Free Medical Care (GVFMC), with private clinics now included in the national TB M&E system, in a health insurance system, and actively engaged in ambulatory treatment for TB patients. TB and HIV care services were traditionally only permitted in the public sector, but Healthcare reforms commencing in 2014, expanded outpatient care through integration of TB services into the PHCP sector. Careful analysis of these reforms revealed that they, theoretically, allowed for engagement of private clinics in provision of TB care through the state funded GVFMC. However, uptake of the new provisions and private healthcare sector integration into TB care service networks was hampered due to insufficient information and collaboration mechanisms. Since one of objective of the BMF project is to support the engagement of the private sector in TB care, the project solicited strong support from the Almaty healthcare department actualize private sector engagement in TB care. A strategic plan for public-private collaboration in the provision of TB and TB/HIV care, was developed in 2017 including training of private TB doctors to improve TB screening and diagnosis, and to ensure better integration of private clinics in the public health care system through enhanced communication and collaboration between HIV and TB specialists.. Currently 16 private clinics are certified to provide GVFMC funded TB care in Almaty city. The next step is to scale up to additional facilities and to widen the scope to also include HIV care.

CSOs working with key populations at risk for TB and HIV, are also engaged, keeping in close contact with public and nonpublic health care providers for referral, to support adherence to treatment and to provide psycho-social support (including legal support when treatment is denied). Key results include engagement of 4 NGOs and 16 private clinic providers as well as increased TB screening of more than 18,000 individuals from key populations (including prisoners & ex-prisoners, PLHIV and TB patients, drug users, migrants) for TB including 113 individuals meeting symptomatic criteria and TB positivity rate of 24%. In addition, treatment adherence was provided to more than 150 TB patients and in 2017, civil society engagement resulted in the first TB patient-led NGO in Kazakhstan. Engagement of the private sector increases healthcare system capacity in TB detection and treatment. Enhancing private provider capacity and adjusting the system including M&E are important to ensure access to quality TB care. Favorable legal environments and guaranteed state funding support scale-up of public-private collaboration.

BMF Nigeria uses integrated quality improvement tools (ISTC and SafeCare Standards) to stimulate the improvement of holistic health service delivery and TB/HIV services in supported sites. Following an assessment, the standards identify critical gaps in patient care. A quality improvement plan is developed to address these gaps, with facility staff trained and regular M&E visits conducted to assist facilities in achieve systems improvements in a timely manner. These tools were adopted by the Lagos State government in preparation for its upcoming state-wide health insurance scheme. The network currently includes 60 private healthcare facilities located in 13 local governments (LGAs) in Lagos State with LGA geographies that include sites with a high concentration of at-risk populations (e.g. slums dwellers, migrants, sex workers and PLHIV). All sites are currently engaged with the State TB Program and have a combined monthly patient utilization of more than 40,000 individuals. Efforts to strengthen TB/HIV services include capacity building of staff, provision and management of test kits to avoid stock outs and expiry, improved data capturing and management, provision of required recording and reporting tools and national TB guidelines.

To date, 684 TB patients were diagnosed across the 60 sites. Of these, 635 (93%) were tested for HIV, of which 40 (6%) were found to be co-infected. 33 (83%) of the co-infected patients were initiated on ART which is slightly higher than the national average which stands at 81% (WHO 2017 TB country profile). Partners also developed and digitized a tool and trained screening officers to actively screen presumptive TB patients presenting in out-patient departments identifying them for further screening and evaluation (including HIV screening and GeneXpert testing). By partnering with HIV-focused CSOs effective linkage of co-infected patients diagnosed in stand-alone DOT centers is now better facilitated in order to provide comprehensive HIV services. In addition, tracing of index case contacts started in 2017 with 527 TB patients interviewed and 688 close contacts screened including 101 (14%) children below 6 who were all enrolled on isoniazid preventive therapy (IPT) . Contact investigation identified 89 (13%) persons with presumptive TB of which 9 (10%) were confirmed.

In the Philippines, TB and HIV integration commenced more than eight years ago through the Philippine DOH However, only 84% of people living with HIV (PLHIV) are screened for TB (Joint Program Review 2016); and only 19% of TB patients are screened for HIV (WHO 2017 Global TB Report). With an unprecedented rise in PLHIV in 2017, the DOH declared HIV a national emergency; while the TB incidence is estimated at 573,000 per year (National TB Prevalence Survey 2016). Activities are implemented through 8 clinics including publicprivate mix DOTS (PPMD), sexual and reproductive health and rights (SRHR), hospital-based, stand-alone, and mall-based clinics. LoveYourself is one partner clinic, an NGO focusing on community-powered HIV testing through its community centers. In 2016, LoveYourself began symptom-screening and testing for TB among its PLHIV clients. Presumptive TB patients were referred to DOTS facilities and monitoring of these referrals to DOTS facilities was not part of the protocol.

LoveYourself remained unaware of their referrals' TB status, subsequent adherence to daily TB medications, needed TB follow-ups, and TB contact investigations. In collaboration with the DOH and the Mandaluyong City Health Office, BMF is working with LoveYourself to be a "one-stop shop" for quality TB and HIV disease care. For example, training highlighted an important health system barrier in that the National TB Control Program Manual of Procedure algorithm for GeneXpert testing for PLHIV required two TB symptoms. LoveYourself shifted from 2- symptom screening followed by GeneXpert testing to 1-symptom followed by GeneXpert testing in November 2017. LoveYourself also installed a GeneXpert machine, and secured an initial stock of cartridges, allowing the application of the algorithm to more PLHIVs seen at the clinic. As a result, from February 01 to October 31, 2017, LoveYourself 662 PLHIV were screened for TB; with 193 classed presumptive; and 39 (20%) bacteriologically confirmed; all 39 (100%) started on treatment . When it shifted to 1-symptom followed by GeneXpert testing in November 2017, 485 PLHIV were screened; 181 presumptive; 42 (23%) bacteriologically confirmed; and all 42 (100%) started on treatment.

The intervention also highlighted an unexpected hitch in the current accreditation system. While LoveYourself is already successfully implementing HIV services, they were not deemed eligible for HIV service accreditation, and subsequently service reimbursement, under the PhilHealth HIV package. Subsequent to adding TB services to their portfolio, the clinic achieved PhilHealth accreditation as a PPMD facility with full access to PhilHealth reimbursement for TB services in September 2017. This accreditation enhances the clinic's health facility status under Philippine regulations, making them eligible to also apply for HIV accreditation. This accreditation was finally awarded in April 2018.

## **LESSONS LEARNED AND RECOMMENDATIONS**

The BMF collaboration leverages the respective skills and mandates of each partner which in its sum creates a wealth of opportunities for linking, collaboration and learning. Though each partner has different sets of priorities and often differing philosophies and communication styles there is a consistent adherence to common principles. These are centered around the

importance of amplifying patient and civil society voices particularly for key populations, regular monitoring and review of data to identify weaknesses and areas for improvement, as well as a consistent drive towards health care systems alignment and sustainability starting well before project close out.

