

Global Progress Report on the *Three I's*

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Based on presentation by Kevin M. De Cock
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Outline

- Global, technical and local support to the 3 I's
- Need for but poor performance on the 3 I's
- Three I's Meeting (April 2008): outcome
- The Three I's as core HIV/AIDS business
- Next steps (2009)

WHO 2004 policy on collaborative TB/HIV activities, or what are the Three I's?

A. Establish NTP-NACP collaborative mechanisms

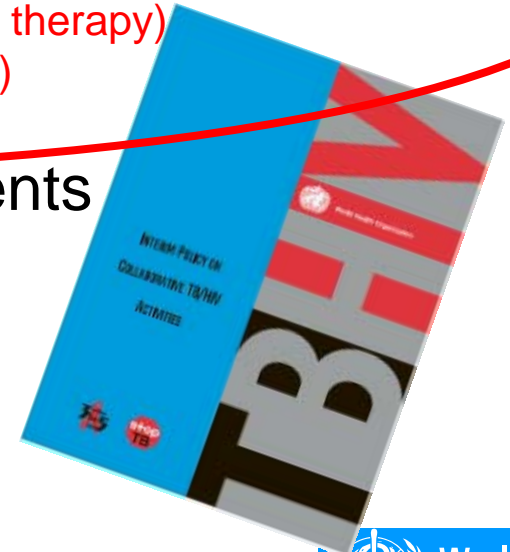
- ◆ Set up coordinating bodies for effective TB/HIV activities at all levels
- ◆ Conduct surveillance of HIV prevalence among TB cases
- ◆ Carry out joint TB/HIV planning
- ◆ Monitor and evaluate collaborative TB/HIV activities

B. Decrease burden of TB among PLHIV (the "Three I's")

- ◆ Establish intensified TB case finding (ICF)
- ◆ Introduce INH preventive therapy (IPT or Isoniazid preventive therapy)
- ◆ Ensure TB infection control in health care and congregate (IC) settings

C. Decrease burden of HIV among TB patients

- ◆ Provide HIV testing and counselling
- ◆ Introduce HIV prevention methods
- ◆ Introduce co-trimoxazole (CTX) preventive therapy
- ◆ Ensure HIV/AIDS care and support
- ◆ Introduce ARVs



Technical and local advocacy

Scientific literature

- JAMA paper on HIV/TB (published)
- IPT article (submitted to Lancet)
- INH/CTX co-formulation dossier and paper (pending)
- IPT FAQs (in clearance)
- Communications materials (e.g., fact sheets, updated website, newsletter, etc.)

Advocacy "Pull"

- Expand HIV advocacy to include HIV/TB
- Increase key community organizations treatment literacy on *Three I's*
- Country-level *Three I's* meetings
- Monitor progress using HIV/TB indicators



TB/HIV Protest, Mexico, IAS 2008

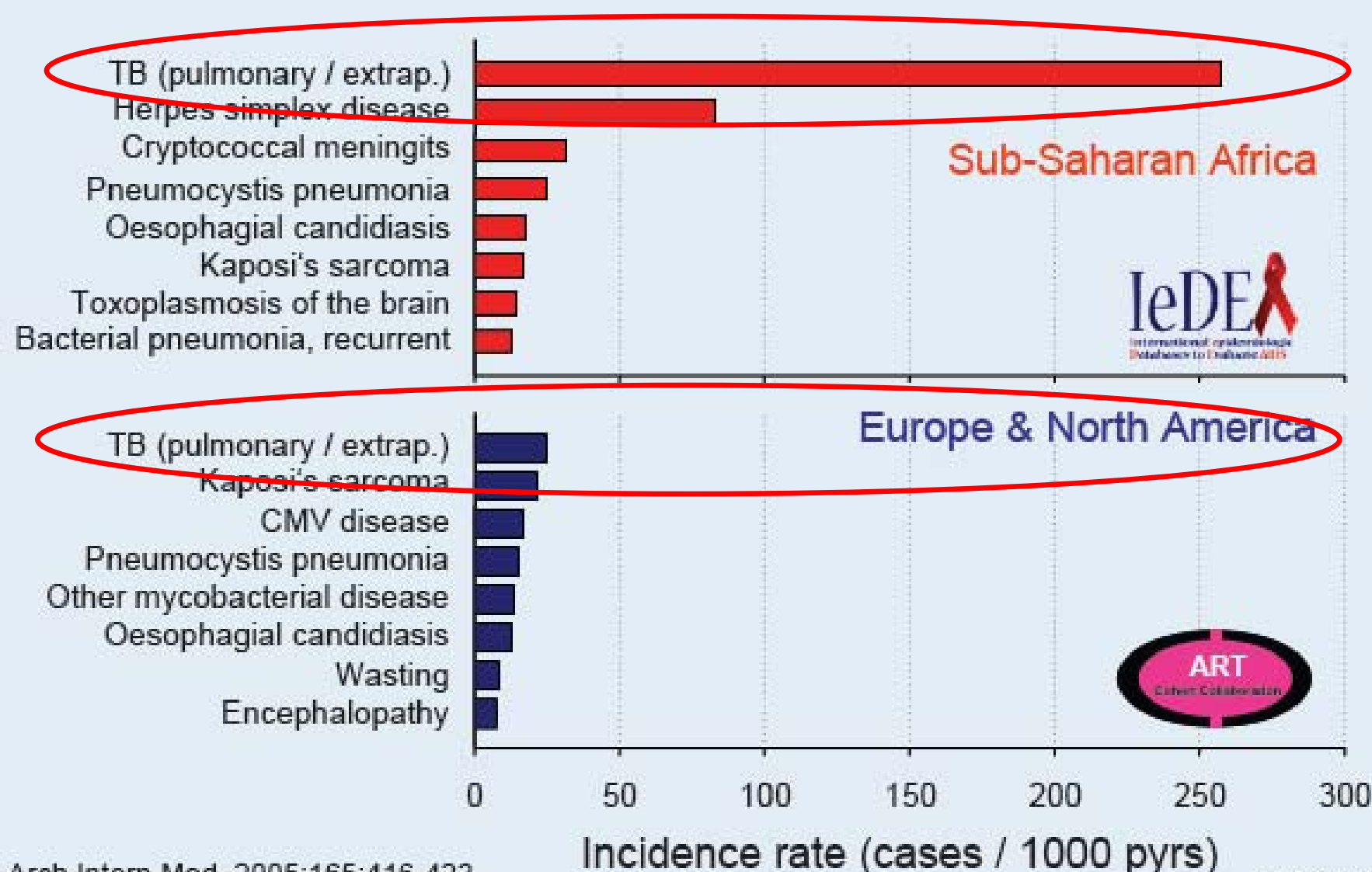
Global advocacy: Three I's "push"

