Uganda 100-day TPT scale up

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Introduction

- In 2018 the UNHLM political declaration put TB prevention as one of the key elements to ending the TB epidemic.

- A ¼ of the world’s population (1.8 billion) have LTBI and carry a lifetime risk of getting sick with active TB disease.

- This risk can be substantially reduced by TB Preventive Treatment (60% among PLHIV and 70% in U5 contacts).

- Tuberculosis is the leading cause of death among People living with HIV even in the era of ART
Introduction

- In 2017, 32% of the AIDS related deaths were due to TB globally
- To End TB, it is not only essential to treat active TB when it happens but to prevent it from happening. “Closing the tap”
- Uganda endorsed a form of TPT called Isoniazid preventive therapy (IPT) and has been providing IPT to PLHIV for about 5 years now
Trends in IPT uptake in Uganda

- Prior 100-day IPT scale up plan, uptake of this important intervention was still low even with Surge efforts.

- The 100-day plan is a critical intervention that will put Uganda back on track towards achieving the UNHLM and END TB targets.
National IPT Targets

2018 2019 2020 2021 2022

TB prevention Among PLHIV and children under 5 yrs

Gap to be covered by the 100 day scale-up plan
The 100-Day Accelerated IPT Scale-Up plan

- On 3rd July 2019 was the launch of an accelerated plan to reach 300,000 PLHIV with TPT within 100 days.

- **AIM:**
  - To help initiate 50% of all PLHIV in need of this life saving treatment.

- The 100 days was the first step towards complete roll out of IPT.

- MOH organized and set in place all the tools & supplies needed to accomplish this task (IPT scale up toolkit).
Systems Approach to TPT coverage and retention

Inputs

• INH/ B6
• Competent H/W
• Data tools – IPT registers
• Job aids, guidelines, ICF tools
• Coaches/ district mentors

Processes to improve coverage and retention

• System to identify all eligible clients (line listing, file review, separating files and stickers)
• System to reach all eligible clients (clients brought to the facility, H/W goes out to the clients, phone calls, CHWS)
• Efficient system to attend to the clients when they come (identified clients, pre-packing of INH with ARVs, fast tracking stable clients, education and counselling)
• System to follow up and retain clients on TPT
• Data management systems
• System to sustain INH/ B6 stock levels

QI

Output

• All eligible clients identified

Outcome

• All eligible clients receive TPT; TPT clients complete therapy

Impact

• Reduced TB incidence and mortality

Outcome

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Key Action Areas

1. Systems for IPT Delivery:
   - Address Client Flow and Facility systems for delivery for Fast track clients, new clients,
   - Plan to reach stable clients in the community based DSDM

2. INH/ B6 Stocks
   - Improve Provider Skills for Stock Management

3. H/W competence and skills
   - Provide ‘just in time’ skills building to a multi-disciplinary team and job aids
   - Focus on reducing ‘know-do’ gap

4. Availability of data tools and use:
   - Share targets, create a plan for meeting the daily clinic targets.
   - Use data on PLHIV in care and ever enrolled on IPT to determine gap

5. Create awareness/demand
   Simple key messages DAILY for the clients to address adherence and increase demand
TB Prevention for PLHIV in DSDM

- All PLHIV & U5 contacts have their IPT initiated at the Facility where the health worker;
  - Screens clients to exclude active TB & contra-indications of isoniazid
  - Prepares the patient or caretaker for IPT
  - Prescribes the recommended dose for the client’s weight
  - Records in the IPT register

- Align IPT and ART refills

- Developed SOPs for guidance on providing IPT in community models
Monitoring for IPT 100-day scale-up intervention

- Indicators reported on weekly by districts
  - Number of individuals initiating IPT
  - Number of individuals completing IPT from among the previous cohort (quarterly).

- Weekly dashboard shared with NTF, IPs and DHOs every Friday

- Detailed analysis at all levels on performance of districts and facilities. Those not achieving targets were engaged for improvement.
Role of District Health Teams

❑ Commissioning of TPT at facilities to be undertaken to re-assure confidence of HCW and clients
❑ Oversight for IPT implementation in the district
❑ DHOs/MMS ensure drug availability, emergency drug redistribution, adverse drug reaction reporting etc.
❑ With support from IPs, assist in quantification and redistribution of child courses to facilities in district
❑ Conduct weekly monitoring meetings with all stakeholders including Networks of PLHIVs
❑ Ensure reporting of IPT coverage from implementing facilities
❑ Ensure accountability for performance on IPT uptake and completion at facilities
The Role of the Implementing Partner

- Collaborate with MoH NTF to plan & execute a multi-stakeholder response
- Support the identification of health facilities suitable for increase in coverage and uptake of TPT for PLHIV and retention through CQI approach
- Conduct entry meeting with DHO & DHT to sensitize about the 100 Days
- Analyse & address capacity building & mentorship gaps at the H/Facilities
- Facilitate the collection and transmission of routine weekly data from sites
- Support collection of monthly data on medicines
- Ensure drug availability, emergency drug redistribution, adverse drug reaction reporting, etc
- Support conducting CQI projects to strengthen IPT implementation
- Engage DHTs in the TPT scale up process and share weekly dashboard with the DHO and health facility teams
Expected results

Primary Result

- 300000 PLHIVs screened and initiated on IPT at 382 selected H/facilities
- 100% completion rates for individuals that initiated IPT in quarters: October-December 2018, and January-February 2019.

Outcomes

- Increase in availability of INH 300mg and Vitamin B6 at central stores and at initiating sites
- Increased routine screening use of diagnostics to rule out active tuberculosis amongst PLHIV
- Increase in collaboration and integration of planning and implementation for HIV and TB services at national, district, facility and community levels.
- Increase health worker skill and confidence in initiating IPT
- Increased in the application of quality improvement science in identifying and in action on barriers to IPT uptake.
RESULTS
Over half a million PLHIV initiated on TB IPT between 1st Oct 2018 & 6th Oct 2019

65.3% of all initiations were during the 100-days period
Overall 100-day performance is 343,674/304,391 (113%) NON-PRIORITY sites contributed 17% of the total IPT initiation during the campaign period.
There was variability in Performance by HF level with GH, RR hospitals and Clinics including those in Mulago performing lower than their target.
AGE & GENDER DISSAGREGATION FOR PLHIV WHO INITIATED IPT DURING 100-DAYS CAMPAIGN

- PLHIV, < 5 Yrs, 2,499, 1%
- PLHIV, 15+ Yrs, Female, 211,506, 62%
- PLHIV, 15+ Yrs, Male, 117,729, 34%
- PLHIV, 5-14 Yrs, 11,940, 3%
Conclusions

- Overall, 526,354 PLHIV have initiated IPT, representing ~ 41.5% of the MoH UG TX_CURR target for FY19.
- 65.3% of the IPT initiations above occurred in the 100-DAYS campaign period.
- The 100-DAYS IPT scale up campaign performance was successful with 113% performance of the targeted 304,391 PLHIV.
- Overall, HC IIs, HC IIs & HC IVs exceeded their targets while RR hospitals and General hospitals did not achieve their 100-days target.
- 17% of the clients initiated on IPT during the campaign period were in NON-PRIORITY IPT facilities.
- PLHIV aged <15 yrs constituted 4% of those who initiated IPT in the campaign period. A total of 3,467 HIV negative children initiated IPT in FY19 of whom 32% were initiated during the campaign period.
Acknowledgements

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PREVENT TB

THANK YOU