For example, each country initiative recognizes the importance of patient trust in their health care provider identifying key barriers related to HIV/TB-related stigma and discrimination. In Kazakhstan, PLHIV discrimination from healthcare workers is identified as a main gap in attaining trust in PHCP service provision. As such, activities to reduce stigma and discrimination among medical staff of PHCPs include trainings, working meetings and information/ education materials. Local NGOs, through a small grant program are also engaged to provide consultations with clients on their rights and options in medical care and cases of discrimination are openly discussed and addressed through working meetings with top management of the 20 partner public and private clinics. This year the project also introduced PhotoVoices as a means for patients to tell their stories, raise awareness, and make their voices heard.

The BMF implementation is also characterized by regular review and monitoring of data to identify areas of weakness and to collectively address solutions for improvement, often drawing from successes seen in other counties. For example in Nigeria community intervention activities across 4 LGAs (advocacy, mobilization and screening) were conducted in 80 small communities to drive demand to 15 low yielding sites. Prior to this intervention, many of these sites reported zero persons diagnosed with TB or HIV even after being supported by the project for over a year. Out of a total of 8,021 people in attendance, 1,876 (23%) were identified as having presumptive TB and 4,117 (51%) were screened for HIV. 31 individuals tested positive for HIV, 7 (23%) of which are co-infected. All the co-infected patients were initiated on treatment in the low yielding sites and the success of this outreach encouraged staff to find more patients within the facility. As BMF starts to plan for its last year of implementation, replication and sustainability of engagement of the non-public sector after project completion is paramount. In each country this requires collaborative engagement with government health structures such as the NTP, DOH/MOH and other state/municipal level authorities. In the Philippines the National Health Insurance Program (NHIP), which is managed by PhilHealth, provides some reimbursement for TB and HIV services. In addition, the DOH NTP provides medicines, supplies, and equipment to partner clinics. Within the duration of project life, partners are motivated and prepared to become accredited with the PhilHealth as providers of the TB package as well as the Outpatient HIV Treatment package. As accredited providers, project clinics will be eligible to receive reimbursements from PhilHealth for either or both benefit packages even after the project. This accreditation process is already completed for LoveYourself clinic (see description above) and under preparation for the other facilities. Similarly, in Nigeria, Lagos state will launch its own health insurance scheme in September 2018, which includes alignment of all vertical programs. This benefit package includes TB/HIV prevention and management. A capitation fee will be giving to empaneled healthcare facilities providing this services resulting in more patients being able to access quality TB/HIV services. All these achievements were only made possible through the unique partnership of the consortium, which brings together the necessary skills and networks required to address the complex needs of people affected by TB and HIV to the common cause. This is further augmented by the ability to not only pool and utilize skills within a given context, but also share the linking and learning across country and regional borders. Experiences and ideas as well as advice are regularly shared between the project countries, for the benefit of all. The project is in its final 1.5 years of implementation. An external evaluation is planned for the final year and once all data is collected and analyzed “lessons learned and best practices” will be documented and published.

**ANNEXES:** N/A

## 26. MULTIPLE COUNTRIES

### 26.1 TITLE OF THE PROGRAMME: HIV testing of patients with presumptive TB

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- **Programme is being implemented since:** 2018
- **End date of the programme:** /
- **Responsible parties:** Government, Civil Society, Private Sector, Academic Institution
- **Population reached:** People living with HIV, Miners (especially exposed to silica), People who inject drugs, Prisoners and other populations in closed settings, Migrants (documented and undocumented), Refugees of internally displaced populations, Children, Women and girls, Young people/adolescents
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

Persons with TB symptoms ("TB presumptives") have been shown to have disproportionate HIV prevalence, and are an effective way to target HIV testing for higher yields. This particular programming requires that HIV programs screen persons for TB in order to identify those who might require HIV testing; as such, it has the potential to enhance both HIV and TB case-finding and bring the TB and HIV programs into better alignment.

#### DESCRIPTION

In the COP18 guidance this year, we are promoting HIV testing of persons with TB symptoms, both in the facility and in the community. This will require HIV partners to develop TB screening as part of the screening for HIV testing. This should substantially increase HIV case-finding, while at the same time increasing TB case-finding. Ideally, this TB screening is coordinated with the National TB Program, as those who are identified as having TB symptoms will be referred to TB diagnostic centers. One potential additional benefit is that the TB and HIV programs will work more closely.



## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

We do not yet have data on this programming, as it was introduced as a part of COP18 guidance.

## **LESSONS LEARNED AND RECOMMENDATIONS**

On the country level, this will require enhanced communication and coordination between the TB and HIV programs, which may have the added benefit of forcing a more productive working relationship (sorely needed in many countries).

## **ANNEXES**

COP18 Guidance

## 26.2 TITLE OF THE PROGRAMME: TB preventive therapy in PEPFAR

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- **Programme is being implemented since:** 2017
- **End date of the programme:** /
- **Responsible parties:** Government, Civil Society, Private Sector, UN or other inter-governmental organization, Academic Institution
- **Population reached:** People living with HIV
- **Has the programme been evaluated/assessed?** Yes. Through the collection of PEPFAR MER indicators
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

TPT has been a recommendation from the WHO and PEPFAR for many year, but uptake has been sluggish in previous years. The associated indicator, and program targets, were optional; as a consequence, very few countries developed ambitious programming.

### DESCRIPTION

In 2017, reporting of TPT was made mandatory, and countries were compelled to declare targets for treatment. The COP18 guidance prominently featured TPT, with specific toolkits and guidance documents being developed at the agencies. There were no mandatory targets, but countries were urged to develop ambitious targets commensurate with their capacity.

### RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

WE are currently waiting data for Q2 of COP17, but anticipate an substantial increase from COP16. The COP18 targets were substantially higher than in previous years, indicating increasing scale-up.

### LESSONS LEARNED AND RECOMMENDATIONS

Ambitious scale-up across all countries requires addressing both clinician and programmatic concerns. While it is important to coordinate responsibilities across the National TB and HIV programs at the country level, it should be made clear that TPT is a routine part of HIV care, and the primary responsibility of the HIV program.

**ANNEXES**  
COP18 Guidance

## 27. MULTIPLE EAST AND SOUTHERN AFRICAN COUNTRIES (South Africa, Malawi, Mozambique)

**TITLE OF THE PROGRAMME: Improved TB Care and Outcomes for PLHIV and at risk of acquiring HIV in Southern Africa**

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- **Programme is being implemented since:** 2017
- **End date of the programme:** 2017
- **Responsible parties:** Government, Civil Society, UN or other inter-governmental organization, Academic Institution
- **Population reached:** People living with HIV, Miners (especially exposed to silica), People who inject drugs, Prisoners and other populations in closed settings, First nations/indigenous people, Migrants (documented and undocumented), Refugees of internally displaced populations, Children, Women and girls, Young people/adolescents
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