High-level meetings--*Three I's "push"*

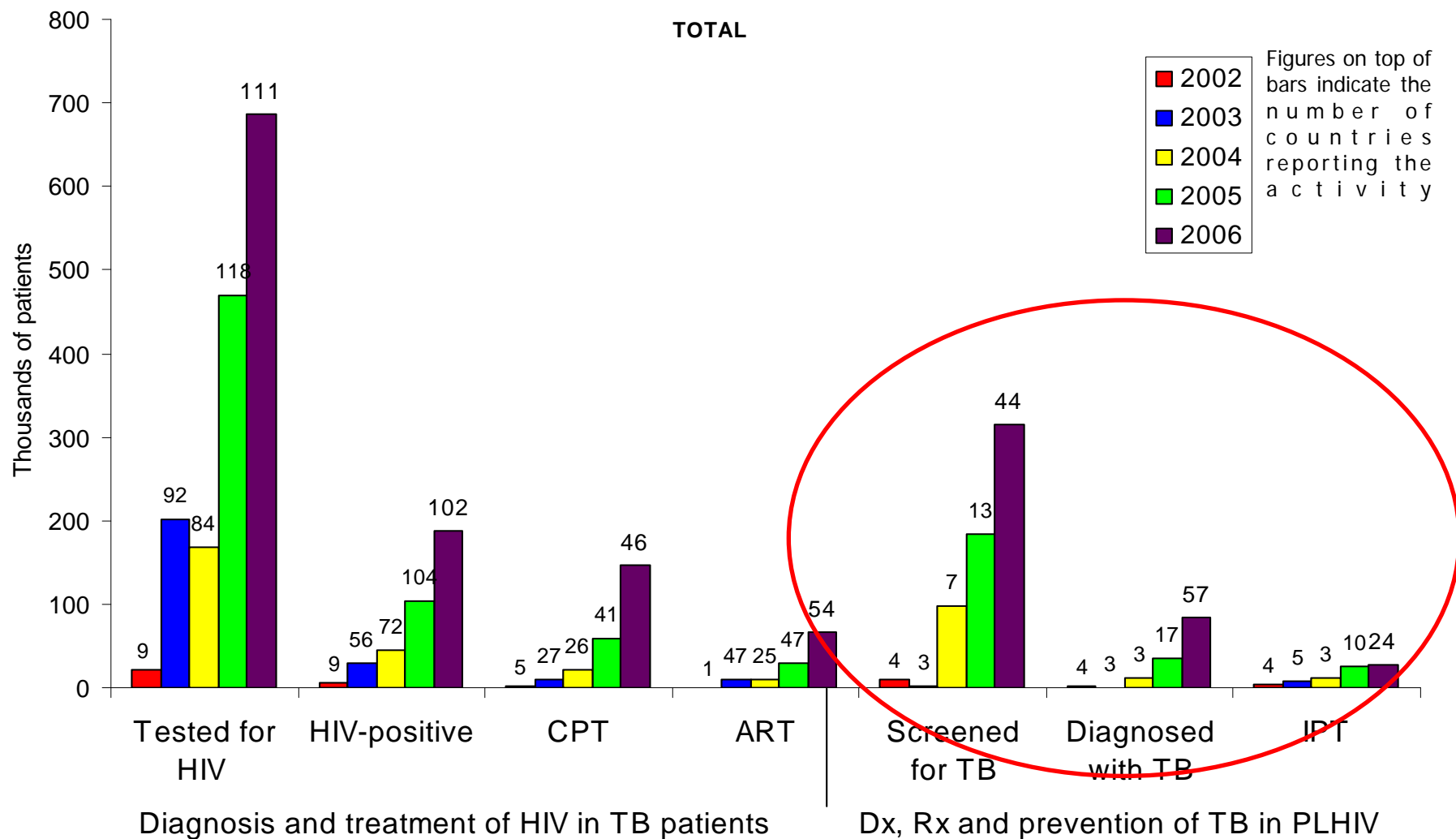
- PCB for UNAIDS (Thailand 2008)
- PEPFAR Implementers Meeting (Uganda 2008)
- UN meeting on HIV and TB (June 2008)
- IAS (Mexico 2008)
- Union Meeting (Paris 2008)
- National AIDS and TB Program Managers (Addis 2008)
- ICASA Senegal satellite/program managers (Dakar Dec. 2008)



