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Overcoming An Old Scourge With A New Face (HIV/TB Co-Infection)
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Vietnam TB/HIV control in closed setting

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The roles of TB/HIV control in closed settings

- Closed settings: prisons, correctional institutions and social sponsored centers (SSCs).
- Humanity: they have a right to receive health care
- They are the highest risk group for TB and HIV
- TB MDR rate, TB/HIV rate: very high
- These patients are a part of community ➔ very important infectious source for these institution's staff (now) and community (future)

Situation analysis - prisons

- Survey 2004 - 2005
- Objective: Burden of TB (TB suspects, abnormal chest X-ray, TB AFB(+) and TB drug resistance
- Techniques: Clinical interview and examination, Chest X-ray, Sputum direct smear, culture and DST for Tuberculosis.
- Result:
  - **9,7%** had history of TB diagnosed, but with corrected treatment only **30%** among them.
  - Cough 2 weeks or more **33,4%** (25,2-56,9%), abnormal chest X-ray 12,4%, TB-suspect on chest X-ray film **7.1%**
  - SS: 1843 = 26%, SS(+): 80 (4,3%), **16-fold** > community.
  - DSTs – 178, DR – 64% (S, H), **MDR – 17.4%**

Situation analysis – 05/06 camps

- Survey 2004 - 2005
- Objective: Burden of TB (TB suspects, abnormal chest X-ray, TB AFB(+), AFB(-) and EPT, HIV testing.
- Techniques: Clinical interview and examination, Chest X-ray, Sputum direct smear, culture, screening HIV testing.
- Result:
  - **12.3%** had history of TB.
  - Cough 2 weeks or more 819 **(20,7%),** TB-suspect on chest X-ray films 393 **(9.96%)**
  - Diagnosed: PT SS(+) 22cases, SS(-) 59 cases, EPT 6 cases
  - Prevalence rate: PT AFB(+) **$558/10^5$**, all forms: **$2206/10^5$**
  - Prevalence of HIV(+): **15.4%** (11.8 – 32%).
  - TB among HIV(+) – **6.59%** ; HIV(+) among TB Pts - **45.97%**

Situation analysis – Social Sposored Centers

- Low living standard, low support from family, low risk for HIV infection, high risk for TB disease
- Survey 2004 - 2005
- Social sponsored centers for patients with chronic mental illness people:
  - prevalence TB SS(+) # 1,1 % *(26/2332: 0.3 – 1.4%)*
- Social sponsored centers for elder helpless people:
  - prevalence TB SS(+) # 1,6 % *(27/1739: 0.96 – 5.3%)*

Models for TB/HIV control in the closed settings

1. TB unit similar to District TB Unit
2. TB control similar to Commune health post

Models (1)

1. TB unit similar to District TB Unit (DTU):

- Burden of TB: 50 or more AFB(+) annually *(+ extra ordinary)*
- Available health staff and infrastructure
- Be provided: Training, TB drugs, equipment and consumable materials from provincial TB center.
- Function as district TB unit: IEC, case finding (including active case finding in cooperation with provincial TB center), treatment management, recording and reporting as required.
- Obey supervision of provincial TB center and in collaboration with DTU.

Models (2)

2. TB control similar to commune health post:

- Burden of TB: <50 AFB(+) annually
- Building human resource and infrastructure
- Be provided: Training, drug, consumable materials from DTU
- Function as Commune health post: IEC, referring TB suspects (or sputum specimens), DOT, recording and reporting as required.
- Obey supervision of DTU.