Southern Africa has some of the highest TB case rates and has been at the epicenter of the global HIV epidemic with elevated TB/HIV coinfection rates of 50-77%. Around a third of the world's 22 high-burden TB countries are in Southern Africa, and most countries in the subregion are above the WHO threshold for a TB emergency. Eight of the 14 countries with the highest TB incidence are in Southern Africa. While the unprecedented rise in TB cases has been largely driven by HIV, mining has been historically associated with high TB incidence. In South Africa, TB incidence is 4-7 times higher among miners and ex-miners than among the general population. Zambia's recent TB prevalence survey found that TB prevalence in mining areas was 3-5 times higher than the national TB average. 33% of new TB cases in Sub-Saharan Africa are attributed to mining. The dual epidemic is challenging to manage - even well-managed TB programs cannot easily control the rise in TB in settings with high HIV prevalence without robust HIV responses. MDR-TB is becoming an increasing threat to health and development gains. Inadequate MDR-TB treatment can lead to highly lethal extensively drug-resistant TB (XDR-TB). Resistant forms of TB require the use of much more expensive drugs, with higher levels of toxicity and higher case fatality and treatment failure rates. Individuals who are treated inappropriately continue to transmit TB, but countries are ill equipped to identify and

respond efficiently. With growth in regional migration, global travel, and the emergence of drug-resistant TB, early detection and effective treatment are paramount. Putting in place systems for early detection, diagnosis, and surveillance of MDR-TB will have multiple benefits for tackling the growing problem of antimicrobial drug resistance (AMR). In mining operations and communities, several factors combine to create a “perfect storm” for TB infection and transmission. Working conditions inside mines constitute a high-risk environment for TB transmission, resulting from poor ventilation and exposure to silica dust. Resulting silicosis is a significant risk factor for TB. Health-seeking behavior of miners is not conducive to early diagnosis and treatment as a result of the high opportunity cost of accessing care, persistent stigma, and fears over losing their jobs.

## **DESCRIPTION**

The World Bank launched in 2017 a Regional TB Program for Southern Africa, with a first phase covering Lesotho, Malawi, Mozambique, South Africa and Zambia. This Program involves multiple collaborative efforts and is a major piece of a wider regional effort to control TB while strengthening critical dimensions of health systems. In most of those countries the Program covers 3 mutually reinforcing components: (i) improve the demand for and availability of high-quality TB, HIV and occupational lung disease services in targeted geographic areas; (2) strengthen selective aspects of health systems in the sub region to better manage the TB/HIV co-infection; (3) fund technical support to strengthen regional capacity and promote regional innovation through sharing of knowledge and evidence from interventions implemented under the first 2 components. This regional program targets mining communities, high TB and HIV/AIDS burden regions and cross-border areas. The program also directly benefits women, particularly in the small-scale mining sector. 122 Million USD have currently been allocated to improve coverage and quality of TB/HIV co-infections control and regional capacity. As part of this program, the World Bank is leading and financing TB allocative efficiency studies using the Optima TB model. The objective is to provide evidence on optimal resource allocation across the different TB interventions for best TB incidence and mortality impacts. An Optima TB allocative efficiency study was completed for Gauteng Province, South Africa.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

At the request of the South Africa National Department of Health (NDOH), several policy and programme questions were addressed in this analysis on best allocations across geography, sub-populations and TB interventions in Gauteng Province. The collaboration brought together experts and data from different institutions such as the National Health Laboratory Services, Sizwe Tropical Disease Hospital, Aurum Institute, Chamber of Mines and different directorates within Gauteng DOH, with the National TB Programme closely involved throughout. The key results from the Optima TB modeling studies were the following:

- If the Gauteng province maintains its current level of funding but allocates its budget differently, it could, by the end of the TB Strategic Plan in 2022:
  - Reduce the number of active TB infections in the general population by up to 40%
  - Reduce the number of active TB infections among PLHIV by up to 40%
  - Reduce the total number of TB deaths by up to 30% (ca. 2000) – Reduce the number of TB deaths among PLHIV by up to 30%

- To maximise impact, funding would need to be reallocated as follows:
  - Maintain Active Case Finding coverage levels in PLHIV as a priority activity
  - Transition to shorter MDR-TB drug-regimens
  - Invest in pre-treatment linkage to care and patient tracing, especially for MDR-TB
  - Reallocate some funding from PHC-based case finding to outreach in TB hotspots
  - Improve the quality of mass-screening at primary healthcare clinics
  - Further scale-up of ART in the general population: Increasing ART coverage to 65% of all PLHIV would have a significant positive impact on the TB burden in PLHIV by decreasing active TB prevalence and the number of MDR-TB cases by around 30%
  - Improve linkage to TB care in correctional services, which could yield up to a 50% reduction in DS-TB prevalence
  - Enhance TB infection prevention and control for the ~55,000 public health care workers
  - Maximize the integration and use of TB routine data to strengthen program implementation, e.g. with systematic analysis of TB treatment outcome data in mining sector by HIV status

## **LESSONS LEARNED AND RECOMMENDATIONS**

A key lesson learned is that important health impact can be gained -even with a constant budget- through optimized allocation. In Gauteng, the modeling results suggest that an optimized budget would allow for a 35% reduction in active TB cases and 28% reduction in TB deaths by 2022 by sustaining 2016 TB financing levels and making specific changes/ reallocations towards optimal allocations.

TB strategy and programming needs more descriptive analysis, mathematical modelling, use of geospatial analysis and data to inform programs. HIV programs have benefited from a number of decision science tools and methods that can now be transferred to TB programs.

Also, concomitant management of TB and HIV remain an utmost priority in the co-epidemic setting. Active case finding in patients in HIV care needs to be implemented systematically and frequently as 4 out of 5 new TB cases are found among HIV clients. Further ART scale-up has the best potential to decrease active TB prevalence in PLHIV, and yields the most substantial decrease in the projected number of MDR cases. Simultaneously increasing the coverage of key programs for PLHIV (ART, TB diagnosis, IPT), was projected to reduce the number of DS- and MDR-TB infections by 65% by 2035.

The modelling also suggested that reaching TB incidence targets is challenging due to the constant reactivation of latent TB which is especially high in PLHIV and also an effect of cofactors like the growing number of older people in Gauteng, and high levels of diabetes. This emphasises the need to address the TB challenge in a health sector-wide fashion. Based on this valuable experience, three further TB allocative efficiency analyses are being launched in Malawi, Mozambique and additional South Africa provinces.

These studies will be used to inform budget allocation and the implementation of Regional TB Program. Following up on the completion of the Gauteng analysis as well as the national Optima TB studies completed in Belarus and Peru, a series of 15 TB Allocative efficiency and TB implementation cascade analyses will also be conducted, beyond Southern Africa.

## **ANNEXES**

Optima TB website: <http://www.optimamodel.com/tb/>

Country example of an Optima TB application:

<https://openknowledge.worldbank.org/handle/10986/27475>

## 28. MULTIPLE SOUTHERN AFRICAN COUNTRIES

### 28.1 TITLE OF THE PROGRAMME:

Screening and Active Case Finding under the TB in the Mining Sector in Southern Africa Programme (Mozambique, Botswana, Lesotho, Malawi, Namibia, Swaziland, Tanzania, Zambia)

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- **Programme is being implemented since:** 2016
- **End date of the programme:** 31 December 2017
- **Responsible parties:** Civil Society
- **Population reached:** People living with HIV, Miners (especially exposed to silica), Children, Women and girls,
- **Has the programme been evaluated/assessed?** Yes. ADPP's Intervention has been assessed as part of a wider TIMS programme evaluation carried out Khulisa on behalf of the The Global Fund between the period February-March 2018.
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** Yes. The programme is part of the TB in the Mining Sector in Southern Africa programme a regional response promoted by SADC in response to the Southern Africa Declaration on TB in the Mining Sector

#### BACKGROUND

Mineworkers in Southern Africa are particularly vulnerable to HIV/AIDS. In South Africa, HIV prevalence rate among mineworkers varies from 25pc to 50pc (IFCT, 2004). In Zambia 18pc of the copper mineworkers are estimated to be HIV positive (IFC, 2004). Studies in Namibia have shown that prevalence in some zinc mines were 5pc above the national average (IOM, 2010). High prevalence and transmission rates of HIV, coupled with confined, humid, poorly ventilated working and living conditions further increase the risk of developing active TB among mineworkers. In fact, mineworkers in Southern Africa present a higher TB incidence than any other population in the world and it is estimated that 3,000 to 7,000 per 100,000 miners are infected with TB (Baleta, 2012).

