TB/HIV Collaborative activities in Rwanda: From Policy to implementation.

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Rwanda / Ministry of Health
RWANDA

- Superficie: 26,338 Km²
- Population: 10,943,000 Ha
- Life expectancy: 53.4 years
- GDP/Capita: 570 $
HIV Program in Rwanda

- HIV Prevalence: 3%
- PLWHIV on ART 2011: 100135 patients (1100 cases per month).
- Decentralization of SERVICES:
  - HIV
    - VCT: 94.5% (485/513)
    - PMTCT: 88% (451/513)
    - ART: 76% (390/513).
ART scale up in Rwanda

Patients on ART

H.Facilities
Notification of TB cases
1995-2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Sm+</th>
<th>EP</th>
<th>Sm-/nd</th>
<th>Retreat</th>
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<td>2010</td>
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TB notification by HIV status
(all cases)

2004 2005 2006 2007 2008 2009 2010
1337 2276 2561 2673 2560 2529 2199

5330 5444 5722 5341 5281 5115 4866

HIV- HIV+
TB/HIV Policy

- **TB Division – HIV Division stakeholders workshop**
  - Representation from TB/HIV programs, governmental institutions, partners and international experts

- **Objective: discuss TB/HIV integration, make decisions and recommendations for a policy**

- **Results:**
  - Policy developed, approved by MOH on Oct. 03, 2005 and disseminated
  - National TB/HIV working group established and regular meetings held
Objectives of TB/HIV integration

- **For TB patients**
  - To stimulate VCT among TB clients
  - To accelerate access to HAART for TB/HIV co-infected
  - To reduce TB incidence among HIV patients
  - To improve TB diagnostic algorithms
  - To increase adherence and cure rate among TB patients by using the HIV adherence tools
- **For HIV patients**
  - To have an easier access to TB diagnosis and treatment
  - To develop a one stop service
  - To benefit from existing TB network to support HIV
- **For the health services**
  - To pool TB and HIV staff and integrate training: No recruitment out of existing TB service but rather re-enforcement
  - To improve staff morale

Slide courtesy of MSF (E. Goemaere)
Revision of Guidelines and Tools

- TB and HIV technical manual revised to include TB/HIV chapter
- TB training modules developed to include TB/HIV sessions
- TB and HIV recording and reporting tools revised to include information on TB/HIV
- System for M&E of TB screening, developed and implemented
- IEC materials developed and distributed
TB/HIV Model Centers
TB/HIV Model Centers – training centers
… to Sites Nationwide

- TB/HIV national WG adopted model for TB/HIV Integration as national model
- Theoretical Training of TB nurses.
- Practical Training at Model centers.
- Joint follow up by HIV Division, TB Division, Partners
One Stop Services for TB Patients with HIV through the TB service

- HIV Counseling, Testing and C&T
  - HIV CT (PIT)
  - Enrollment into care (or shift HIV file to TB service)
  - Venopuncture for CD4 count
  - Medical consultation, prescription of CTX, ART
  - Distribution of CTX and ART (shift pharmacy tools, follow up of ART and CTX stock cards)
  - At the end of TB treatment the patient is referred and accompanied to the ART clinic for further follow up

- Home visits
Advantages of the One-Stop TB Service

• **Improves the quality of care**
  – Better quality since patients are seen by the same providers for both TB and HIV in one service.
  – Patient centred approach
  – Limits the number of appointments of the patients only to the TB service;
  – Increase adherence to ART
  – Reduce stigma linked to HIV

• **Reduce the risk of transmission of TB within HIV services (VCT, ARV, PMTCT)**
  – Reduces exposure of people living with HIV to TB;
• All patients enrolled in HIV care and treatment should be screened for TB at their first visit and at least every six months thereafter

• A symptom based 5 question checklist was developed to screen all HIV-infected patients attending HIV care and treatment services for TB.

• Patients who screened positive on the questionnaire are considered TB suspects and referred for further workup and evaluation per national guidelines for the diagnosis of active TB.
TB screening questionnaire

1. Has the patient been coughing for ≥ 2 weeks?
2. Has the patient been having night sweats for ≥ 3 weeks?
3. Has the patient lost ≥ 3kg during the last 4 weeks?
4. Has the patient been having fever for ≥ 3 weeks?
5. Has the patient had close contact with a tuberculosis patient?

If “Yes” to any question: evaluate for TB
Prevalence of HIV in TB patients

- 2004: 45% tested, 48% HIV+
- 2005: 68% tested, 46% HIV+
- 2006: 72% tested, 42% HIV+
- 2007: 89% tested, 38% HIV+
- 2008: 96% tested, 34% HIV+
- 2009: 97% tested, 34% HIV+
- 2010: 98% tested, 32% HIV+
- Q1-3 11: 97% tested, 29% HIV+
Detection of HIV among TB suspects

- 2009: 86% Tested, 12.0% HIV+
- 2010: 89% Tested, 7.2% HIV+
- Q3 2011: 98% Tested, 4.8% HIV+
Care and Treatment for TB/HIV Coinfected.
TB SCREENING AT ENROLLMENT

Included in TRAC net system and reports given monthly eg: Q1, 2012

TB Screening in newly enrolled patients at 403 HIV Clinics (Pre & ART sites) in Rwanda, Q1 2012, n=5914

The prevalence of TB was at 3.2% (190/5914)
Background of IPT in Rwanda

• IPT already used for children under 5 years of age who live in close contact with a sputum positive pulmonary TB (PTB+) case.

• In 2010, TB and HIV Divisions within Rwanda Biomedical Center organized a workshop on IPT and it was decided to implement IPT for PLHIV in the national TB/HIV policy.
IPT implementation in 3 sites pilots from August 2011 to March 2012

<table>
<thead>
<tr>
<th>SITES</th>
<th>Nb of Active PLHIV</th>
<th>Nb PLHIV enrolled on IPT</th>
<th>Nb PLHIV developed TB during IPT</th>
<th>Nb PLHIV with Side effects</th>
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</thead>
<tbody>
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<tr>
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<td>5338</td>
<td>4136</td>
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77,5% 0,07% 0,8%
# Minimal IC package for HF (From 2009)

1. Elaborate an IC Plan and assign an IC focal point.

2. Provide regular training on IC controls and IC plan.

3. Outside waiting areas; if inside: regular triage and separation of people with cough, TB suspects and TB patients.

4. Regular IEC sessions on cough hygiene in waiting areas and hospitalisation wards.

5. Separate ward for hospitalization TPM+ patients.

6. Open windows and doors in high risk services (consultations, TB, ARV, MI).
Challenges related to TB-HIV integration

• MOH TB and HIV programs:
  – Communication and collaboration between 2 traditionally vertical programs
  – Difference in approach to site support (partners)

• Sites:
  – Space (counseling room), cross training, work load,
  – Rotation of staff; need of continuous capacity building
  – Accurate recording and reporting of TB/HIV data
  – Establishing adequate human resources to supervise and monitor program outcomes
Way Forward

• Reinforce participation in the national TB/HIV working group to harmonize implementation strategies among partners
• Continue site support (supportive supervision, quality assessment)
• IPT scaling up
• Strengthen infection control
Rwandan ‘recipe’ for success

• Government commitment to integrating TB and HIV programs and services.
• Strong TB and HIV programs and motivated team to support continuous TB/HIV training and supervision at decentralized district and facility level
• TB/HIV focal persons within HIV-TB Divisions

• Establishment of 2 model centers and recruitment of TB/HIV focal point persons to design, implement and assess innovative strategies for TB/HIV integration

• Integration feasible with addition of minor resources in the existing system (reorganization crucial)
Thank you