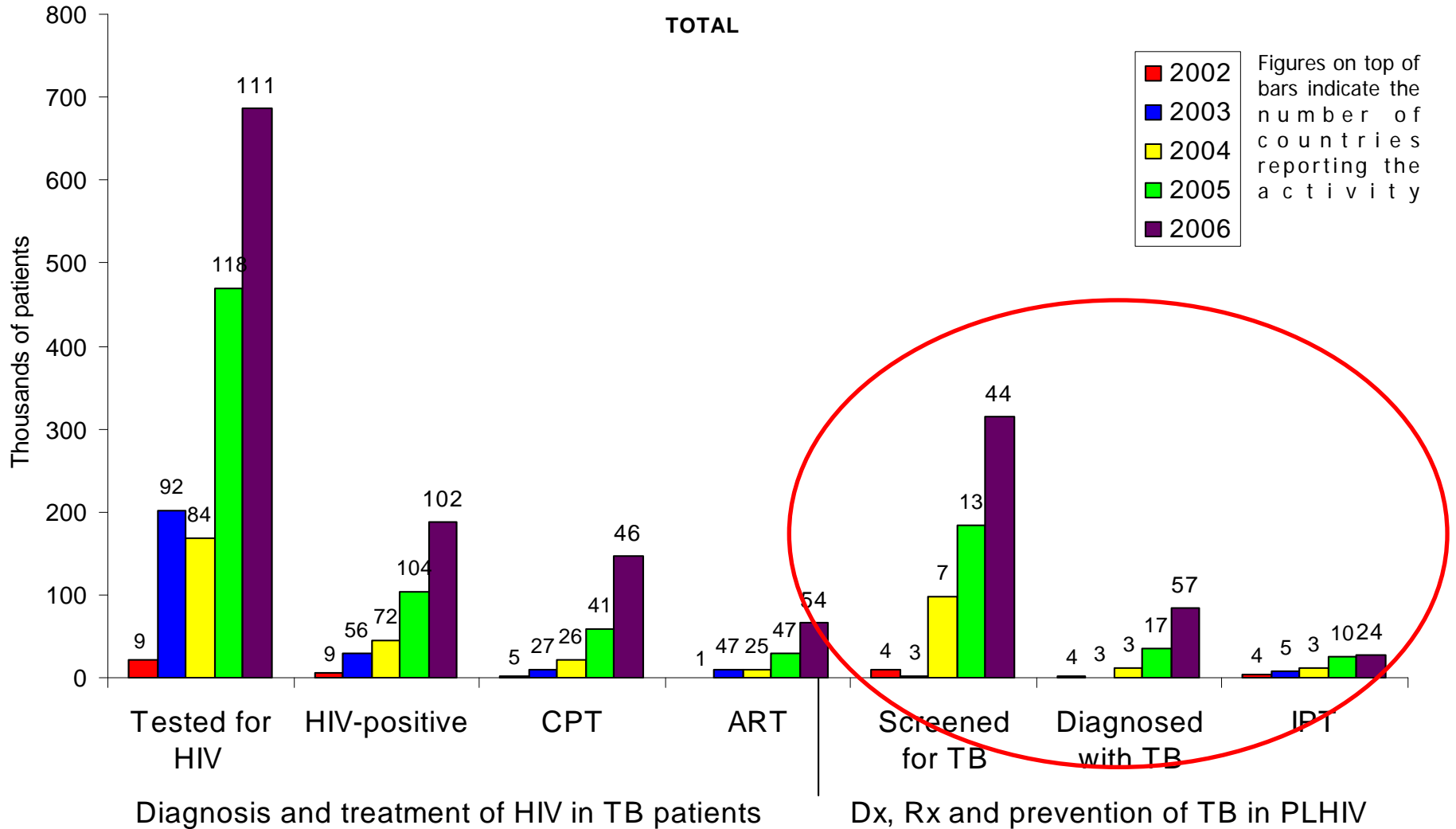
Most common OIs in first 3 months



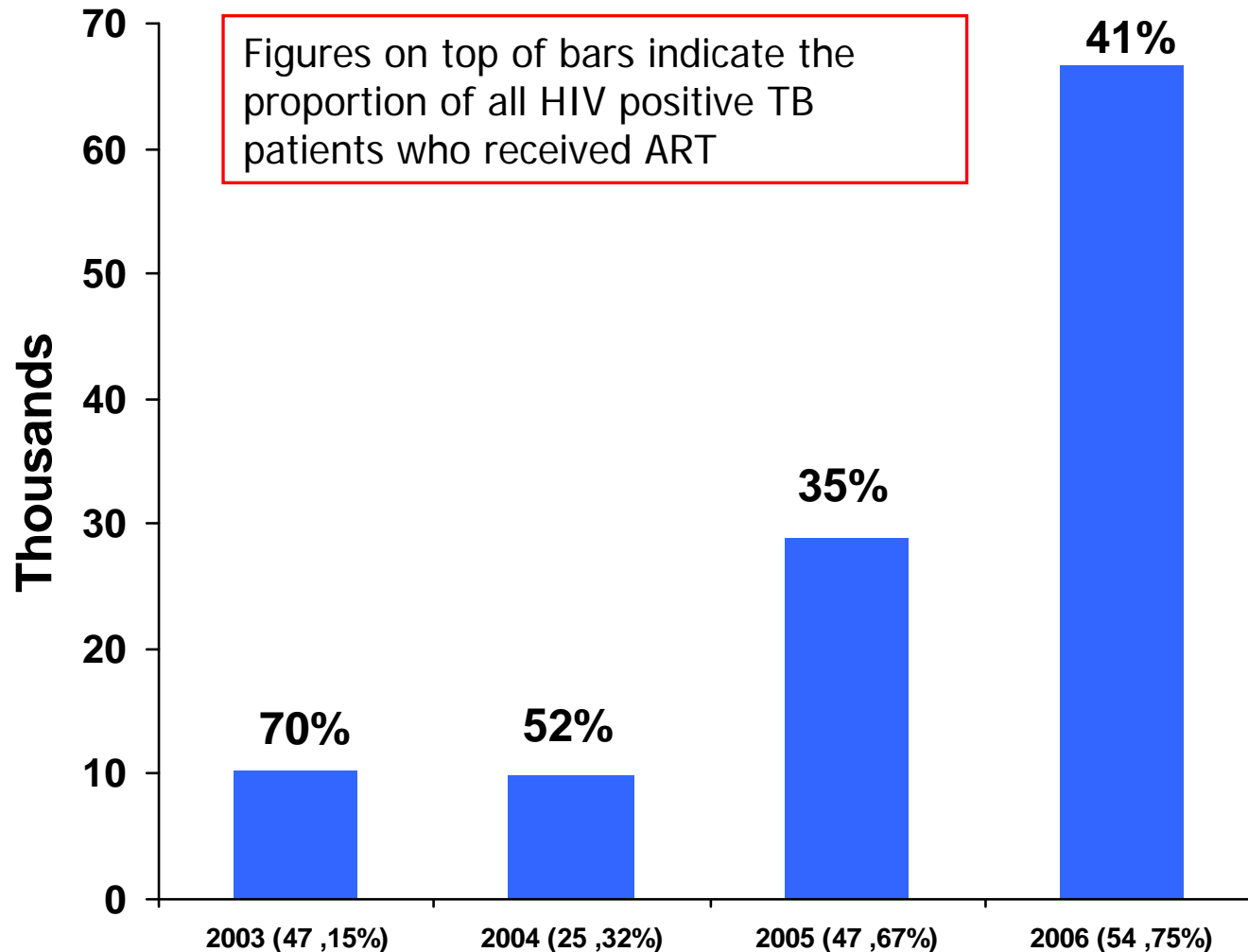
Global progress in implementation of TB/HIV interventions (2002–2006)



Global progress in implementation of TB/HIV interventions (2002-2006)