TB is the leading cause of death amongst HIV positive people and Southern Africa has the highest HIV/TB co-infection rates in the world (WHO, 2016). In high TB and TB/HIV burden countries like in Mozambique, it is estimated that 61% of TB-related deaths were co-infected with HIV (WHO, 2018; GBD, 2018). Such a context and the evidence on mineworkers'

vulnerability to HIV and consequently to TB have resulted in the development of regional policies from the Southern African Development Community (SADC) in addition to political and policy level commitments to address TB and HIV amongst mineworkers in the region. One of the main programmes developed part of these commitments was the development of the TB in the Mining Sector in Southern Africa Programme (TIMS).

## **DESCRIPTION**

TIMS is an ambitious regional and multi-objective programme funded by the Global Fund and overseen by a Regional Coordinating Mechanism (RCM). The first phase of TIMS (2015- 2017) sought to scale up the coordination of regional, crossborder and multi-sectorial interventions to support the delivery of TB prevention, treatment and care services to mineworkers, exmineworkers, their families, and communities around the mines and in labour-sending areas. Within this pilot project, ADPP Mozambique was the civil society organisation tasked with the coordination and of grass-root level interventions focused on TB screening and active case finding amongst mineworkers across eight countries: Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Tanzania and Zambia. ADPP Mozambique led the implementation of activities in Mozambique and acted as lead of a consortium of 7 other national NGOs: Humana People to People Botswana, Partners in Health Lesotho, DAPP Namibia, DAPP Malawi, DAPP Zambia and Ariel Glaser Paediatric Foundation Tanzania. The intervention had a budget of 3.7million USD across the 8 countries. Project sustainability during this first phase was fully addressed as the pilot project served to design and implement a subsequent 2-year intervention between 2017-2019

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

The project's activities implemented between October 2016 and December 2017 resulted in the following achievements:

- Mobilised, raised awareness and increased demand for TB/HIV diagnostics and treatment services across 21 districts in 8 countries
- Provided TB screening services to 228,293 KPs, exceeding set targets of 218,500KPs and identifying 6,8% presumptive cases amongst all KPs screened
- Facilitated TB diagnosis for 8,886 people with TB-like symptoms, ensuring diagnostic of over 80% of presumptive cases identified in the last quarter of implementation
- Identified 831 TB patients all forms (9% of all tested) and TB provided treatment support.
- Ensured 100% TB patients knew their HIV status.

## **LESSONS LEARNED AND RECOMMENDATIONS**

ADPP Mozambique began its work in the field of health over 10 years ago with a specific focus on HIV/AIDS prevention and treatment. ADPP's expertise in community-level interventions in Mozambique working with a wide range of donors including USAID, CDC and The Global Fund have allowed it to develop integrated successful TB/HIV approaches building on its HIV background.

ADPP's work is a good example of how the HIV civil society sector can contribute to the much-needed meaningful civil society engagement in the global response to reduce the disproportionate burden of TB amongst people living with HIV. Moreover, through this project, ADPP extrapolated its national experiences in Mozambique to the Southern Africa region by leading and providing technical assistance to a consortium of 7 other national civil society organizations working in 7 other countries under the TB active case finding component of TIMS. The success in TB active case finding amongst mineworkers across the eight countries was founded in the support provided through the respective National TB Programmes at national, provincial and district levels. Their support was crucial to facilitate the project's compliance with



national guidelines and algorithms, deliver training to outreach field staff, solve bottlenecks for the provision of diagnostics and facilitate project data and reporting.

Despite its notable achievements, the project could have benefited from better integration between HIV and TB. Although the TB/HIV co-infection amongst communities of mineworkers in Southern Africa is known and well documented, the design of TIMS as a regional intervention did not fully integrate the two diseases and this was felt as a missed opportunity by the civil society implementers. For instance:

- HIV testing services at the community: the intervention's budget was solely focused on the provision of TB screening and TB diagnostic services. HIV testing strategies had to be limited to referral to the nearest health facility given the lack of availability or training for outreach staff in HTC, the provision of HIV RDTs and other supplies. However, the community activities saw on an everyday basis the demand for HIV testing and counseling by clients at the community that could not be met. Whilst efforts were dedicated to promote and facilitate referrals, the fact that this fell outside the scope of work agreed for field activities with the donor also limited the time and efforts that could be allocated to it.
- Preventive treatment: Provision of TB Preventive Treatment at the community for HIV+ clients or according to WHO guidelines is very limited in rural and deprived setting in Southern Africa. Stock outs of IPT for children are a reality and uptake amongst HIV+ clients is very limited. The project was also not able to appropriately fill in this gap given its focus on case finding rather than prevention.
- Integrated indicators: The project's indicators as per the performance framework did not consider joint TB/HIV indicators. Although client's HIV status was considered during the TB screening, because HIV testing fell out of the activities, it could not be provided nor recorded. The project kept a patient database for TB clients and dedicated significant efforts to reporting the HIV status of all TB-positive clients, but this was not a request in the performance framework. Similarly, uptake to ART for clients found with HIV and monitoring of treatment adherence was not part of the project's framework. Although field activities did not neglect this, it would have been easier to dedicate sufficient efforts and collect relevant data with a more enabling framework.
- Nutrition support: Lack of nutritional support hinders patient's ability to cope with TB treatment, particularly when they are also co-infected with HIV. Yet, nutrition support is expensive and the project was unable to fund this as the project focused on notification of cases – rather than monitoring patient's successful treatment outcomes. To mitigate this, the project provided cooking demonstrations using locally available resources and linked patients to nutrition support provided at clinics by other programmes (usually based on BMI), but a comprehensive nutrition package would have been beneficial to the treatment adherence and cure rate of TB patients identified by the project.

## **ANNEXES**

N/A

## 28.2 TITLE OF THE PROGRAMME:

Review of Occupational Health and TB Service delivery in 7 SADC countries (Botswana, Lesotho, Mozambique, Swaziland, Tanzania, Namibia, Zimbabwe)

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- **Programme is being implemented since:** 2016
- **End date of the programme:** ongoing
- **Responsible parties:** Academic Institution
- **Population reached:** Miners (especially exposed to silica)
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** No

### BACKGROUND

Southern African mineworkers and ex-mineworkers have amongst the highest incidence of TB in the world. Despite this, the mining populations are not a key population in many of the SADC countries, with even less focus on ex-mineworkers. Key contributors to this heightened TB incidence include HIV, mobility, silicosis and a poor living environment in mines and peri-mining areas.

In order to stem the tide of the epidemic in this sector, focused interventions aimed specifically at this key population are required. One such intervention is the establishment of Occupational Health Service Centres (OHSC) aimed particularly at the sector. This programme is part of the Global Fund 'TB in Mines in Southern Africa (TIMS) grant'.

The Wits Health Consortium (WHC) is the PR for the programme and it implements via selected SRs.

