Nationwide scale-up of IPT and ART amongst TB patient in Cambodia: Successes and challenges

The 17th Core Group meeting of the TB/HIV Working group
Beijing, 9 - 11 November 2011
Mean Chhi Vun, MD, MPH and Dr. Mao Tan Eang
NCHADS and CENAT
Email: mchhivun@nchads.org
www.nchads.org
Current Situation of HIV and TB in Cambodia

- Total population in 2010 was around 14 million*
- First case of HIV was detected in 1991 and first AIDS case was diagnosis in 1993
- Main route of HIV transmission is heterosexual intercourse
- In 2010, the HIV prevalence among general population age 15+ was 0.8% and the estimated number of PLHIV eligible to start ART (CD4 ≤ 350 cc/mm³) was 52,180
- As of June 2011 the ART coverage was 92% (44,299/4,286 children on ART)
- The HIV prevalence among TB patient is declining from 11.8% in 2003 to 6.1% in 2009

- Cambodia is one of the 22 high burden TB in the world
- 64% of the total population have been infected with TB
- The incidence of TB all forms is 442 per 100,000
- The prevalence of TB all forms is 693 per 100,000
- The mortality caused by TB is 71 per 100,000
TB/HIV Collaborative Activities

• 1999: TB/HIV Sub-Committee was set up

• 2002: TB/HIV Framework has been endorsed by MoH

• 2003: TB/HIV Pilot Projects at 4 sites: TB screening at OI and ART service and IPT, but no progress

• 2003: Joint statement between TB and HIV Program:
  - Clearly defined role and responsibility of each Program: LSM
  - Joint training activities

• 2006: SOP for HIV testing among TB patients (PITC)

• 2009: Revised TB/HIV Framework (on progress)
Result of TB-HIV collaborative: 2008 and 2009

- HIV testing coverage amongst TB patients is increasing from 32.4% in 2008 to 74 % in 2010.

- TB symptom screening amongst PLHIV is increasing from 46% in 2008 to 71 % in 2010.

- Number of PLHIV who received IPT are 77, 66 and 44 in 2007, 2008 and 2009 respectively.
Challenges in Increasing ICF and IPT (before 3I)

- No clear evidence/tools for ruling out TB among PLHIV
  - E.g. What symptom(s) accurately predict absence of active TB?

- Screening and diagnostic steps for TB need to be:
  - Simple and feasible
  - Accurate and low cost etc

- Fear of INH resistance from using mono-therapy

- Absence of clear model lead to pilots and studies but no widespread implementation
How to Increase the access to ICF and IPT: Linking HIV/STI/RH/TB Services at District Level
Rapid Scale Up Implementation of 3Is including IPT

- NCHADS and CENAT participated in the 15th Core Group Meeting of the TB/HIV TWG that was held from 3 to 4 November 2009 (Implementation of 3I)

- NCHADS has attended WHO Workshop to finalize the Guidelines for implementing 3I strategy that was held in January 2010

- NCHADS, CENAT and its partners started to develop SOP for implementing 3I strategy in January and finalized in March 2011, based on the recommendations of the 15th core group meeting in November, IDTB Study Preliminary result and WHO workshop in January.

- Ministry of Health has endorsed the SOP for 3I on the 23rd of April 2010.

- The first orientation workshop on how to start 3I was conducted by NCHADS, CENAT and its partners on the 29th of April 2010
  - Joint Statement between NCHADS and CENAT to support the implementation of 3I (IPT) including joint work plan, joint training activity, LSM, M&E

- The implementation of 3I commenced in June 2010 in 8 pre-ART and ART sites and expanded to 28 pre-ART and ART sites by March 2011, then scale up to 34 ART Sites as of September 2011.
Evidence Based Approach to Increase ICF & IPT
IDTB study in Cambodia, Thailand, Vietnam

1,748 consecutively enrolled PLHIV, 8 OP clinics
Extensive workup for TB on all patients including 3
cultures of sputum, blood, urine and LN (if present)

Algorithm for screening and diagnosis
based on characteristics of TB+ versus TB
negative patients

Screening algorithm incorporated into
National SOP’s approved by MoH April
2010

Scaling Up of the Implementation of 5 I Strategy

- ICF
- IPT
- IC/TB

3 Is

- Immediate ART: MoH Approved in Feb 2010
  - ART shall start when CD4 ≤ 350 cells/mm³
  - For TB/HIV, ART shall start immediately after 2 Weeks of TB treatment, regardless CD4 cell count (CAMELIA)