Conditions for implementation

1. Legal mechanism to **access** to these institution
2. Collaboration of these **institution's staff** – show them benefits not only for prisoners but also for themselves
3. Need **co-operation** of NTP with NAP, MoH, MOLISA and MPS:
   - Established coordinating committee
   - Issued coordination mechanism
   - Use existing resources for needed activities

Stepwise implementing

1. Stakeholder conferences to get **consensus and plans**
2. Training for all related health workers
3. Setting up TB unit appropriately (Model: staff, equipment,...)
4. IEC for all staff and "learners" on TB, HIV and relationship between TB and HIV and prevention
5. Strengthening case finding and treatment management:
   - Periodic active TB detection for PLWHAs
   - Screening TB for prisoners before entering
   - DOT for treatment
   - Implementing referral mechanism for cases who transferred to other institutions or go back to community.
6. Monitoring and supervision

Preliminary results

- Established 38 TB units in 05/05 camps and prisons
- Increasing number of patients: 2648, 3602, 4313 in years 2004, 2005 and 2006 respectively (data from MPS)
- Intensified TB case finding 6-monthly or yearly by sputum smear and/or chest X-ray in prisons and 05/06 camps .
- Treatment and referral management are improving
- Treatment outcome is not yet as expected due to high mortality, transfer out rates.

Model of TB unit in prisons

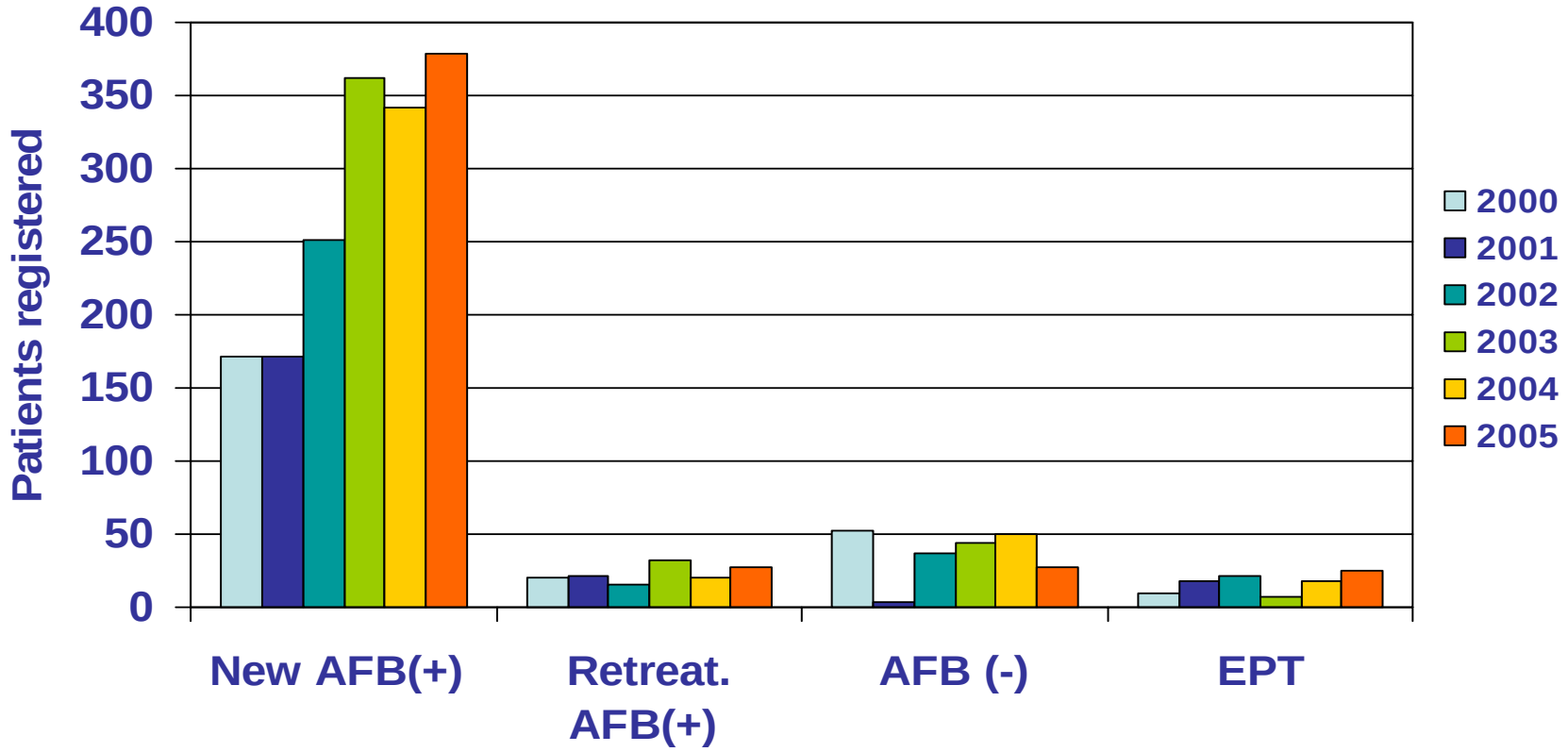
Activities	Pre-implementing	Post-implementing
Training	NO	Standard techniques and counseling
IEC	not or not regular	directly or indirectly
Laboratory	referring to DTU	- Labs with capacity of case finding - Slide rechecking system (EQA)
Case finding (passive or active)	No or delayed # 10-15 cases annually No TB AFB(-) or EPT	early detection # 90-100 cases annually / one - Diagnosed TB AFB (-) (HIV)
Cases with Complications	many hemoptisy, pneumothorax, pleurisy	- significantly decreasing