### DESCRIPTION

The objective of the OHSC programme is to provide comprehensive, decentralised occupational health and compensation services to mineworkers and particularly exmineworkers with the aim of actively diagnosing TB and occupational lung diseases (OLD). The programme was executed in several phases:

1. Pre-establishment:
  - A thorough environmental scan was performed, using; mapping data, prevalence data, country information, overview and location of existing health facilities, mine locations. Inputs from NTP Managers were used to understand gaps in the coverage of national TB

programmes. This information was used to determine the best possible location of the OHSCs.

- A review of similar facilities in South Africa was performed to capture learnings
- It was decided to locate the OHSCs within existing health facilities for infrastructure and referral purposes

2. Establishment:

- A Sub Recipient (SR), North Star Alliance, was selected to build and equip the OHSCs. Each OHSC consists of 3 shipping containers built on a concrete plinth, with essential equipment installed to perform a basic occupational health examination.

The major equipment includes:

- a. Digital X-RAY
  - b. Audiometer
  - c. Spirometry
  - d. GeneXpert machine (4 module)
  - e. Generator
  - f. Minor medical equipment and consumables (blood pressure machines, urinalysis, glucometer, etc.)
- Time to establish each OHSC ranged from 6 weeks to several months (please refer to lesson learnt section)

3. Operations:

A SR, OGRA Foundation, was selected to provide the services and to manage all aspects of operations. Key functions of this SR included:

- a. Recruitment of personnel – key amongst them are nurses and doctors with experience and qualifications in occupational health
- b. Development of an operations manual that describes the standard operating procedures for running the facility
- c. Social mobilization within key populations and liaison with exmineworkers organisations
- d. Providing a consistent service subject to quality assessment by the PR

4. Long-term sustainability:

In order to ensure long term sustainability, the following actions were taken:

- a. A Memorandum of Agreement was signed with all participating countries which commits them to taking over the facility after the grant ends
- b. A transition plan to effect the above in a phased manner will be put in place
- c. Skills development of medical personnel vis training workshops ensure maintenance of high clinical standards

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

The OHSC programme currently covers 7 SADC countries and consists of 10 functioning clinics – all set up to the standard specifications listed above. As there is very little baseline data on the mining key population in the region, comparisons are best made with national prevalence data. Additionally, some of the services offered at the OHSCs are not offered by national systems at all e.g. compensation for TB/silicosis.

The data emerging from the 10 OHSCs indicate high TB yields (well in excess of national baselines) as well as a high rate of occupational lung disease. The TB yield is highest on those centres that serve mainly artisanal and small scale miners. It would appear that a targeted approach i.e. mining key populations, via a dedicated facility yields far higher TB case finding rates than a more generalized approach Kindly refer to the annexures for further detail.

## **LESSONS LEARNED AND RECOMMENDATIONS**

The programme to date has generated several key lessons:

1. Set up
  - Extremely important to have all stakeholders on board prior to selection of OHSCs sites. This ensures buy in from the start of the process
  - Would have been preferable to have a single SR/SP to implement the set up and operationalising. With separate SRs, issues of hand over and ownership tend to add complexity
  - The logistics chain needs to be planned and agreed well in advance. Much time was lost due to delays with transportation and customs clearance
  - Explore other options besides containers. Prefab buildings or the use of unoccupied premises within hospitals may be preferable from a space and infrastructure point of view - on site needs assessment to determine what facility best suits that situation
2. Staffing
  - Clear job descriptions and outputs are necessary prior to recruitment
  - Involvement of local hospital management in recruitment is essential as these personnel will be absorbed into the hospital structure at the end of the grant
3. Operations
  - Establish an operations manual in advance of operations. This should contain all the key procedures and protocols for running the centre
  - Establish a clear reporting framework that has sign off by the NTP or local hospital. This is important as data needs to be integrated with national systems.
  - Maintenance contracts for high value equipment is essential
  - A well-documented and implemented supply chain process for consumables will avoid stock outs of consumable items
  - Reliability of electricity and water supply should be determined in advance of operations
  - A local oversight committee consisting of management, key populations and community organisation will go a long way in ensuring efficient operation of the centre and addressing community concerns

## **ANNEXES**

N/A

## 29. MULTIPLE WESTERN AND EASTERN EUROPEAN COUNTRIES

**TITLE OF THE PROGRAMME: Screening and Active Case finding under the TB in the Mining Sector in Southern Africa Programme**

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- **Programme is being implemented since:** 1 January 2015
- **End date of the programme:** /
- **Responsible parties:** Civil Society
- **Population reached:** People living with TB
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the implementation of the National AIDS Strategy?** No
- **Is the programme part of a national AIDS or TB strategy?** No

### **BACKGROUND**

TB is the world's leading infectious killer, resulting in 1.8 million deaths and 10.6 million new infections globally in 2015. But despite the urgent need to combat the epidemic, TB has remained low on the global political agenda, failing to receive the attention and resources it warrants.

TB is not an issue exclusive to countries outside of the EU. In 2015, there were over 60,000 people with TB in the EU. Portugal for example, has some of the highest TB rates in Western Europe, mainly driven by high HIV rates among drug users. While a third of London's boroughs suffer from high rates of TB much of which can be attributed to poor housing, poor nutrition and chronic ill health. While the number of TB cases in Europe is falling at around 5% per year, in order to reach the targets set in the End TB Strategy and the Sustainable Development Goals (SDG), the reduction in TB notification rate needs to be twice as fast in the EU than current levels.

#### a) Drug resistance

Of particular concern is the rise of drug resistant TB (DR-TB) in Europe, which highlights the slow progress made in combating the disease. Despite a decrease in TB cases over the last five years, the WHO Europe region has the world's highest rates of multi-drug resistant TB (MDR-TB). 120,000 cases of DR-TB were reported in the region in 2015, accounting for over 20% of all the drug resistant cases in the world. The situation is worsening with one in six new TB patients in the WHO Europe region being diagnosed with MDR-TB, as well as half of the people previously diagnosed with TB, now being diagnosed with MDR-TB. Many of the WHO Europe Region DR-TB high priority countries are in EU Member States: Bulgaria,

Estonia, Lithuania, Latvia and Romania - with Estonia, Latvia and Lithuania reporting MDR-TB in up to 21% of people with TB. While treatment success rates have increased by 3% to 51% between 2011 and 2015, this is not fast enough to handle the growing crisis. More than half of people with MDR-TB in the region either fail treatment, stop treatment or die, contributing further to DRTB. Extensively drug resistant TB (XDR-TB) or forms of the disease to which there are no treatment options available are also increasingly common, with over 2,000 cases of XDR-TB notified in 2015.

In addition to the catastrophic human cost, the economic burden caused by TB in the region is enormous. A recent review commissioned by the UK, led by economist Lord Jim O'Neil, estimated that by 2050, DR-TB will be responsible for an additional 2.1 million deaths at an economic cost of \$1.1 trillion in the WHO European region alone. MDR-TB can put huge strains on national TB programmes and health systems as the cost of treating MDR-TB can be five to one hundred times more expensive than standard TB cases.