Antiretroviral therapy for HIV-positive TB patients, 2003–2006



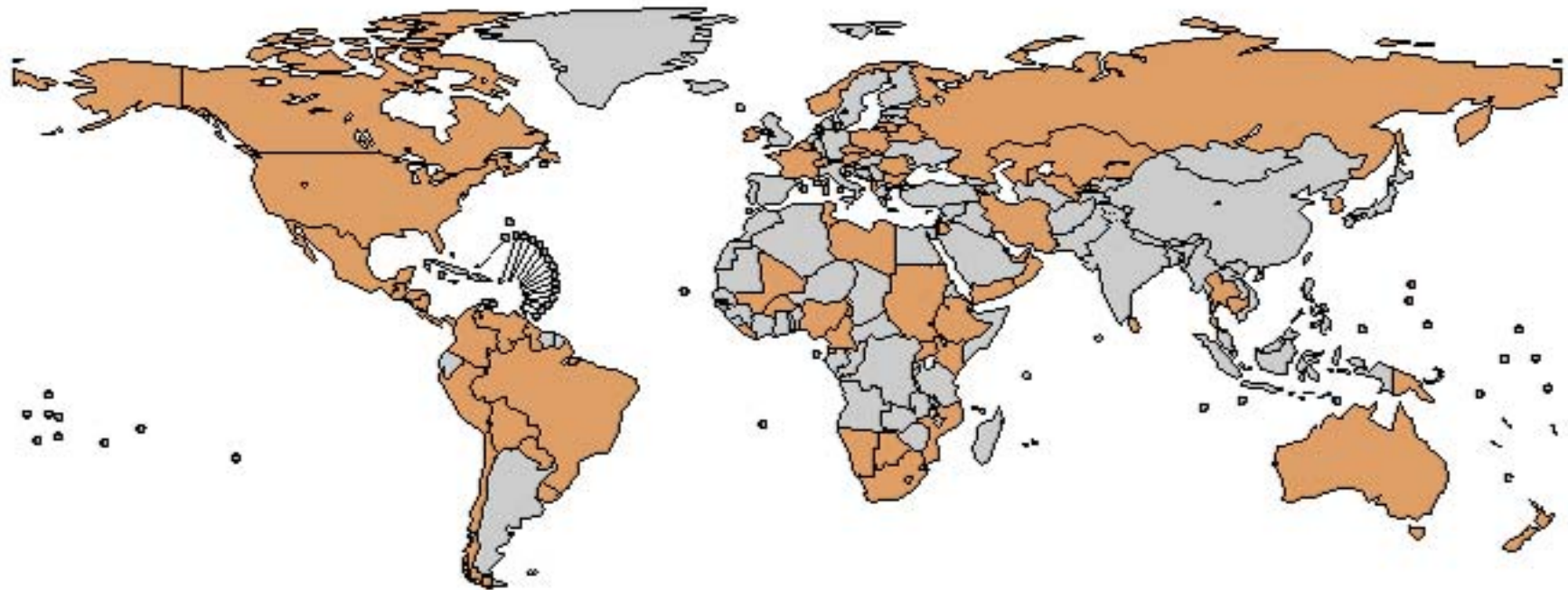
THE
STOP TB
DEPARTMENT



World Health
Organization

(Number of Countries reporting; % of total estimated HIV+ TB patients accounted for by those Countries)

Countries with Policy/Data on IPT (2006)



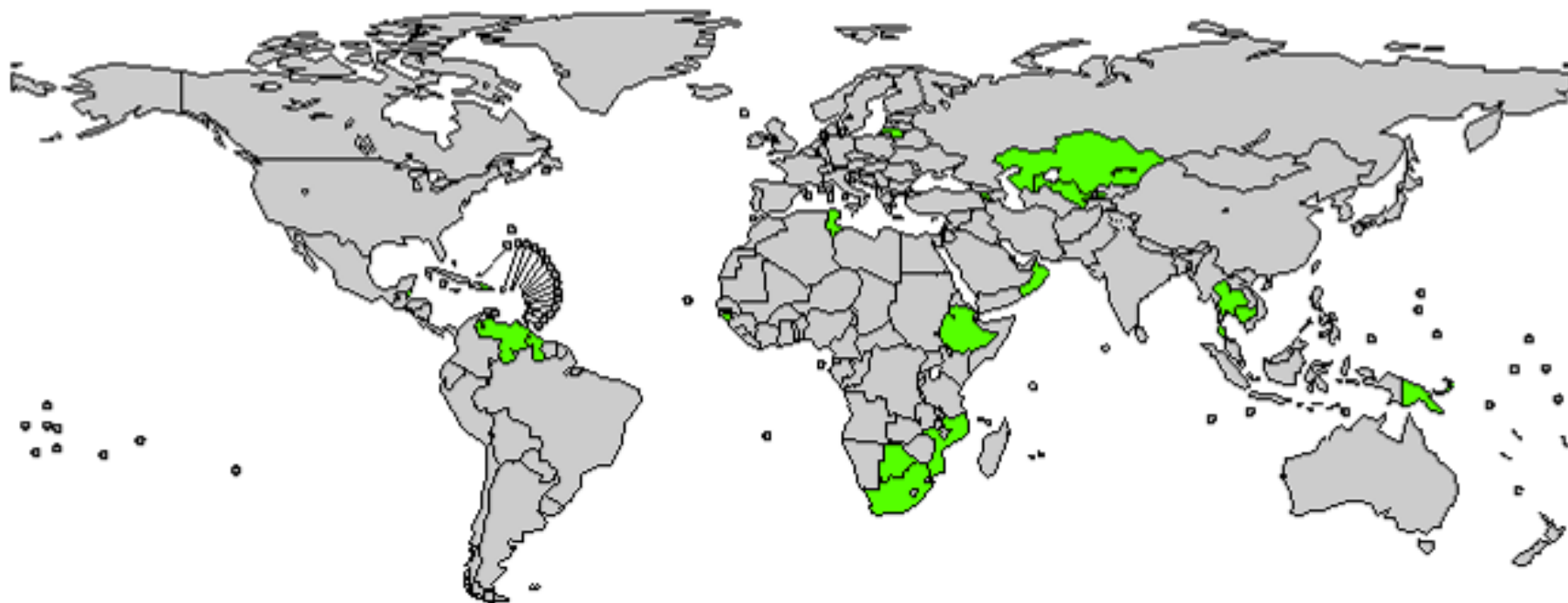
 Countries reporting IPT policy/activity