- Integration of TB and HIV Services through LR
Linkages between HIV/STI/RH/MNCH/TB

Integration or LR of HIV/STI/RH/MNCH/TB services

UA to HIV Care and Treatment

UA to HIV/STI/RH/TB Services

2010

Civil Society

Partners

PRD/OD/HC
NCMCH
NCHADS
CENAT

2015 (MDG 4, 5 and 6)

2010

UN Award for MDG 6 (HIV)
Linking TB and HIV Services

HIV Team

- VCT
- Referral Card
- Feedback Form

OI/ART (A/C)

- ICF
  - Screen negative, do TST if possible
  - IPT: 6 M (no TST)
  - IPT
  - IPT

TB Team

- TB Ward
- TB Diagnosis

R and F (suspected TB)

Integrated Lab:
- HIV testing
- TST, SSM
- others

X Ray

TB Ward

TST+: 36 M
6 M (no TST)
TST+: 36 M
HIV Service Delivery Model: Linked Response Approach (’08): guide for PMTCT and TB/HIV scale-up

HC

+ HC Satellite

HC

VCCT

Referral and Follow-up
HCBC Team/NGO

Referral and Follow-up

Referral and Follow-up
HCBC Team/NGO

Referral and Follow-up
HCBC Team/NGO

Referral and Follow-up
HCBC Team/NGO

Community

HIV information, TB ANC, BS, Drawing blood for HIV testing (PW, TB,...)

HCBC Team/NGO

Referral and Follow-up

Referral and Follow-up

Referral and Follow-up

Referral and Follow-up

Referral and Follow-up

Referral and Follow-up

HCBC Team/NGO

Linked HIV Testing, VCCT, Safe Delivery, ANC, BS, TB care

RH (Hub)

OI/ART, PAC, VCCT, STI, ANC, BS, Safe delivery EPI, TB care, Lab, LSM, Data Management, Coordination, M&E

VCCT
Orientation Workshop on the Implementation Of Three I’s Standard Operating Procedures

Cambodiana Hotel, Phnom Penh, April 29th, 2010
Work Plan to start 3I (IPT) at OI and ART Site

OI/ART clinicians and TB officers
- Work Plan: Capacity Building, Coordination, M&E, LSM
Number of new Pre-ART, TBS (-), New Pre-ART patients start IPT and Total IPT started in semester, from Semester 2 - 2010 to Semester 1 – 2011 at TST and Non TST Implementation

**IPT:**
- 2009 = 44
- 2008 = 66
- 2007 = 77

Source from CENAT

**Note:**
1. In Semester 2-2010, there’re 6 OI-ART sites implemented TST and 14 OI-ART sites implemented Non-TST
2. In Semester 1-2011, there’re 6 OI-ART sites implemented TST and 23 OI-ART sites implemented Non-TST
Result of ICF and ART amongst TB patient

- Percentage of TB symptom screening amongst PLHIV in:
  Semester 2-2010 was 66,5%
  Semester 1-2011 was 86,5%

- Number of TB/HIV patient received ART in:
  Quarter 4-2010 was 128
  Semester 1-2011 was 214
Remaining Challenges

- Work load for staff of TB and HIV services at all levels
- Limited capacity to own and monitor the TB/HIV collaborative activities at OD level
- Poor follow up TB- HIV co-infection patient to access ART and TB treatment (need to go beyond HIV testing among TB cases for outcomes: % of TB-HIV co-infection receiving ART and TB treatment)
- Insufficient transportation fee to support TB-HIV patients
- High rate of lost to follow up for reading the result of TST
- Limited access to more TB Rapid diagnosis: TB liquid culture and Xpert MTB/RIF.
Next steps

❖ Scale up the Implementation of IPT
  ▪ 2011:
    • Expand IPT to 45 pre- ART and ART Sites for Adult (80%)
    • Introduce IPT in 4 Pediatric AIDS Care sites
    • Strengthen a systematic referral and follow up linkages within and
      between TB and HIV and community based support service under
      supervision of HIV and TB District Coordinator (Increase the access
      to ART and TB treatment)
  ▪ 2012: Nation-wide Scale Up ICF and IPT

❖ Monitor and evaluate the performance of ICF/ IPT
  ▪ Revise Monitoring indicators and reporting format
    • Use CQI method for patient level analysis
    • Evaluate performance of the TST sites by end of 2011

THANK YOU