In addition, new EU Member States, such as Bulgaria and Romania, have ill-capacitated health systems, characterised by extensive hospitalisation, limited primary care, central planning and an overly hierarchical management. Such treatment facilitates the development of drug resistance. TB care and treatment is still transitioning from expensive hospitalisation to an ambulatory model where the majority of care and treatment of people with TB would take place outside hospitals.

b) TB/HIV

HIV and TB remain a deadly synergy, as co-infection is increasing at its fastest rate with a sharp increase of HIV prevalence in people with TB, almost doubling in the past four years. The WHO Europe region is the only region in the world where HIV infection rates are on the rise. Of the 10 countries with the highest TB/HIV burden which make up 90% of the people living with both TB and HIV in the region, five are in the EU: Spain, France, Portugal, UK and Romania. In 2015, only one high-prevalence country, Estonia, showed a decrease in the prevalence of HIV among TB patients.

The treatment success rate of someone with TB and HIV is dismally low; at 41% it is even lower than success rates for DRTB. Currently, in the European region a person living with HIV and TB is seven times more likely to not complete treatment and three times more likely to die than newly detected TB cases.

TB and HIV services often run as parallel, disconnected programmes. Frequently, the coordination and referral mechanisms between programmes are limited, if not nonexistent, at national level. Even policies that call for coordination between TB and HIV programmes at national level aren't usually translated into practice at service delivery level. Reflecting the importance of tackling the infections jointly, the WHO Europe Regional Office changed its name to the Joint Programme for HIV, TB and Viral Hepatitis and in 2016 the EC widened the remit of the EU Civil Society Forum from only HIV, to also include TB and Hepatitis organisations.

At the same time, as the economies of the region are growing, many countries in the EU and WHO Europe region are gradually becoming ineligible for donor support to national health systems. However, increases in GDP are often not accompanied by an increase of health spending, as a result TB and HIV programmes and services targeting vulnerable groups and key affected populations are often abandoned. There is therefore a substantiated worry that the progress made so far in the TB and HIV response will be lost due to a lack of political will and financial commitment.

c) Lack of access to and development of new tools

To end TB, there is an overwhelming need for the accelerated uptake of existing tools and for the development of new ones. Estimates show that without new tools to fight TB after 2025 existing tools will be exhausted.

The field of research and development of new TB drugs, diagnostics and vaccines has suffered from a chronic lack of investment, resulting in an alarmingly bare pipeline of promising compounds and drugs. Prioritising new tools to end TB would have a major public health impact and provide a rapid return on investment. However, it will require coordinated efforts from across the international community to overcome the market failure, which is preventing the development of new medicines. In previous years, the G20, which includes Italy, the UK, France, Germany and the EC, have prioritised tackling antibiotic resistance. Under the 2017 German G20 presidency, G20 Health Ministers met for the first time and recognised TB as a key component of the AMR threat. The prioritisation of AMR and TB in future G20 presidencies will be critical to ensuring that these commitments are realised with adequate financing. Civil society pressure on G20 governments will be crucial to achieving this.

d) Political will to ending TB in the region

Progress on TB has been hampered by a chronic lack of political will. Many Western European Member States have a generally low burden of TB and so have not invested significant resources to tackle it. However, in Eastern European countries, where the TB and MDR-TB incidence is much higher, governments are often unable to invest in policies due to insufficient resources, or are unwilling to prioritise policies that mainly target most at risk groups.

In recent years, the EC has recognised and highlighted sustainable development as central to the development and cohesion of the EU, mainstreaming it into the Europe 2020 strategy. In 2016 the EC, committed the EU to be a front-runner in implementing the 2030 Agenda and the SDGs, together with its Member States. In order to achieve SDG 3 “Ensure healthy lives and promote well-being for all”, the EC should complement Member States’ action by developing legislation and other initiatives on public health, health systems and environment related health problems, which includes the target of ending TB as a public health threat.

The informal EU Health Ministers’ meeting held in Bratislava in October 2016, agreed to support the development of an integrated EU Policy Framework on HIV, TB and Viral Hepatitis. Further to this, the European Parliament called on the Commission and the Member States to develop a comprehensive EU Policy Framework addressing HIV, TB and Hepatitis. This is something that civil society organisations, including TBEC have been calling on the EC to develop.

The United Nations will hold a High-Level Meeting (HLM) on TB in 2018, with the hope of accelerating national, regional and global action. With Slovakia recently announced as the President of the General Assembly, with oversight of the HLM, civil society in Europe, especially TBEC, will be critical to influencing the process and ensuring that the voices of people affected by TB are central to the discussions.

e) Strengthening the role of Civil Society

Civil society has a positive role to play in health and acknowledgement of this is slowly filtering into governance and policy documents among international and regional decision makers. As seen in the special report on the Dublin Declaration by the European Centre for Disease Prevention and Control (ECDC), “civil society plays a critical and central role in integrating marginalised HIV populations into the response to ending HIV. Unfortunately, the number of civil society organisations active in TB advocacy remains low. Building capacity and facilitating the engagement of civil society to play an integral role in the TB response is therefore essential if TB is to be eliminated. However, governments in some part of the region do not recognise the important role of civil society and affected communities. In Eastern Europe, the Balkans

and Central Asia civil society engagement remains weak, but has significant potential to gain influence as countries enter or seek entry into the EU.

## DESCRIPTION

### Overview

TB Europe Coalition (TBEC) is the only regional civil society network, working exclusively on TB issues in the WHO Europe region. It has 180 members (civil society organisations and individuals) in 35 WHO Europe countries. The network aims to strengthen the role of civil society within the regional response to TB, and ensure political and financial commitments to end TB. TBEC two areas of engagement are: 1) advocacy (at national, regional and international levels) and 2) capacity building of TBEC members. TBEC has also identified three overarching thematic priorities for the region – domestic financing, peoplecentred TB policies and TB R&D and equity in access to existing TB tools.

In 2015, TBEC obtained a multi-annual grant from the European Commission's Consumers, Health, Agriculture and Food Executive Agency under the 3rd EU Health Programme.

Operational Grant "Strengthening the role of civil society within the TB response in Europe" allowed the strengthening of the network's operational capacity and substantially expanded TBEC's outreach activities. In 2018, TBEC received a subsequent operational grant for a period of 4 years (2018- 2021), with the core operations of the operational grant delivered by staff members of TBEC member organisation - RESULTS UK, based in the UK.

As part of the operational grant, TBEC has identified four key outcomes:

1. Sustainable, transparent and accountable TB network able to represent TBEC members and support and strengthen individual and collective TB advocacy efforts in the WHO Europe region;
2. TBEC network with means to outreach and engage members and facilitate sharing of information, policy content and advocacy tools for effective national and regional level TB advocacy;
3. TBEC has developed strong relationships with partners such as HIV and health regional civil society organisations, community organisations and multilateral institutions including WHO, thus, increasing advocacy for coordinated response to the epidemics and joint efforts to tackle TB;
4. TBEC members have the capacity and capability, skills and knowledge to effectively influence robust TB and TB/ HIV policies and national and regional level to adequately combat the epidemics.

The operational grant, thus, consists of 4 main work streams:

Work stream 1: Governance, Accountability Mechanisms and Sustainability This work stream involves the development of clear and accountable TBEC governance structures within a legal entity and day-to-day management and administration of the network itself in order to foster TBEC network growth and sustainability in ong-term. A key aspect of this work stream is the focus on increasing accountability and transparency of the network.

