

HATIP

HIV & AIDS Treatment in Practice

Issue 114 | 24 July 2008



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Improving TB/HIV collaboration: practical examples from the 2008 HIV Implementers' Meeting

This edition of *HIV & AIDS Treatment in Practice* covers the practical aspects of TB/HIV collaboration, looking at lessons from a wide range of countries presented at the recent HIV Implementers' Meeting in Kampala, Uganda.

The first article looks at improving the diagnosis of HIV in TB patients, and reports on how programmes have tackled the service design problems that contribute to the low rate of HIV diagnosis in this group of patients.

The second article looks at how HIV care, including antiretroviral therapy, can be delivered to TB patients. Is it best done through TB programmes or HIV clinics, or does it depend on the setting - and the patient?

Three related news reports at www.aidsmap.com look at other collaborative issues:

- TB/HIV collaboration: [an overview](#).
- [Monitoring and evaluation](#): how partners and funders are trying to harmonise monitoring and evaluation of TB/HIV activities.
- How well are HIV programmes doing at [incorporating the Three I's](#)?
- [What difference does community-level TB/HIV activism make?](#)
Examples of successful interventions from Swaziland, Uganda, Cote D'Ivoire and Nigeria.

Readers are also invited to fill out a Stop TB Partnership questionnaire on TB/HIV collaborative activities.

Theo Smart, Editor

Improving HIV diagnosis in TB patients: new approaches bearing fruit

Improving HIV diagnosis in TB patients: new approaches

A growing number of programmes in PEPFAR-focus countries have introduced provider-initiated HIV testing and counselling for TB patients, according to reports at the HIV Implementers' Meeting in Kampala, Uganda, but they have taken different approaches to introducing the service.

Some reported good results from training TB clinic staff to directly provide HIV testing and counselling, while in other settings, lay counsellors are being hired on to provide the services at the TB clinic. In other settings, co-location of an ART clinic with a HIV testing and counselling service on-site — with aggressive outreach and education of TB clinic clients—led to fairly good rates of HIV testing, even when TB clinic staff were initially reluctant to refer patients.

The gateway to essential services

HIV testing is the gateway to other services for HIV including HIV prevention services, cotrimoxazole, HIV treatment and care, and, of course, ART — all of which are essential for good long-term outcomes of people coinfecting with TB/HIV. But experience has demonstrated that simply referring people with TB — whose survival may depend upon knowing their HIV status — to a stand-alone voluntary counselling and testing (VCT) facility leads to low rates of HIV testing. Many will delay testing, often until it is too late.

Last year, WHO endorsed introducing provider-initiated testing and counselling (PITC) together with expanding voluntary counselling and testing (VCT), releasing guidelines to assist countries to standardise and expand provider-initiated testing and counselling through healthcare facilities ([download pdf version of guidelines here](#)).

But how best to provide PITC depends on the local setting so teams working on the ground have had to adapt their approach based upon the available resources (especially human) and support system. It is clear however, that regardless of how HIV testing and counselling is delivered, educating TB staff and people with TB about TB/HIV coinfection, as the availability of HIV services (preferably on site) increases testing uptake.

Scaling up HIV testing in Tanzania

In Tanzania — where about half of people with TB also have HIV — the Program for Appropriate Technology in Health (PATH) has been working with the Ministry of Health and Social Welfare and the National TB and Leprosy Programme to introduce HTC into the PEPFAR-funded clinics in the regions where PATH works (Makame).

The programme was piloted at three sites in 2005, and began scaling up nationally in 2006. The project started out by recruiting, training and deploying TB/HIV coordinators to the regions and districts, who then trained local healthcare providers using a manual on PITC that had been translated into Kiswahili. By March 2008, PITC was introduced into 9 regions and 31 districts in the country. By the second quarter of 2008, 84.2% of newly diagnosed TB patients were receiving PITC. (Note: other PEPFAR partners are helping coordinate PITC services in other parts of Tanzania —for instance, a poster from ICAP reported that 90-96% of those with unknown status accepted PITC in Tumbi Regional Hospital (Maruchu)).

But according to Dr Mohammed Makame, of PATH, there have been some hurdles along the way. For instance, many TB facilities had no private physical spaces to discretely provide HIV testing and counselling; the supply of HIV test kits was sometimes erratic; and, there was a general shortage of clinicians with knowledge of TB and HIV co-management, continued poor understanding of PITC amongst clinic staff, and a shortage of staff to perform testing and counselling in some facilities.

