



GHAIN SUPPORT TO TB-HIV INTEGRATION IN NIGERIA

END OF PROJECT MONOGRAPH

GHAIN SUPPORT TO TB-HIV INTEGRATION IN NIGERIA
END OF PROJECT MONOGRAPH

TABLE OF CONTENTS

Introduction	4
<hr/>	
GHAIN's TB-HIV strategy	6
<hr/>	
Program achievements	7
<hr/>	
Discussion	9
<hr/>	
Conclusion	10
<hr/>	
References	11

INTRODUCTION

The relationship between HIV and tuberculosis (TB) epidemics is well established (WHO, 2009). HIV is a key risk factor for the reactivation of latent Mycobacterium tuberculosis infection and increases the risk of recurrent tuberculosis (Korenromp et al, 2003) making TB the leading cause of death among HIV-positive individuals (WHO 2009a). The World Health Organization (WHO) estimates that HIV-positive people are nearly 20 times more likely than HIV-negative people to develop TB in countries with a generalized HIV epidemic (ibid). With the third largest number of people living with HIV (PLHIV) in the world, Nigeria's substantial burden of TB is not surprising. Globally, Nigeria ranks fourth in total number of TB cases with nearly half a million in 2007, 27% of whom are co-infected with HIV (WHO, 2009a). Even though HIV is known to affect more females than males, the reverse is the case with TB, with available data showing more male infections (Allotey and Gyapong, 2008)

Historically, global and national responses to TB and HIV epidemics have worked separately implementing vertical disease programs. However, the synergy between the two control programmes is increasingly recognized. This dual epidemic has a better chance of being controlled through combined and coordinated efforts for both TB and HIV (WHO, 2009a). In response to the gap in integrated TB-HIV programming, the WHO HIV/AIDS and TB departments developed several guidelines and tools on TB-HIV integration (WHO 2003, WHO 2004a, WHO2004b, WHO 2004c). The WHO recommended twelve collaborative TB-HIV actions and 'The Three I's': Isoniazid Preventive Treatment (IPT), intensified case finding for active TB, and TB infection control, as key public health strategies to decrease the impact of TB on people living with HIV (WHO 2009b).

TB and HIV service organization prior to GHAIN integration pilot

The National TB Control Program is structured along the three tiers of government at the Federal, State and Local Government Area (LGA) levels, with the National TB and Leprosy Control Program (NTBLCP) responsible for providing the framework for the control of TB. The Directly Observed Therapy Strategy (DOTS) was adopted in 1993. This was later broadened to include the global Stop TB Strategy in 2006. The national level facilitates policy and human resource development, resource mobilization, technical support including monitoring and evaluation (M&E) of state programmes. The state level coordinates TB control activities in each state and also provides technical assistance to LGA level.

Although there was a National TB-HIV working group that was functional at the national level, there was little collaboration between HIV and TB programs at the state and LGA levels and at the operational levels within the health facilities. Integration between TB and HIV programs at facility levels were challenged by limited knowledge and experience on TB-HIV collaborative activities by antiretroviral therapy (ART) and DOTS care providers, as well as TB and HIV programme managers. Other barriers included weak referral systems between TB and HIV programs, stigma on the part of TB patients in accessing HIV Testing and Counseling (HTC), and dilapidated infrastructure in DOTS sites.

The Global HIV/AIDS Initiative Nigeria (GHAIN) has been a key supporter of TB-HIV integration activities in Nigeria since 2007. Launched as a pilot program in Cross River and Lagos States of Nigeria, the program now supports TB-HIV integration in 186 sites across every state in the country. The wide coverage of the GHAIN was a good leveraging opportunity to provide a one stop access to TB-HIV services, thereby improving very significantly TB case finding amongst people living with HIV/AIDS (PLHIV), and vice versa. The integration of both programs has also added value in information sharing and problem management among the various communities in Nigeria where GHAIN provided support.