Work stream 2: Communications and Outreach From an internal, administrative perspective, this work stream focuses on strengthening communications and engagement with members through the on-going maintenance of the TBEC website, listserv and social media (in EN/RU). This will strengthen TBEC and provide foundation for development of a generation of powerful TB advocates in the region. Furthermore, this work stream also focuses on increased engagement with TBEC members and promotion of such engagement amongst TBEC members via listserv and 1-2-1 communications.

Work stream 3: Policy and Partnerships This work stream focuses on advocacy work and building partnerships at national, regional and global levels to strengthen TBEC's advocacy reach, capacity and capability to influence TB policies and ensure greater coordination between EU civil society networks working on public health infectious diseases. Additionally, the TBEC



Secretariat will advocate on behalf of the network in the following key moments: G20 meetings, UN HLM on TB, WHO/EU civil society gatherings, International AIDS Society Conference, World Union Conferences.

Work stream 4: Skills and Knowledge This work stream focuses on the evaluation of skills and knowledge of TBEC members via an in-depth skills audit and subsequent development of a training plan. In addition, the TBEC Secretariat will carry out various country visits to gather information about TBEC member skills and knowledge and examples of best practices in TB advocacy and service delivery that can later be showcased as evidence of the benefits of CSO involvement in fight against TB at national and regional levels.

Target groups:

Civil society: TBEC members - civil society organisations and TB activists - will be the primary target group for its activities. TBEC will provide a transparent and accountable governance framework for regional advocacy and capacity building activities, ensuring proactive communication with TBEC members on the latest regional and international advocacy opportunities and facilitating information exchange amongst TBEC members. Civil society and TB activists in the EU Member States and Eastern European and Central Asian (EECA) countries will be the focus of TBEC's skill and knowledge audit exercise, best practice gathering and training and mentoring plan. Furthermore, TBEC will focus on building stronger relationships with key regional health networks such as TBPeople, GTBC and EHRA.

National decision makers: TBEC will continue relationship-building initiatives, targeting relevant national decision-makers with a specific focus on collaboration and coordination between TBEC membership and members of national and European parliaments who are part of the Eurasian Parliamentary Group on TB (the regional branch of GTBC). TBEC will continue to support members' engagement with national governments ahead of the first UN HLM on TB, relevant EU meetings/conferences (EP, EC, ECDC and CHAFEA), G20, the Global Fund replenishment etc..

International and regional decision makers: TBEC will continue to engage with various international organisations such as: a) WHO Europe regional office to secure the inclusion of civil society perspectives in the WHO guidelines and position papers on various areas of TB policy in relation to issues such as integrated health systems or people centred care; b) the Stop TB Partnership to actively coordinate the advocacy efforts ahead of the UN HLM on TB; and c) the G20 with specific focus on advocacy towards the EU and European G20 countries. TBEC also will work with other key stakeholders in Europe in order to contribute to an effective regional response to TB such as the International Union for Lung Health, International AIDS Society, and the Global Fund to Fight AIDS, TB and Malaria.

## **RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME**

TBEC has grown into a strong, well-recognised and respected network. The EC CHAFEA 2015-2017 FPA three-year operational grant has been invaluable to the growth of the network. By the end of April 2017 the coalition had more than 180 members representing 35 different countries throughout the WHO European region (up from 158 members in 24 countries in 2014). The grant has allowed TBEC to widen the network by mapping the various TB advocates and organisations in the region, carry out country visits and regional trainings, modernise the TBEC website and provide continuous information updates in English and Russian (EN/RU). TBEC has also been able to increase its advocacy efforts with international and regional decision makers such as the Global Fund to Fight AIDS, TB and Malaria, the WHO and European Commission (EC). The TBEC now has focal contacts in almost all countries in the WHO Europe

region, as well as the capacity to communicate in EN/RU, which ensures regular feedback and understanding of the key issues across all members.

TBEC members regularly contribute to public consultations on the fight against TB in Europe, actively participate in relevant EU and WHO forums and stand available to provide information and advice to policy-makers on issues that the network has particular expertise. TBEC's Secretariat members are part of the WHO Regional Coordinating Committee on TB, an interactive platform for stakeholders such as donors, technical agencies, professional societies and patient and community representatives to exchange information related to multidrug and extensively-drug resistant tuberculosis responses and advocate for action and the Regional Green Light Committee for the WHO European Region. Different TBEC members are also systematically involved and selected as civil society representatives in National TB Programme Reviews organised by WHO Europe throughout the region.

During last three years, TBEC continued to strengthen its position as a key civil society network, working on TB issues in the wider European region. Throughout the year, TBEC carried out various advocacy activities on various TB policy aspects such as:

- transition and sustainability;
- people-centred care;
- antimicrobial resistance;
- investment in TB R&D; o integrated health systems;
- upcoming UN High-level meeting on TB;

The continuous financial support from the EC allowed TBEC Secretariat and Steering Committee members to actively participate in various regional and international conferences such as AIDS International Conference, Wolfheze, the Union conference on Lung Health, amongst others. The grant also allowed to closely engaging with various international and regional stakeholders such as the EU (EU Global Health Policy Forum, European Parliament working groups, permanent representations of the EU MS to the EU, CHAFAEA, DG SANTE amongst others), WHO (annual meetings of Green Light and TAG TB Committees) and the Global Fund. Furthermore, TBEC strengthened the regional partnerships with Eurasian Harm Reduction Association through joint country visit to Bulgaria in 2017, and worked closely with the Global TB Caucus in order to strengthen ties between the CSOs and the parliamentarians, and TBPeople, with specific focus on EECA engagement. Since its creation in 2009, TBEC members have reported significant challenges in contributing to an effective TB response at both the national and regional levels. There is a clear ask from TBEC members to increase the depth of their knowledge and advocacy skills to be able to effectively influence policies and spending. Therefore, TBEC actively informs, trains and engages civil society organisations and individuals working on TB at national level. It does this via regular country visits, online webinars and publications on relevant TB issues, ad hoc financial assistance to members to attend international and regional conferences, meetings and workshops, as well as various individual and organisation-based mentoring activities. In 2017 alone, TBEC visited Bulgaria, Georgia, Belarus, Tajikistan, Azerbaijan and Moldova. The visits were set to include CSOs advocacy capacity building, facilitating linkages between civil society and national and international stakeholders on TB in the countries as well as to document the successful practices and lessons learnt within the implementation of CSOs advocacy activities.

## **LESSONS LEARNED AND RCOMMENDATIONS**

### **Strengths:**

TBEC continued to strengthen its position as a key civil society network, working on TB issues in WHO Europe region. The TBEC network strengths are rooted in the professional and geographical diversity of its membership, which ensures legitimacy of TBEC's representation of regional civil society.

TBEC has focal points in almost all countries of the region, as well as capacity to communicate in Russian and English, which ensures regular feedback and comprehensive and representative understanding of the key issues.

TBEC's strengths are also rooted in the extensive pool of knowledge amongst Secretariat and Steering Committee members that ensure TBEC submissions are evidence-based and truly represent the interests of TBEC members. TBEC's professionalism in advocacy and capacity building has been recognised not only by institutional decision makers such as WHO or the EU by inviting TBEC to attend various coordination meetings such as WHO TAG TB, Green Light and RCC Committees or the EU CSF on HIV, TB and Hep, but also by other regional civil society networks and EU project implementers such as Eurasian Harm Reduction Association or Global TB Caucus.