Employing lay counsellors in Lesotho

In Lesotho, lay counsellors are filling that gap. Dr Biggie Mabaera of University Research Co, (URC) reported on their efforts helping to introduce HIV testing and counselling into TB clinics in 6 out of Lesotho's 10 districts. When the project started in 2006, TB clinics referred people with TB to ART sites or voluntary counselling and testing centres (VCT) for HIV testing — and only 16% of them followed through on the referral. According to Dr Biggie Mabaera,

the TB officers were simply too “overwhelmed with other responsibilities” to provide HIV testing and counselling themselves.

So instead, URC trained lay counsellors who became paid employees providing the service at the TB clinics. Two weeks were spent training on HIV testing and counselling, with further training on tuberculosis symptoms and signs, the relationship between tuberculosis and HIV, and how to record TB/HIV data.

Improvement was rapid. Over the course of 2007, 52% of the registered TB cases were tested for HIV (78% of whom tested HIV-positive), and by the first quarter of 2008, 74% of the people with TB were being tested. One hospital, which had tested less than 1% of its TB patients in 2006, tested 75% of the TB patients in the first quarter of this year after the addition of just one lay counsellor late last year.

One challenge is that the lay counsellors are already being given other responsibilities in these busy clinics. Nevertheless, “lay counsellors - when they are properly supervised can allow facilities to both rapidly expand HIV testing and counselling for TB patients and also implement integrated TB/HIV management. HIV testing and counselling uptake can also be improved by offering HTC right in the TB clinics, rather than by referring patients to the ART clinic or to the VCT centres,” said Dr Mabaera.

Resistance to PITC in South Africa

As reports from the first South African TB Conference (held this July in Durban) will later confirm, many TB clinics in the country are struggling with how to scale up HIV testing. Several presenters at that meeting reported that people with TB refuse to be tested because they do not want to have to deal with having two diseases at once. In light of this, there are lingering concerns about how to introduce PITC and at the same time keep HIV testing voluntary. (Reports from the South African TB Conference will be published over the course of this month).

At the HIV Implementers' Meeting, Dr Munira Khan of the CAPRISA AIDS Treatment Programme described their attempt to introduce PITC for people with TB at the Prince Cyril Zulu Communicable Disease Centre (PZC-CDC) in eThekweni district in KwaZulu Natal, the district with the highest burden of TB (and with the worst outcomes). HIV coinfection rates in the district are over 50%.

Before the eThekweni HIV treatment clinic was set up with testing and counselling on site, the PZC-CDC also relied on traditional VCT (and had low testing rates). TB programmes have generally driven HIV screening for their clients in other countries, but perhaps given the ambivalence about HIV testing in South Africa, in this instance, the HIV clinic drove the introduction of PITC into the TB clinic.

This proved challenging however.

“Initially the concept of PITC was difficult to promote – particularly amongst the TB staff. And this was reflected in our referral rates, which were low in the first two months,” said Dr Khan. In fact, the TB staff only referred 10% of the TB patients for testing. Since training for the TB staff about HIV coinfection took place, referral rates have increased, but only to 31%. This is still a long way from routine referral for testing.

So to further enhance uptake, the HIV clinic conducted outreach in the TB clinic by putting up posters outlining the on-site HIV services in the TB waiting areas, and by providing informal health education sessions on hygiene, the link between TB and HIV, TB treatment and adherence, as well as on HIV treatment – all the while, promoting counselling and testing. Additionally, “once it was

discovered that many men had difficulty relating to young female counsellors, male counsellors were hired,” said Dr. Khan.

In addition to hiring more counsellors, to further increase capacity to meet increased demand, the counselling space was divided to provide for more private counselling booths. Eventually, the site also began offering ‘group’ pre-test counselling sessions (with individual post-test counselling).

In the 19 months after PITC was first introduced, 2375 new smear positive patients were seen at the TB clinic, 1,457 of these were approached about testing; and 975 (67%) agreed to test.