Model of TB unit in prisons

Activities	pre-implementing	post-implementing
TB drugs / Diag. materials	Provided, but not regularly / self-bought	- Be quarterly distributed - Staining material monthly
Treatment outcome	- No or delayed - No DOT - No monitoring SS - No referral regulation - Cure rate very low	- Treatment register with DOT - Monitoring SSs: 2, 5, 8 months - Referral with document and feedback requirement - Cure rate: 75-85%, Failure 8-16% - TB Pts are cared in separate areas
Recording and reporting	No or not adequate	- Regularly and consistency

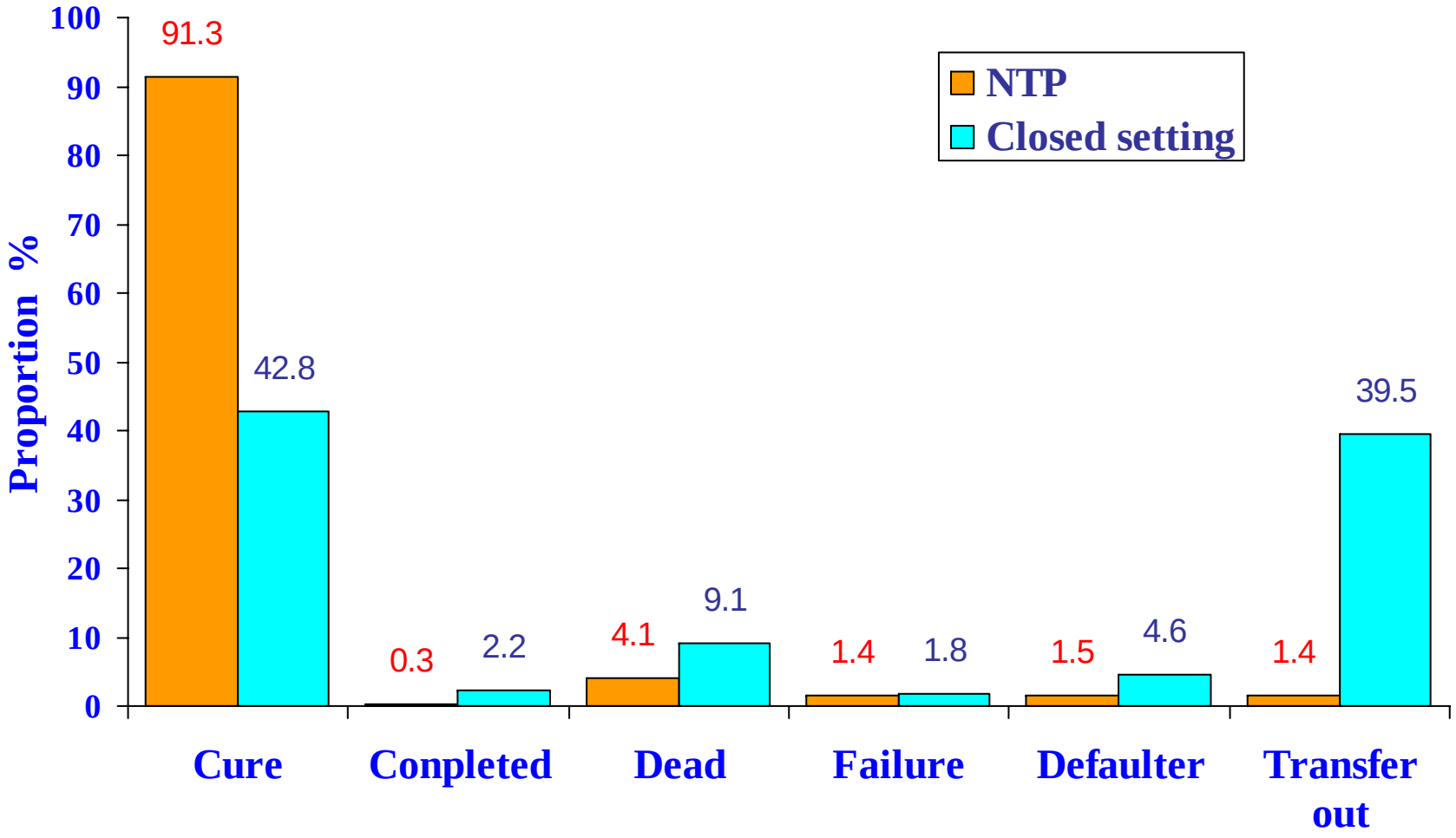
Treatment registration in some prisons (B2 region)