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.



Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

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Countries reported provision of IPT to PLHIV, 2006 (N=24)



Key

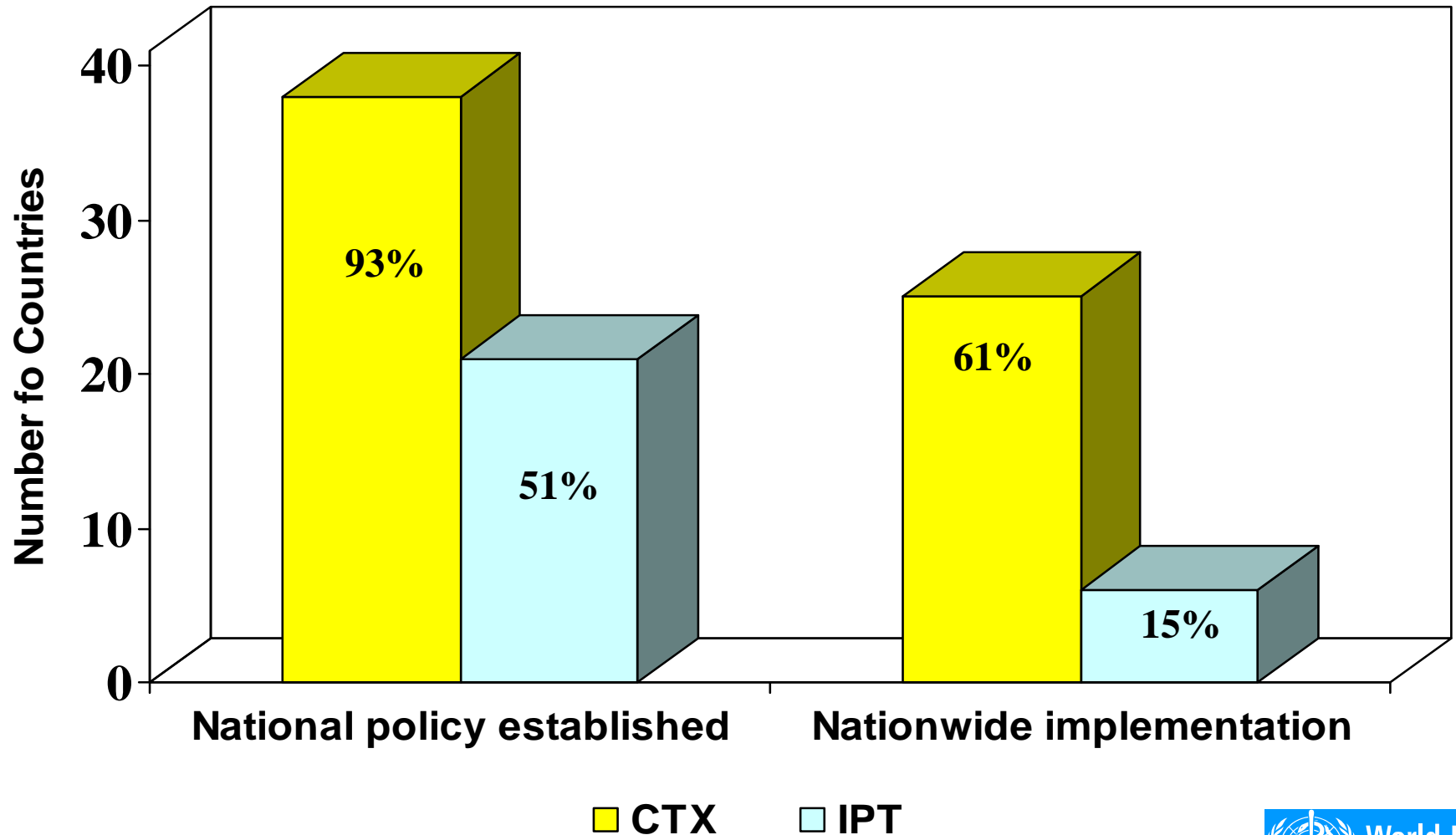
-  No reported activity
-  Countries reporting IPT

- Only 0.08% of PLHIV put on IPT globally
- Botswana report 70% of the global PLHIV on IPT

* Brazil provides IPT but did not report for 2006



Establishment and implementation of national CTXp and IPT policy (N=41)



Source: Vitoria et al, IAS, Mexico, 2008.

