REGIONAL RESPONSE TO TB AND HIV/AIDS EPIDEMICS

STATUS OF TB AND HIV/AIDS COLLABORATIVE ACTIVITIES IN ECSA REGION : Swaziland, Kenya, Uganda, Tanzania, Malawi, Zambia and Zimbabwe

Overview

Tuberculosis (TB) infects about 10 million people annually of which about 8 million of the infected persons develop active TB. Globally, tuberculosis incidence is rising by about 1% per year (Global TB Report 2005). This is almost entirely as a result of increases in the sub-Saharan Africa while in the other five regions; incidence is stable or falling. WHO estimates that almost 28% of TB in the African Region is attributable to HIV; hence HIV is clearly noted as one of the chief factors facilitating the increasing TB incidence in the region.

The impact of HIV/AIDS on TB stems from the fact that a big portion of the world is infected with Mycobacterium tuberculosis. The suppression of the immune system by HIV leads to activation of the dormant bacilli, and TB follows HIV infection with an average delay of 7 years (Williams et al).

Evaluation of the Regional Response to TB and HIV/AIDS Epidemics

ECSA Health Community Secretariat completed a multi-country study; Swaziland, Kenya, Uganda, Tanzania, Malawi, Zambia and Zimbabwe, to ascertain progress made on TB/HIV Collaboration, determine some of the critical issues that need to be addressed to strengthen collaboration and make recommendations on what countries could put in place as an expanded and effective response to both epidemics in a synergistic manner.

The assessment focused on evaluating progress made to this day with respect to; Policies and approaches in place for guiding collaborative TB/HIV activities, Private sector and NGO level of involvement in the implementation of collaborative TB/HIV activities, Level of implementation of collaborative TB/HIV activities from national to district and facility level, Extent to which the existing TB and HIV/AIDS guidelines and protocols do address collaborative TB/HIV issues, Sources and level of funding towards supporting collaborative TB/HIV activities and Challenges and constraints faced by countries with respect to implementation of collaborative TB/HIV activities.

Findings on National Challenges

1. Increasing numbers of both TB and HIV/AIDS patients to be cared for by the health system
2. The need to strengthen the TB/HIV collaborative forum within the national TB and HIV/AIDS Programmes

Although all districts have community DOTS, expanding and strengthening the existing DOTS infrastructure and linking it to the expanded voluntary counseling and testing services for HIV/AIDS, will provide the most important entry point for identifying people with AIDS who are eligible for ARV treatment.

Study Recommendations

1. Continue intensification of HIV prevention activities and facilitate behavioral change as well as prevention of new TB infections.

2. Constitute a TB/HIV collaborative forum through which all TB/HIV collaborative issues can be discussed and priority activities agreed

1. Continue the capacity building interventions for the staff to support the National.
2. Continue rolling out HIV/AIDS programme activities, especially VCT and ART countrywide in order to ensure access to such services by TB patients as well as to strengthen collaboration.
3. ECSA – HC to share the report and follow up implementation of the recommendations at country level

Policies and Approaches guiding TB/HIV collaborative activities

The NTP is part of the HIV/AIDS/STI and TB unit at the central level, and is responsible for planning, coordination, monitoring, training and evaluation of programme performance. TB control services are provided throughout all health facilities of the government, mission, uniformed forces and some large private organizations. The district serves as the central locus of management of TB control activities; and district health offices are normally responsible for facilitating patient diagnosis, treatment and follow-up through the facilities in the district in addition to supervising TB control activities and reporting on treatment outcomes. Hospitals mostly serve as diagnostic and treatment initiation centres while health centres or municipal clinics largely serve as treatment continuation centres.

Funding for TB is almost entirely met by government. The government funds TB as a separate budget line item through provinces and at national level. At the ART treatment is being rolled out using a comprehensive care approach. Also being rolled out is VCT, PMTCT, home based care and STI treatment. The ART roll-out was fashioned into phases

TB/HIV Issues & Interventions

TB/HI co-infection is estimated at 69% among TB patients in Zimbabwe and HIV/AIDS is said to be largely responsible for the ongoing increase in TB case notification. In view of this, the TB programme has been instrumental in efforts to address TB/HIV issue

There was no specific TB/HIV committee, task force or focal person but the fact that both TB and HIV/AIDS programmes fall under the same unit provides an opportunity for ongoing collaboration through the weekly unit level technical meetings. Despite this, there was still an apparent gap and lack of synchrony on TB/HIV collaborative issues between the TB and HIV/AIDS programmes as a result of not having a focal point person.

Political Commitment to TB/HIV

Zimbabwe's response in the fight against HIV/AIDS dates back to 1985 when the National AIDS Coordination Programme (NACP) was created in the Ministry of Health and Child Welfare to coordinate the National responses. Initial activities of the NACP focused on universal screening of all blood products, strengthening of treatment of sexually transmitted infections, HIV surveillance, IEC campaigns and overall HIV/AIDS control coordination

Monitoring and Surveillance

Zimbabwe established the sentinel surveillance system for HIV and syphilis in 1990, and implemented surveys in 1991, 1993, 1994, 1995, 1997, 2000, 2001, and 2002. The methodology of the surveillance was changed in 2000 with the introduction of parallel ELISA testing

as opposed to using single test in 2000. Other changes in 2000 involved addition of one sentinel site. These surveys continue to be the main source of information on trends of the epidemic

On service level monitoring, only the TB programme had well established tools and system for

Capacity Building

The health sector in Zimbabwe is currently experiencing increasing difficulties with retention of personnel and maintaining the necessary service delivery support logistics as a result of an ongoing macro-economic instability. This underlying problem is severely limiting the extent to which the TB and HIV/AIDS programmes can continue to be strengthened and scaled up.