“We also found that there was a high degree of refusal to test initially,” said Dr Khan. So they conducted a separate study to find out why people didn't want to be tested. By far, the leading reported reason proved to be that people ‘already knew their status.’ “It is important to note, however, that there was no proof of knowledge of status at this time of contact,” she said, (or that the knowledge was current). ‘Fear of being positive’ (especially among men) and a ‘desire to treat TB first’ were the next most common excuses, followed closely by “no time to wait.” A similar number also reported that they were already on ART.

Improving the quality of the service to test ALL – and not just some – TB patients for HIV

Similarly, a poster presentation from Uganda suggested that understanding the reasons why people choose to test or not, and then improving the quality of the service accordingly, would increase testing (Okot-Chono). Despite it being national policy since 2006, HIV testing in TB patients remains very low in the country, at around 30%. So a questionnaire was administered to four hundred people with TB in five districts. Of those who had not previously tested for HIV, 65% tested after receiving their TB diagnosis. In a multivariate analysis, factors that significantly increased the uptake of HIV testing included ‘feeling that their privacy was observed,’ a short waiting time (under an hour), and education about the importance of HIV testing for people with a recent TB diagnosis (and the links between TB and HIV).

But another study finding was that a large proportion of those diagnosed (over a third) had tested for HIV prior to TB, and didn't retest. “Patients who were found to be HIV-negative [before their TB diagnosis] need to re-test for HIV before completion of TB treatment, and TB care providers should be urged “to routinely practice PITC for all TB patients,” the study's authors concluded.

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Getting the formula right to deliver HIV services, including ART, to TB patients with HIV

TB programmes and clinics face significant hurdles linking people with TB who they test and diagnose with HIV to other HIV services included antiretroviral therapy (ART) — even when those services are co-located — according to reports at the 2008 HIV Implementers' meeting in Kampala, Uganda.

While there is widespread agreement that these services are essential, programmes are adopting different approaches to TB/HIV service integration — with responses ranging from 'one-stop' shops to escorted referrals. But the success of these approaches may vary from setting to setting.

"In our setting, people chose not to go to the ART clinic that was right around the corner...a one-stop shop was not enough," Dr Mike Kalulu of Lighthouse Trust in Lilongwe, Malawi told the meeting.

It's becoming increasingly clear that providing more convenient access to HIV services is only part of the solution. People with TB diagnosed with HIV also need information, counselling and support to address stigma, disclosure issues and other fears that are a barrier to uptake of HIV treatment and care.

Improving the care of TB patients diagnosed with HIV

More TB programmes and clinics in resource-limited settings are routinely testing people with TB for HIV, but, in order for testing to make a difference, TB patients who test for HIV should also receive prevention services, cotrimoxazole to prevent serious infections, basic care and treatment for opportunistic infections and other HIV-related condition, and eventually ART.

At one time, TB clinics could only make referrals to HIV clinics for those services, but experience has demonstrated that referrals between these separate programmes — often housed in separate facilities — tend to lose high numbers of patients.

"It is not uncommon for HIV-TB coinfecting patients to slip through the cracks in the referral system and be lost to follow-up after completion of TB treatment, resulting in lack of timely access to ART and the consequent unfavourable outcomes for both HIV and TB," wrote Dr Vikas Inamder and colleagues in a poster on the integration of HIV care and support for TB patients in South India.

When it comes to providing HIV care and treatment, including ART, most TB programmes and clinics respond by either trying to make the referral process airtight or by finding a way to deliver some or all of those services on site (either co-location of ART and TB clinics or by providing HIV services within the TB clinic).

Prevention services

After testing for HIV, TB patients need HIV prevention counselling and support just like anyone else — but this service is often overlooked. According to a Population Council survey in three

provinces in South Africa, less than 20% of TB clinic patients reported receiving any HIV prevention information (Maphanga).

TB patients who test HIV-negative should receive counselling and services (access to condoms, etc) to keep them that way. It is an integral part of HIV testing and counselling. But if the person tests positive for HIV, it could also trigger a number of other useful interventions, as Dr Reuben Granich of WHO pointed out during a discussion on TB/HIV integration.

"When someone has a positive test result, it represents an important prevention opportunity because they all have partners and families who are at risk for HIV. Some countries are now moving to partner testing and actually taking it to the next level in terms of seeing TB patients as a part of a larger family and a larger community," he said.

The practice in Rwanda can serve as a model.