2000 – 9th 2005



(An Phuoc, Bo La, Z30D, Z30A, Cai Tau, Chi Hoa)

Treatment outcome of PT AFB(+) 2004



Lessons learnt

- Political commitment: Coordinating body (NTP, NAP, MoH, MOLISA, MPS)
- Lack of staff (retired and turnover), lack of competent staff ➔ staff motivation, **HRD are urgent needs** .
- TB DOTS and HIV treatment and care need to be integrated, esp. in closed setting
- Referral procedures is very important, so that these patients can be treated continuously.
- Infection control is utmost important in these setting, but it is difficult due to poor infrastructure.
- Advocacy is also important in order to use effectively existing resource for the needed activities

Next steps

- Sustain political commitment
- Making and training guideline (1) for implementing TB control in closed setting and guideline (2) for TB-HIV collaboration activities
- Advocacy for improving incentive for staff
- Planning investment of infrastructure for TB/HIV unit in the appropriate settings.
- Scaling up these models nation-wide
- Strengthening monitoring and supervision.

BỘ Y TẾ
DỰ ÁN PHÒNG CHỐNG LAO QUỐC GIA

TÀI LIỆU

HƯỚNG DẪN THỰC HIÊN CÔNG TÁC CHỐNG LAO

Contents of the guideline:

1. TB control in the closed settings
2. Drug dependent treatment and TB control
3. TB finding, diagnosis, treatment and management (DOTS) in the closed settings
4. IEC for TB control in closed setting
5. Harm reduction treatments