#### Weaknesses:

When it comes to TBEC membership, the main concern is the limited involvement of the wider membership in TBEC day-to-day activities. This is partially due to the limited capacity of Secretariat to engage in one-to-one outreach or trainings, and due to the lack of initiative from the members themselves (low participation in webinars, limited reply to emails in listserve etc.). However, the re-registration of TBEC membership gives hope for a more active and engaged network.

However, TBEC still experiences limitations when it comes to its capacity to engage in all advocacy and capacity building opportunities at regional and international levels. With an increase in reputation and visibility, TBEC has received many offers and suggestions for stronger involvement and leadership; however, TBEC's Secretariat capacity remains limited – due to available funding.

#### Future opportunities:

In the upcoming years, there are many opportunities for TBEC to strengthen its impact in halting TB. First of all, TBEC's increased reputation amongst international and regional organisations and civil society networks provides good opportunities for joint cooperation – for example, when it comes to projects targeting key populations or HIV-TB policies or joint funding applications, for instance to Global Fund regional grants -, and/ or for joint capacity-building activities at national or regional levels. Secondly, TBEC latest contributions to the launching of the TB REP project, establishing TB People network, and the strengthening of the Global TB Caucus, with its sub-regional Eurasian Parliamentary group gaining increasing visibility, can be further leveraged to both strengthen TBEC and to widen the scope of activities. This would in turn further increase TBEC's visibility and strengthen its reputation as an innovative, committed and active civil society network in the region. Thirdly, any major policy initiatives at international and regional levels on TB related issues such as the UN HLM on TB or EU R&D policy review might provide opportunities for TBEC to start acting in new policy areas, expand the membership and possibly gain access to more funding. Good examples are: the transition process in EECA region, G20 investments in R&D on antimicrobial resistance in view of staggering increase of MDRTB cases in the region, the deadly duo HIV and TB, and the absence of integrated policy approaches, amongst others.

#### Threats:

The main threats to TBEC include: firstly, the lack of long-term sustainable income, and continuous dependability on funding from international and regional institutions/philanthropic organisations such as EC and ACTION (CHAFEA operational grant) and the Global Fund (TB REP project). If donors alter their policy priorities, geographical focus or the rules of conditionality of which organisations can receive funding, it will be very challenging for TBEC not only to engage with relevant external partners and organise activities/provide information for

TBEC members, but also to ensure the day-to-day management of TBEC Secretariat. Secondly, change in geographical focus and preference amongst various international and regional donors such as the Global Fund (moving out of high-burden middleincome countries, which constitutes majority of TBEC members to the least developed countries, mostly in Asia and Africa). Shifts in the geographical focus coupled with increased political reluctance to engage with civil society in some of TBEC member countries would demand TBEC to strengthen its capacity to provide evidence-based reports on how civil society engagement is often the key in providing efficient, successful and low-cost services. Thirdly, sudden key personnel changes within Secretariats and Steering Committee may result in lack of knowledge and expertise on the various TB issues as R&D, transition, HIV/TB policies, ambulatory care etc., and may also impend the implementation of the work plan as different staff are responsible for the implementation of different activities set out in the work plan.

**Lessons learnt:**

In 2017, TBEC carried out its first-ever joint workshop with another regional network – Eurasian Harm Reduction Association and there were several lessons learnt both regarding the capacity building and advocacy (from different training techniques to invited experts) to organisation and coordination of such large workshop (for the first time ever, gathering over 30 participants). The experience allowed not only to compare and strengthen TBEC's understanding of the various capacity building tools, but also expand the network of available experts as the issues, although concerning different themes (HIV, harm reduction and TB), were cross-cutting in terms of transition, donor withdrawal and obstacles experienced at national level.

Furthermore, TBEC actively engaged in G20 advocacy, and, thus, strengthened its understanding of the G20 processes at national and international levels. TBEC also used G20 civil society platforms to its fullest advantage, thus contributing to overall AMR and R&D policies having a greater focus on TB. Similarly, TBEC started and will continue in 2018 to focus on the UN processes and look for advocacy opportunities ahead of the UN high-level meeting on TB that will take place in September 2018. A better understanding of the decision-making processes within the frameworks of regional and international organisations and networks has strengthened TBEC's ability to advocate with and on behalf of WHO Europe civil society.

**ANNEXES**

<http://www.tbcoalition.eu/>

## 30. TANZANIA, KENYA, CAMBODIA

### TITLE OF THE PROGRAMME: Community, Rights & Gender to strengthen national TB responses

#### CONTACT PERSON

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- **Programme is being implemented since:** 2016
- **End date of the programme:** /
- **Responsible parties:** Government, Civil Society, UN and other inter-governmental institutions
- **Population reached:** People living with HIV, Miners (especially exposed to silica), People who inject drugs, Prisoners and other populations in closed settings, First nations/indigenous peoples, Migrants (documented and undocumented), Refugees of internally displaced populations, Children, Women and girls, Young people/adolescents
- **Has the programme been evaluated/assessed?** No. Evaluation has recently commenced.
- **Is the programme part of the implementation of the National AIDS Strategy?** Yes
- **Is the programme part of a national AIDS or TB strategy?** No

#### BACKGROUND

People and affected community-centred programmes are critical if we are to effectively identify and remove barriers impeding access to TB and TB/HIV services for all people. There is a particular need for human rights and gender sensitive programming that unpacks the lived experiences of TB survivors and people most vulnerable to TB. With millions of missing people affected by TB world wide, over a million deaths annually, the rise of AMR and as the biggest killer of people living with HIV, TB most shift the paradigm in how it approaches the response. CRG tools for human rights, gender, stigma, community monitoring key and vulnerable populations have been (or are being) rolled out in strategic countries - including Kenya, Tanzania and Cambodia producing strong results. these processes have been affected community and civil society led, however, multi stakeholder partnerships have been central to this success.

## **DESCRIPTION**

The implementation of the CRG tools at country level aims help find the mission millions of people affected by TB, in particular by identifying and removing barriers to accessing TB and TB HIV diagnosis, treatment, care and support services. In Kenya, Tanzania and Cambodia strong recommendations have been made through the process of implementing the tools - contributing to stronger responses at the country level. The project implementation is led by civil society and affected TB communities enhancing their respective roles, their capacity and leadership in the TB response. This project is implemented in partnership with national TB programmes and with technical support from the Stop TB Partnership.

## **RESULTS, OTCOMES AND IMPACT OF THE PROGRAMME**

Barriers to accessing TB diagnostic, treatment, care and support services have been identified in each of the countries. In particular these barriers are closely connected to issues of human rights and gender. In addition, the process of understanding more about those populations who are particularly vulnerable to TB have been identified. Recommendations have been made in each of the countries (including Kenya, Tanzania and Cambodia) which have been endorsed by national TB programmes and other stakeholders with agreed actions to incorporate the recommendations into national strategic plans and global fund request also adopted.

## **LESSONS LEARNED AND RECOMMENDATIONS**

Going forward there will be additional technical support to further strengthen the recommendations that are made. In addition, supplementary tools will be produced streamlining the various CRG tools into one package and there will enhanced work to connect the implementing partners with other strategic partners at country level.

## **ANNEXES**

<http://www.kelinkenya.org/wp-content/uploads/2018/02/TB-Legal-Environment-Assessment.pdf>