"For every TB patient that we identify with HIV, a home visit is carried out and at that visit, they do sensitisation to do an HIV test on all the family members that are not yet tested," said Dr Greet Vandebriel of the International Center for AIDS Care and Treatment Programs (ICAP) during the symposia, "and this has increased significantly HIV testing."

HIV prevention and testing for the family dovetail nicely with TB contact tracing — another critical intervention for the family's wellbeing because TB usually spreads within the home. TB clinics serving coinfecting populations should thus be equipped to provide these family-based interventions during home-visits. This means training staff, peer educators or community-based DOTS supporters — and providing them with some way of documenting whether the activity was thorough and complete.

This might be facilitated by adapting the 'Family HIV/AIDS care and treatment enrolment form,' developed by ICAP in Ethiopia. Whenever a person with HIV is diagnosed, they are asked about their other family members. This information is recorded on the form, which includes a box for every family member, a legend the counsellor making the home visit can use to note counselling and testing status for each family member, and whether they are on ART yet or not. The form can easily be amended to include TB elements including whether the family member has been screened for TB, diagnosed and on treatment, or given isoniazid preventive therapy (IPT) to keep household contacts from getting TB.

Cotrimoxazole

There is ample evidence that TB clinics can give cotrimoxazole preventive therapy (CPT) to their clients with TB who test positive for HIV — but as a survey in Uganda has shown, (see PEPFAR TB/HIV Intro article), it doesn't just happen automatically. Standard operating protocols must be developed, supply chain management systems put in place and health care workers trained to implement and monitor cotrimoxazole provision, as well as ways developed to educate and support the patient.

In Lesotho, Dr Biggie Mabaera of the University Research Co said that last year supported sites were getting between 60-80% of the HIV-positive TB patients onto cotrimoxazole. Dr Mabaera said it would have been higher were it not for stock-outs of the drug — "a problem that has since been rectified," he said.

Similarly, Dr Fadare Amos Omoniyi of WHO described the rapid rollout of cotrimoxazole at DOTS centres in 12 Nigerian states where WHO and USAID are supporting TB/HIV collaborative services. While attending the TB clinic, cotrimoxazole is provided regardless of CD4

cell count (which most TB facilities aren't equipped to provide). By the fourth quarter of last year, 84 out of 90 of the DOTS centres in those states had implemented the intervention so that, overall, 79% of TB clients diagnosed with HIV at those 90 facilities were receiving cotrimoxazole from their DOTS centre.

HIV treatment and care, including ART rarely accessed

But that, unfortunately, appears to be the limit of HIV services offered to TB clients diagnosed with HIV in many settings.

"CPT, because it is provided at the DOTS centre, in some cases is actually the only anti-HIV/AIDS treatment that somebody that is dually infected has access to in the course of their TB treatment because of the distance to the ARV centre," said Dr Omoniyi.

There are relatively few HIV clinics (at present, only about 240 that can dispense ART) spread across the country, serving a population of over 3 million people with HIV, compared to thousands of primary healthcare clinics.

The Population Council survey of TB and HIV clinics in Gauteng, Northwest and Mpumalanga provinces of South Africa made a similar observation: "ART services are offered at far fewer points than TB services, which can be accessed at primary health centres," wrote Maphanga et al.

In the case of Nigeria, what is even more worrying is that patients aren't referred to the HIV clinics until the very end of TB treatment, which in that country goes on for up to 8 months.

Many programmes are beginning ART sooner in the hope that it will improve outcomes. But survival is poor even when people with TB and HIV have early access to ART, according to a poster describing the provision of ART to seriously ill in-patients at Nkqubele TB Hospital in the Eastern Cape (Verkuijl). With ICAP's assistance, since September 2006, TB hospital began staging patients who test positive for HIV. In-patients who have CD4 cell counts below 50 and/or serious stage IV diseases are started on ART while still on the intensive phase of TB treatment (two months for new cases and three months for retreatment cases), while those with CD4 cell counts between 50-200 are prepared for ART, aiming to begin treatment at the nearest ART clinic immediately after discharge (during the less intensive phase of TB treatment).

But even with aggressive treatment, mortality remains high: 16% during preparation for ART and 21% after starting ART (compared to an overall mortality of 24% for the hospital during the same period). (It should be noted that immune reconstitution inflammatory syndrome (IRIS) and drug-resistant TB were a problem in this population).