MINISTRY OF HEALTH
NATIONAL TUBERCULOSIS CONTROL PROGRAMME

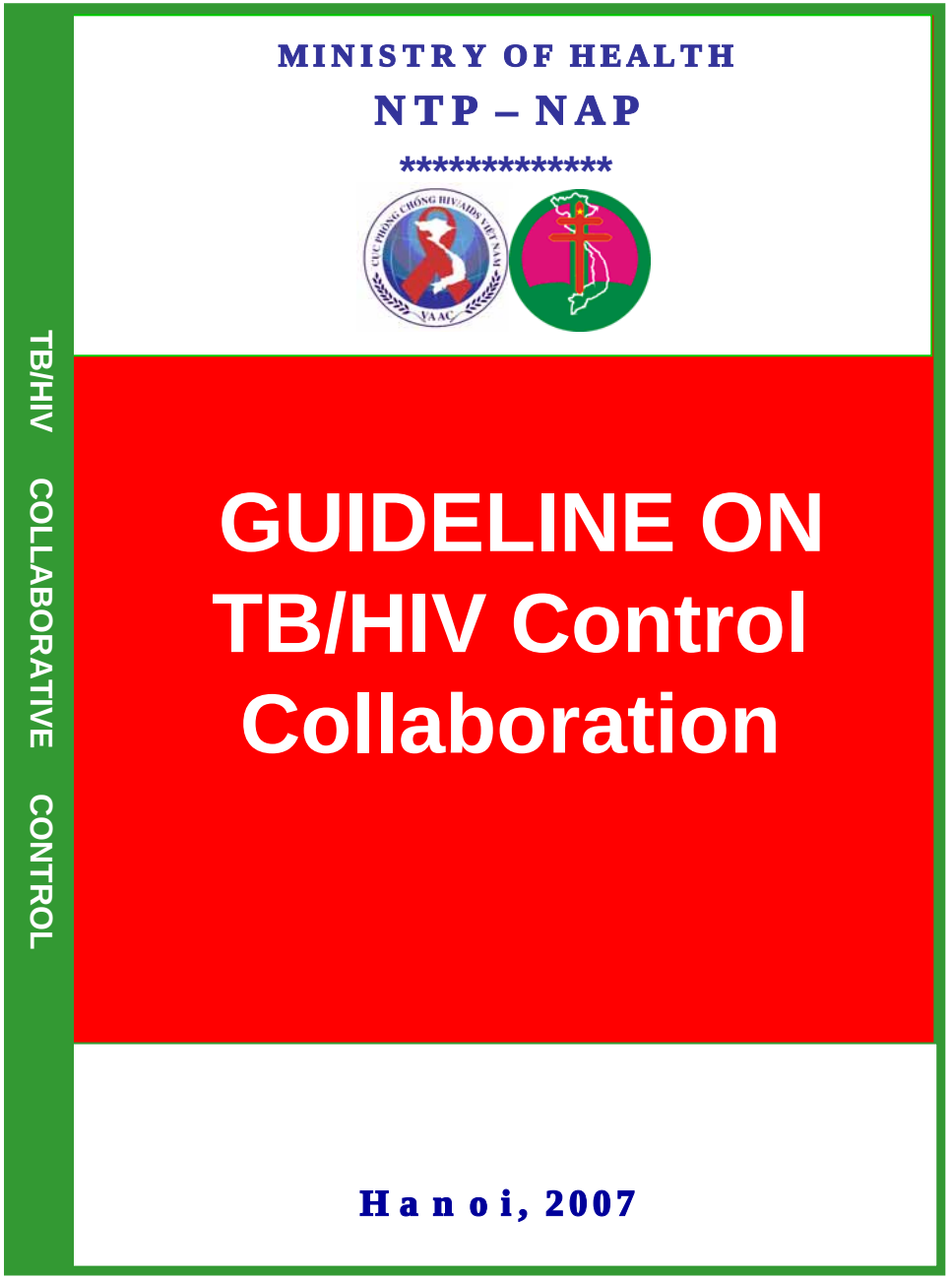
GUIDELINE ON TUBERCULOSIS CONTROL

IN PRISONS AND CORRECTIONAL INSTITUTIONS

Hà Nội, năm 2007

Content of the Guideline:

1. Collaborative protocol for TB/HIV diagnosis and treatment
2. TB intensified case finding among PLWHAs
3. HIV counseling and testing for TB patients
4. Tuberculosis treatment for TB/HIV patients
5. ART for TB patients
6. OIs Diagnosis and treatment for TB/HIV patients
7. IPT for PLWHA
8. TB transmission prevention and control
9. HIV transmission prevention
10. Recording and reporting forms of TB/HIV collaboration activities



THANK YOU !