GHAIN'S TB-HIV STRATEGY

GHAIN provided a model that strengthened referral links in co-located TB and HIV clinics to optimise the acceptability of the interventions by patients, service providers and programme managers. TB and HIV services remained separate with parallel supply chain management system but the basic programmatic and service arrangements within the health facility was expanded so that HIV diagnosis, prevention, care and support services are integrated into the DOTS program while TB screening, care and support services are incorporated into the HIV program. To implement the model, GHAIN provided support to upgrade DOTS facilities and Acid Fast Bacilli (AFB) microscopy centres, built capacity through training, onsite mentoring, supporting TB infection control, formalizing and strengthening the referral mechanism between TB and HIV service points. GHAIN developed SOPs and provided job aides to care providers and microscopists. Many DOTS and AFB microscopy facilities were upgraded to meet minimum national standards for the provision of TB-HIV services. A TB minimum standard package, taking into consideration TB infection control measures, was developed to guide the improvements. This minimum package included basic infrastructure, equipment, reagents and consumables for service delivery in the AFB lab and DOTS clinic with good infection control.

Capacity development was supported by training health care workers, TB-HIV programme managers at state and LGA levels on: TB-HIV collaborative activities, detection and management of smear negative tuberculosis, TB infection control, HTC, and AFB microscopy. DOTS providers were trained on HTC. Conversely, HTC providers were trained in the clinical screening of TB. Additionally, health care workers (HCWs) in both TB and HIV service points were provided with SOPs and job aides, and received regular onsite mentoring and supervisory visits by GHAIN technical officers.

PROGRAM ACHIEVEMENTS

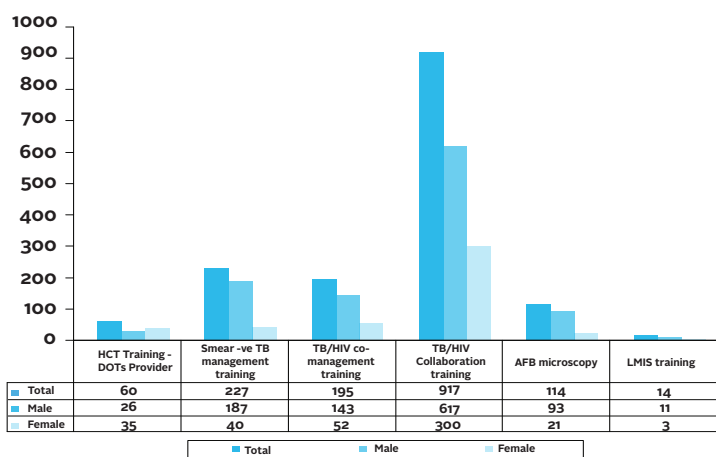


Fig 1: Number of health care workers trained on TB-HIV related curriculum between 2007 and 2010

The referral mechanism between TB and HIV service points was formalized and strengthened through establishment of referral forms and registers, a referral directory, and appointment of a facility based referral focal person to coordinate referral activities.

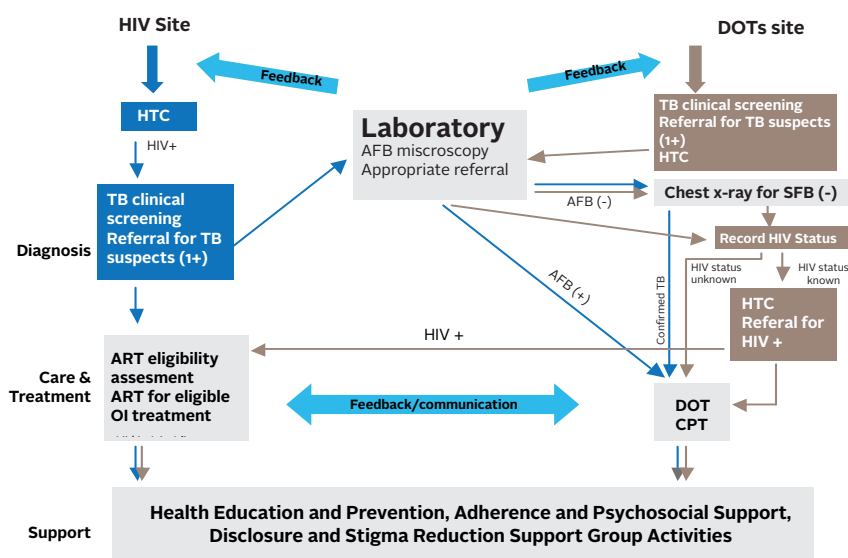


Fig 2: Flow Chart of TB-HIV Integration at Facility Level

HTC serves as a primary entry point for identification of HIV positive TB suspects. All HIV positive patients undergo clinical screening for active TB by trained providers using a set of five questions related to TB: cough for more than three weeks, weight loss of more than 3kg in last four weeks, lymphadenopathy, fever for more than two weeks, and night sweat for more than two weeks.