"Many co-infected are admitted in a very poor clinical condition," wrote the poster's authors, and they recommended that ART should be initiated early in any in-patient with less than 100 CD4 cells.

Dr Omoniyi acknowledged that people with TB/HIV in Nigeria often don't survive to complete the referral to the HIV clinic and make it onto ART, so he recommended that the "available human resources at facilities providing DOTS services – which are mostly at primary healthcare centres that are very close to the people – should be leveraged to provide ARV services for those without access to these services."

But to achieve this, most countries would have to either use clinical eligibility criteria for ART, (WHO clinical staging) and/or treat all patients coinfected with TB/HIV, since CD4 cell count monitoring is unavailable in most primary healthcare clinics, or invest in strengthening the laboratory and probably the human resource capacity at the primary healthcare level.

This approach works in some programmes (see below)— but it cannot be done everywhere.

For example, using a public health approach, Malawi has set up 200 ART clinics in public and private facilities, often staffed only with trained nurses, and has put 100,000 people on ART – an impressive accomplishment from one of the most resource-challenged countries in the world.

TB treatment isn't really provided by primary health clinics in Malawi, however. Instead it is initiated at 48 centralised facilities, and treatment continuation is decentralised to 600 facilities. People with TB/HIV automatically qualify for ART, unless they have high CD4 cell counts (and CD4 cell monitoring isn't widely available).

In Malawi, the goal is to get people onto treatment, and ART is supposed to begin two months after initiating TB treatment. But ART simply cannot be prescribed at the TB continuation clinics that are run by non-medical staff (like social workers/government officials).

So at present in Malawi, people with TB/HIV must be referred to the ART clinics – with mediocre uptake.

"Sixty percent of our TB/HIV patients don't get on ART," said Dr Kalulu. It should be noted however that only a few programmes in the world are reporting higher rates (see later in the article).

Disappointing results with co-located TB and HIV clinics in Malawi

But what's more disturbing, as Dr Kalulu and colleagues discovered, is that results are more or less the same even when an ART clinic is situated in the same hospital as the TB clinic.

The Martin-Preuss-Centre at Bwaila Hospital in Lilongwe, is the country's first integrated TB/ART facility, opened by the Department of Health and the Lighthouse Trust in 2006. The TB and HIV clinics are actually in two separate wings of the hospital, to assist infection control.

Yet, only 36% of the TB patients with HIV actually complete the referral within the same facility and get onto ART.

To find out why, the team examined the hurdles between the TB clinic and getting on ART.

HIV testing certainly wasn't the problem. Through routine HIV counselling and testing, the TB clinic was able to determine the HIV status of about 92% of the patients. 68% were HIV-positive.

However, there were problems with retention even within the first two months of TB treatment, with 16% lost to follow-up. Some of these may have chosen to continue to get treatment at their local centres – though Malawi has a transfer system that tries to keep track of TB patients. Some were quite possibly dead, indeed, 2% were known to be dead within the first two months.

The next hurdle to ART was that patients need to have a smear-negative sputum result before admission to the ART clinic to make sure they weren't infectious – which meant a sputum collection at the two-month visit. Because of the high number of specimens at the lab, patients had to come back for another clinic visit to get their results and referral to the HIV clinic.

Once they had their smear-negative result, they were sent to the hospital pharmacy to pick up their TB meds and directed to go to the ART clinic reception, *which is right around the corner*. But 30% of the coinfecting patients picking up their TB meds simply chose not to go to the ART clinic.

Those who did register at the ART clinic were given a clinical assessment and attended a group education session on lifelong ART, and instructed to return one week later to start ART.

But 44% of them didn't come back, although a few did straggle in months later.

So co-locating the clinics in the same health facility may not always be enough. However, co-location is not the only way — and in fact, may not be the best way — to provide a ‘one-stop shop.’

One-stop HIV care and treatment provided by the TB clinic

“Even in hospitals where both TB and ART services are offered, they are not offered in the same division. The two services function separately from one another,” the Population Council study noted and the author’s concluded that both HIV clinics and TB clinics needed to be able to provide all the essential TB/HIV services, staffed “with better trained providers who are able to manage and treat both HIV and TB.”