Community Awareness

Community awareness has remained the cornerstone of the national response to HIV/AIDS in Zimbabwe and continues to focus at changing high-risk sexual behaviour and limiting unwanted pregnancies through safe sex practices as a primary strategy.

Funding

Was expected to support treatment scale-up for the year, meaning that

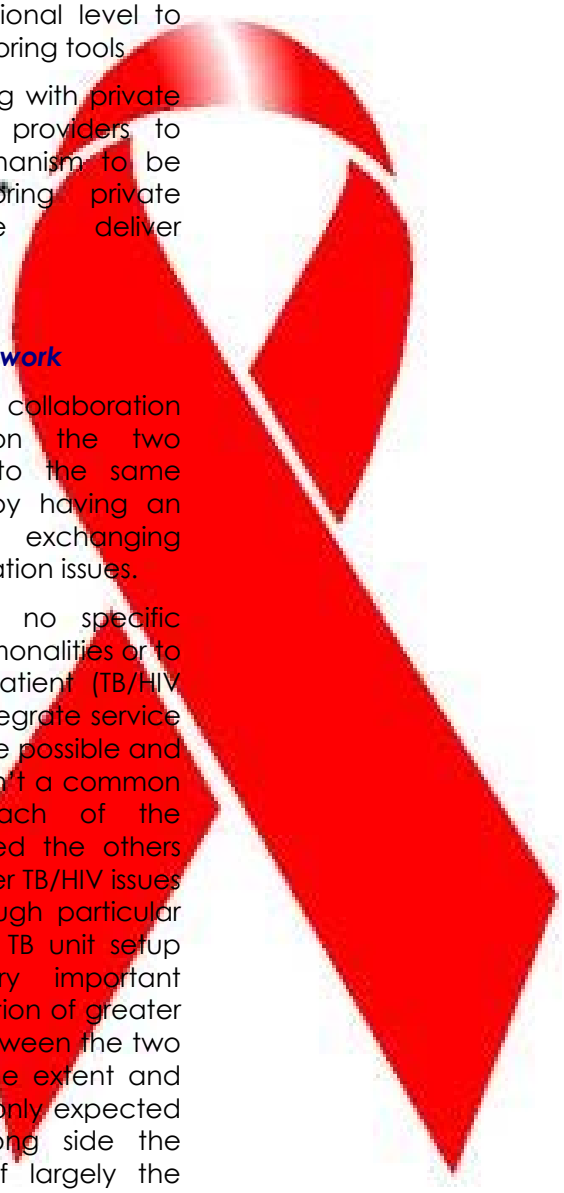
National Challenges

1. Ongoing decrease in numbers of health personnel at services delivery level
2. Limited availability of funding for programme implementation and ongoing scale up.
3. Absence of a TB/HIV focal person, committee and task force at national and any other levels
4. Lack of integration of TB/HIV collaborative issues into HIV/AIDS programmes
5. Slow rollout of the ART, hence ART access to TB patients is not yet guaranteed Inability to track TB suspects
6. Non-existence of tools for capturing of HIV data in TB clinic and non existence of ART registers
7. Non existence of in-house routine HIV testing for TB patients
8. Use of laboratory tests (CD4 count, LFTs and U&Es) as mandatory for ART eligibility
9. High user fees for laboratory and monthly supply of drugs plus low turn-up for ART initiation

Recommendations

1. Continue training more health worker in the lower generic cadres and exploring ways of enhancing retention of those in service
2. Intensify resource mobilization from government and donors
3. Appoint a focal person for TB/HIV collaboration and setup a task force or committee through which TB/HIV collaborative issues can be discussed and priority activities agreed
4. Integrate TB screening into relevant HIV/AIDS interventions
5. Continue ART roll-out including its decentralization to lower level health facilities involved in TB treatment continuation so that clients on both treatments don't have to attend different clinics

6. Conduct community mobilization campaign in the suburbs on overcrowding
7. Continue empowering nurses to take on most of the service delivery interventions
8. Proceed with plans to introduce VCT in all polyclinics and ART in larger clinics in the city
9. Work with the national level to develop ART monitoring tools
10. Conduct a meeting with private HIV/AIDS services providers to agree on a mechanism to be used for monitoring private sector service deliver contribution.



TB/HIV collaboration framework

The current TB/HIV collaboration framework is based on the two programmes belonging to the same organisational unit thereby having an ongoing forum for exchanging information on implementation issues.

There has so far been no specific process to tease out commonalities or to focus on the common patient (TB/HIV co-infected patient) to integrate service delivery approaches where possible and feasible. Although there isn't a common strategy for TB/HIV, each of the programmes has consulted the others and incorporated whatever TB/HIV issues could be addressed through particular programmeThe AIDS and TB unit setup hence presents a very important opportunity for the facilitation of greater ongoing collaboration between the two programmes. However, the extent and depth of collaboration is only expected to slowly strengthen along side the ongoing strengthening of largely the HIV/AIDS programmes