WHO Three I's Meeting, April 2008

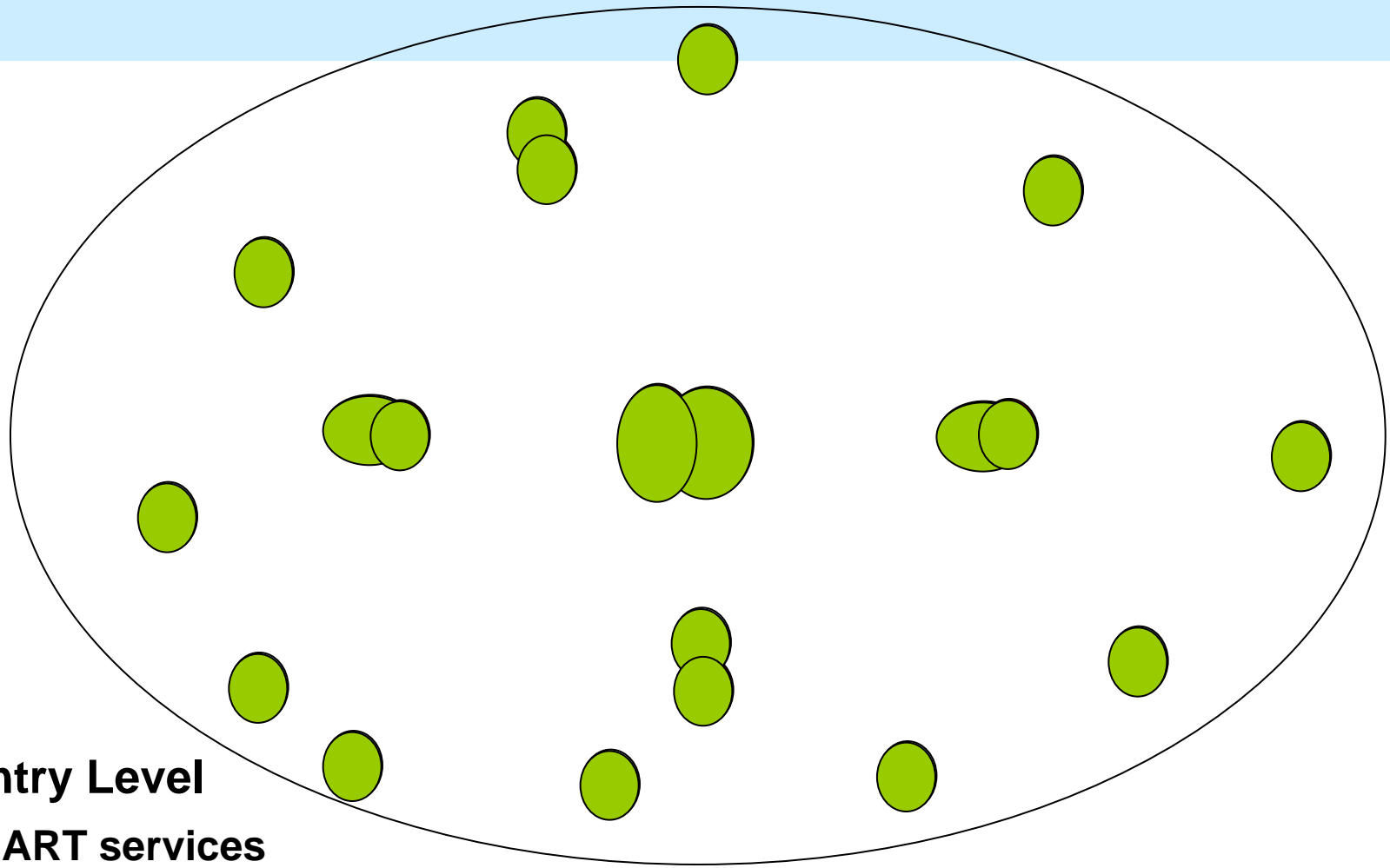
- WHO HIV Department leadership
- *Three I's* are essential for quality HIV care
- Re-conceptualize WHO guidelines
 - Make *Three I's* central to HIV care
 - Develop new TB screening approach
 - TB screening leads to IPT and IC
 - IPT for those without TB symptoms
 - HIV care and treatment should include IC for TB
- WHO Three I's "push" and "pull" advocacy