This approach has been adopted by several groups, including MDH, a PEPFAR-supported partnership between Muhimbili University, the Dar es Salaam City Council and Harvard School of Public Health, after the programme noticed that there were poor referral rates between TB facilities and HIV care and treatment centres and concluded that receiving care at two facilities increased the risk of treatment non-adherence (Makubi).

MDH developed the laboratory and human resource capacity within TB clinics to screen TB patients for HIV and then provide those who were positive with full HIV care and treatment, including ART, if the client was eligible.

The TB clinics achieved high testing rates (87%), and as many as 471 out of 552 (86%) of those who were eligible were started on ART and monitored at the TB clinic until the completion of anti-TB therapy, at which time they were referred to an ART clinic.

According to Dr Kalulu, Malawi is now planning to place ART clinicians in the TB clinic —which would also allow the clinic to initiate ART during the first two months of TB treatment rather than waiting until after the client has a confirmed sputum conversion. But it may remain a challenge getting HIV services to people attending one of the 600 local TB treatment continuation sites.

And even if HIV services are integrated into the TB initiation clinics, there must be a referral to the ART clinic one day, when TB treatment is complete.

Directly observed referrals?

Another option, particularly when the HIV and TB clinics are next to each other or under the same roof, is an accompanied referral — where someone is designated to escort the person with TB/HIV from one clinic to another — which was described as an important part of Rwanda’s programme at last year’s Implementers’ Meeting (see <http://www.aidsmap.com/cms1230941.asp>).

It is working pretty well for a rural facility in Mozambique, the Nicoadala Health Center, which houses both a TB and HIV unit, according to a presentation by Dr Anna Scardigli, a TB/HIV technical advisor to ICAP in that country. In 2007, a TB/HIV focal point nurse was established to accompany TB/HIV patients between services within the facility, reinforce their counselling, and improve data collection. During the last quarter of that year, 45/56 (80%) of the TB patients who were unaware of their status got tested for HIV. Twenty-two were positive and 68% of those enrolled into the ART clinic immediately and 87% within the next few months. 53% of the all the TB/HIV co-infected patients have begun ART (which is either efavirenz or abacavir-based).

Referrals could also be escorted by direct observed therapy DOTS workers, trained community members or peer educators. For instance, the TB programme in South India is using TB DOTS supporters to help make effective referrals to ART centres during

the intensive phase of TB treatment (although only for ART preparation because ART is usually started after the intensive phase is completed in that country) (Inamder). An advantage of working with a DOTS supporter or community adherence supporter is that the patient will have an ongoing relationship — so there could be more than one opportunity to make an effective referral.

TB/HIV education, support and community sensitisation

Another advantage of having a TB/HIV focal point nurse or peer educator is that every point of contact with the person with TB/HIV provides an opportunity to give them information about ART and support.

Given the large proportion of people in Malawi who made it to the HIV clinic, but chose not to come back for treatment, it is clear that the people with TB/HIV were reluctant to start ART — and this could be because there are low levels of knowledge about TB/HIV in the community, heightened stigma and fear of disclosing HIV status to their family. Dr Kalulu suggested that additional factors could also play a role including the pill burden, fear of side effects — and the belief that “the drugs will make them crave more food [and] there is no food security at home.”

To address these factors, the Lilongwe clinic plans to improve HIV counselling in the TB clinic, and intensify information, education and communication efforts for people with TB/HIV.

The team working with Nkqubele TB Hospital also made several practical recommendations in their poster presentation to ensure continuity of care and avoid treatment interruptions and loss to follow-up after referral:

- 1) Disclosure to and engagement of treatment supporters *in the home* (note that this would be facilitated by providing the family-based prevention services mentioned earlier in the article)
- 2) Adequate referral documentation to the nearest ART site
- 3) Follow-up with receiving facility
- 4) Home visits by peer educators, and
- 5) Promoting community awareness of TB and HIV and efforts to address the stigma related to TB and HIV

Working with local community support groups may be the best way to achieve these aims and retain people with TB/HIV in care. And if there are no such groups locally, other reports at the Implementers’ Meeting described how, with a little support, they can be encouraged to grow (see related article).

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about HATiP

A regular electronic newsletter for health care workers and community-based organisations on HIV treatment in resource-limited settings.

The newsletter is edited by Theo Smart (Cape Town) and Keith Alcorn, NAM's Senior Editor (London).

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