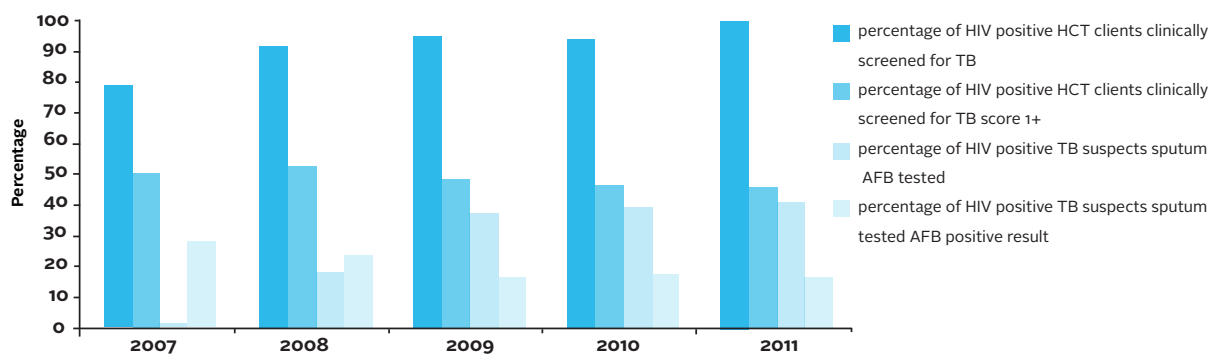


Fig 3: Cascade of TB HIV collaborative activities in All FHI sites (2007 to 2011)

Adaption of the National TB and TB/HIV M&E system

National TB M&E tools were revised to include the essential data elements of TB-HIV collaborative activities. The service integration model guided revisions to the national TB register, HTC client intake forms, TB treatment cards which in turn informed the selection of HIV integration data elements and indicators used in Nigeria.

LGA TUBERCULOSIS CONTROL REGISTER

Date of Reg.	LGA TB No.	Name	Sex	Age		Address (in full)	Treatment unit\health facility	Date Treatment Started	Treatment Category ³	Site ⁴		Type of patient ⁴									
				M/F	(years)					P/PE	N	R	F	RAD	T	O					

FACILITY TUBERCULOSIS CONTROL REGISTER

TB treatment start date ¹	Name	LGA TB No. ²	Facility Client No. ²	Male		Female		Treatment Category	HIV status at TB treatment Start				TB Site		Type of patient ⁵																								
				< 15 yrs	>= 15 yrs	< 15 yrs	>= 15 yrs		HIV unknown	HIV negative	HIV positive non ART	HIV positive ART	pulmonary	Extra-pulmonary	N	R	F	D	T	O																			
								I II																															
Total on this page²:																																							

Data analysis outputs are generated and discussed at monthly GHAIN M&E meetings which are reported and fed back quarterly to the state TB control programme through the LGA TB and Leprosy TBL supervisors for dissemination.

DISCUSSION

The success in TB-HIV collaboration and integration efforts under GHAIN project lay in its strong organization, technical strength and network of offices that monitor and mentor service implementation with the key stakeholders at facility and program management levels. Most of the innovations discussed above have been adopted and adapted by the Government of Nigeria in its national response to HIV. Some of these achievements can be attributed to the “family centered” model for TB and ARV services at some sites where appropriate guidelines and protocols were in place. The access to service of one family member invariably meant an opportunity for the entire family membership to access care and treatment for TB-HIV.