WHO Technical Priorities

- Update and re-conceptualize guidelines
 - Isoniazid preventive therapy (1998)
 - Intensified case finding
 - Infection control for TB (1999, 2006)
- Harmonize *Three I's* HIV/TB indicators
 - IPT start to be collected as part of HIV patient monitoring
 - TB case finding among people living with HIV
 - Infection control plan and TB among health care workers
- Promote INH/CTX co-formulation
 - FDC makes programmatic sense
- Support country adaptation efforts

The *Three I's* Challenge or the how and where? Health facility implementation



Country Level

-  ART services
-  TB treatment and HIV testing services
-  *Three I's* must happen all over

2008–2009: Re-conceptualizing IPT/ICF & becoming core HIV/AIDS business

- WHO ICF/IPT Policy Update (1st quarter 2009)
 - Joint HIV and TB department effort
 - Meta-analysis for IPT complete
 - Meta-analysis for ICF in progress (13 data sets)
 - Screening for TB as gateway to IPT, IC and ICF
- Expert meeting (early 2009)
- Promote implementation of current policies

WHO Technical Priorities

- Update re-conceptualized guidelines
 - Isoniazid preventive therapy
 - Intensified case finding
 - **Infection control for TB**
- Develop and harmonize HIV/TB indicators
- Promote INH/CTX co-packaging and co-formulation
- Support country adaptation efforts

TB Infection Control—10 Keys Actions

Safety without Stigma

TB HIV

Essential Actions for Effective TB Infection Control Safety without stigma*

1. Include Patients and Community in Advocacy Campaigns

The community should be well-educated about TB infection, prevention and control. Patients should understand that they should know their HIV status, may be eligible for isoniazid preventive therapy (IPT) and have a right to rapid TB diagnosis and treatment. They should know that TB can be spread by coughing and expect health care settings and community services to require persons coughing to cover their mouths when coughing. They should understand that health care workers (HCWs) may wear personal respiratory protection sometimes or that they may be asked to wear a mask to protect others. Safety without stigma should be the goal—a request to wear a mask or provide a sputum outside, or in a well ventilated room should not be stigmatizing but is part of a safer clinic for everyone. Patient and HCW safety may include receiving health care in the community to avoid unnecessary admissions to health care facilities. Information, education, and communication (IEC) campaigns should include themes such as “Our community is TB-Safe” or “Our health facilities are stopping TB.”

2. Develop an Infection Control Plan

All facilities should have an infection control (IC) plan and a facility person or team responsible for IC. The plan identifies high risk areas for TB transmission and provides information on TB and HIV rates among health care workers and patients. The plan provides area-specific infection control recommendations for the facility including the laboratory which should have its own specialized standard safety procedures.

3. Ensure Safe Sputum Collection

Collecting and processing sputum are an essential part of the diagnosis of TB. Sputum collection can be potentially hazardous for health care workers and other patients—HCWs should explain to patients that safety without stigma is the goal of good TB infection control and that sputum be collected outside (if feasible) or if necessary, in specially designed rooms with adequate ventilation.

4. Promote Cough Etiquette and Cough Hygiene

Every facility should have a poster on TB infection control and cough etiquette in at least the outpatient department waiting area, admissions area, and casualty department. Patients should be instructed to cover their mouths and nose when coughing, with hands, cloth such as handkerchief, clean rag, tissues, or paper masks. All staff are responsible for safety and should work together to help patients adhere to this practice.

5. Triage TB suspects for “fast-track” or separation

All patients should be screened upon arrival for chronic cough (i.e. >2-3 weeks), fever, weight loss, night sweats, haemoptysis, or contact with a person with TB. HCWs should explain to all clinic visitors that safety without stigma is the goal and that the screening is part of quality care. Patients should understand that they should know their HIV status, may be eligible for IPT and have a right to rapid TB diagnostic services and treatment. Persons suspected of having TB should be “fast-tracked” for rapid diagnosis and care services or should be asked to wait near an open window or in a comfortable area separate from the general

- Involve community
- Develop IC plan
- Safe sputum collection
- Cough hygiene
- Triage TB suspects
- Rapid diagnosis/treatment
- Improve room ventilation
- Protect health care workers
- Capacity-building
- Monitor IC practices

Donors' dialogue and opportunities

Donors' dialogue on *Three I's*

- Global Fund
 - Technical guidance for proposal development
 - Analysis of TB/HIV elements in GF grants (pending for round 8)
 - Mandatory inclusion of TB/HIV elements for HIV and TB proposals?
- PEPFAR
 - HIV/TB template for country operational plans (upcoming)
 - Improved dialogue with PEPFAR country offices
- Gates
 - Discussions regarding WHO's Three I's related efforts

Next steps 2009

- Fast-track implementation of new WHO guidelines
- Implement harmonized HIV/TB indicators
- Resource mobilization
- WHO/ OPS technical support for national governments to support Three I's implementation
- **Strengthen engagement of country-level partners and program managers**



Thank you

<http://www.who.int/hiv/topics/tb/en/index.html>

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**WHO Three I's Meeting,
(Geneva, 2–4 April 2008)**