GHAIN's collaboration with the Global Fund for AIDS, TB and Malaria (GFATM) has effectively leveraged additional resources to improve the efficiency while building capacity, strengthening institutions and improving the overall Nigerian response to HIV/AIDS, Tuberculosis, and Malaria. The strategic concept of the GFATM and United States President's Emergency Plan for AIDS Relief (PEPFAR) collaboration implies a gradual synergy of resources among PEPFAR, GFATM and the GoN to achieve the necessary impact.

With the clear objective of sustainability in the course of the 7 year project, GHAIN built capacity of its major stakeholders and institutions at the national, state, local and facility level in different areas. The support focused on relevant national policy documents, job aids and tools, SOPs and training manuals and has generated a pool of persons to respond to TB-HIV intervention across communities in the country.

The monthly M&E meeting provided an opportunity for program review, decision making, strategies to improve program performance at state and local levels. Procurement and supply chain management is a major milestone on sustainability as this is now the prerogative of the Federal Ministry of Health. GHAIN was instrumental in, strengthening procurement and supply chain systems by building the capacity of government staff in logistics management, reporting and requisition at all levels. Funds were leveraged to support commodities distribution nation-wide during stock-out, as well as the upgrading medical stores within the country.

Despite the progress in improving TB-HIV collaboration and integration in the supported states and health facilities, many challenges still exist. Coordination in some states is weak due to absence of functional TB-HIV working groups for regular joint meetings and planning among key stakeholders. Inadequate human resource is a major limiting factor at most sites. As more clients became aware of TB-HIV linkage, it became difficult for facility staff to cope with increasing client load accessing TB-HIV services. In addition, the centres continuously reported difficulty with staff retention due to low morale and a perceived lack of incentives for the increased work load which the project attracted. The frequent industrial action by staff was a major impediment. Stock out of TB drugs and laboratory reagents in the country is another major challenge. In situations where it resulted from movement delay from the central stores or port, GHAIN supported states and the national TB program with logistic, technical or financial support in distribution to the supported zones. Furthermore GHAIN provided training on logistic management information system for TB control to address the challenges.

CONCLUSION

The TB-HIV epidemic in Nigeria is still unfolding; collaborative activities are still at an early stage in Nigeria and will need to be further scaled up at all levels, as more funds are committed to the implementation of joint TB-HIV activities by all tiers of government and its partners. GHAIN has shown that operational research in TB-HIV in selected sites in Lagos and Cross River states in 2005 are useful to inform scale up of public health programs. Looking ahead, clinical services should be provided by PHC facilities and in the community. Links with community-based organizations, including trained community pharmacists, and home-based care services should be emphasized. PHC peer support groups should provide support to people living with TB-HIV and should reduce the need for secondary level facility-based peer support groups.

REFERENCES

1. Allotey, P., Gyapong, M. (2008) Gender in TB Research. *International Journal of TB and Lung Diseases* 12 (7): 831-836 (Online) available at <http://apps.who.int/tdr/publications/journal-supplements/gender-tb-research/pdf/gender-tb-research.pdf>
2. Korenromp EL, Scano F, Williams BG, Dye C & Nunn P (2003) Effects of human immunodeficiency virus infection on recurrence of tuberculosis after rifampin-based treatment: an analytical review. *Clinical Infectious Diseases* 37, 101–112.),
3. World Health Organization (2003) Guidelines for collaborative TB and HIV programme activities. Geneva: World Health Organization.
4. World Health Organization (2004a) TB/HIV: a clinical manual. Geneva: World Health Organization.
5. World Health Organization (2004b) A guide to monitoring and evaluation for collaborative TB/HIV activities. Geneva: World Health Organization.
6. World Health Organization (2004c) Guidelines for HIV surveillance among tuberculosis patients. Geneva: World Health Organization.
7. World Health Organization (2009a) Global tuberculosis control: epidemiology, strategy, financing. Geneva: World Health Organization.
8. World Health Organization (2009b) Tuberculosis and HIV. Accessed on 10 June 2009 at <http://www.who.int/hiv/topics/tb/en/>.
9. Nigeria Federal Ministry of Health (2009). 2008 national HIV sentinel survey. A technical report. Abuja, Nigeria: Federal Ministry of Health.



Funded by the President's Emergency Plan for AIDS Relief through U.S. Agency for International Development