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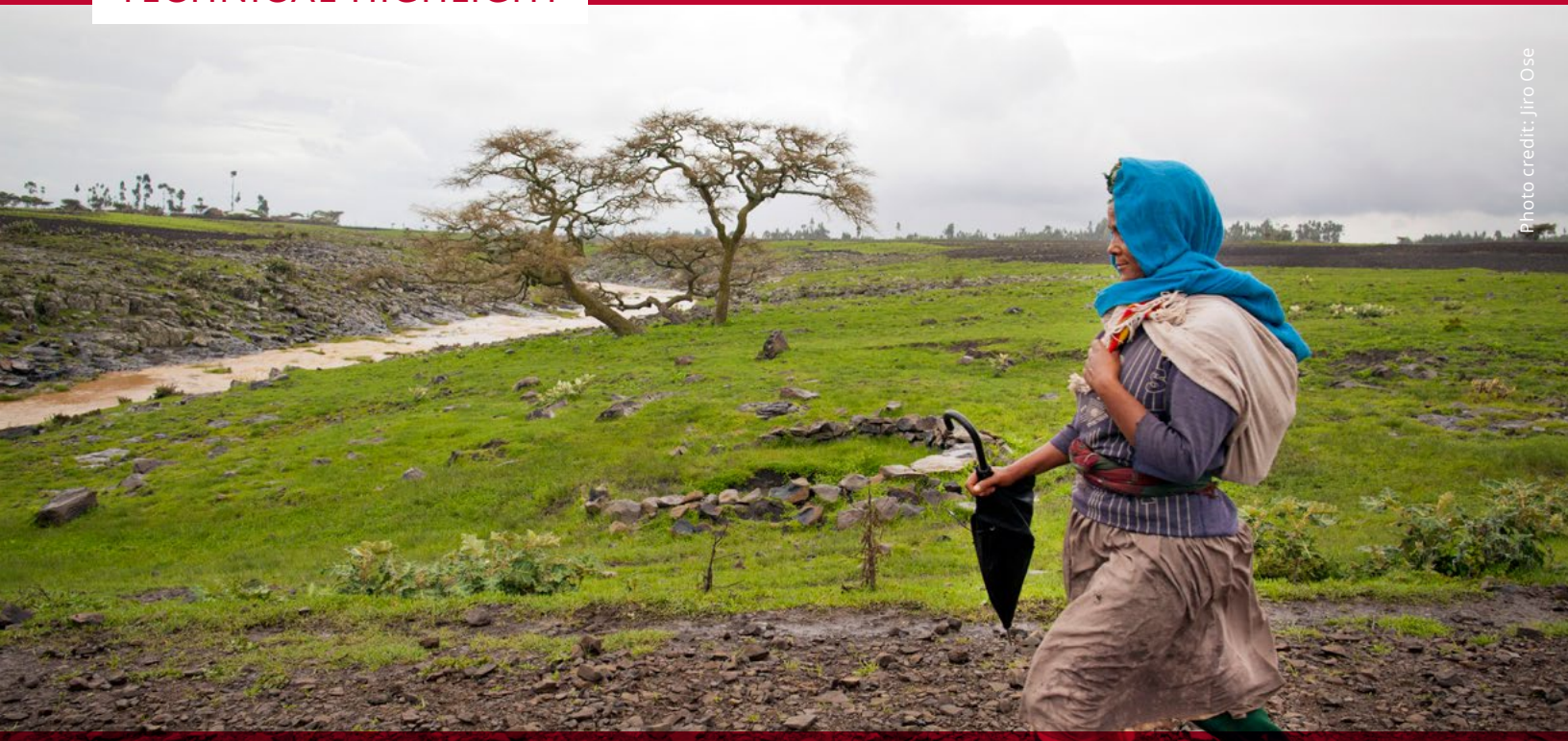
TECHNICAL HIGHLIGHT



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Telephone monitoring to improve IPT uptake: Experience from Tigray, Ethiopia

BACKGROUND

Ethiopia is among high TB-HIV burden countries. Despite efforts to improve access to preventive therapy, for nearly a decade, the uptake of isoniazid (INH) preventive treatment (IPT) among people living with HIV/AIDS (PLWHA) has remained low at the national level. In 2017, INH uptake was only 45%, which is far from the 80% target. This has an implication in terms of increasing the number of incident TB cases, associated mortality, and economic burden. Providing INH to eligible PLWHA is one of the evidence-based measures recommended by WHO that can halt progression of TB from the dormant to the active state.

In 2016, three regions (including Tigray region) had IPT uptake below the national average. IPT coverage for newly enrolled PLWHA remained low in the Tigray region, as 30.6% at baseline in 2017. Less than one-fifth of newly enrolled PLWHA accessed IPT in 2014. The main barriers identified included irregular supply of INH, resulting in stock-outs and interruption of IPT provision that in turn created health care workers' fear of INH drug resistance.

The USAID-funded Challenge TB (CTB) project is the major TB partner to the Federal Ministry of Health that supports implementation of the comprehensive TB program, including TB HIV activities in the Tigray region (population about five million). There are 249 TB service-providing health care facilities, of which 105 also provide HIV/AIDS services.

ETHIOPIA

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STRATEGIC RESPONSE

The CTB project in Tigray provided overall TB program support, including troubleshooting challenges in implementation. One such strategy included conducting regular program reviews in collaboration with the Tigray regional health bureau (RHB) to address operational problems (such as low IPT coverage) as they emerged and to co-create solutions to address those challenges that could affect long-term sustainability of efforts.

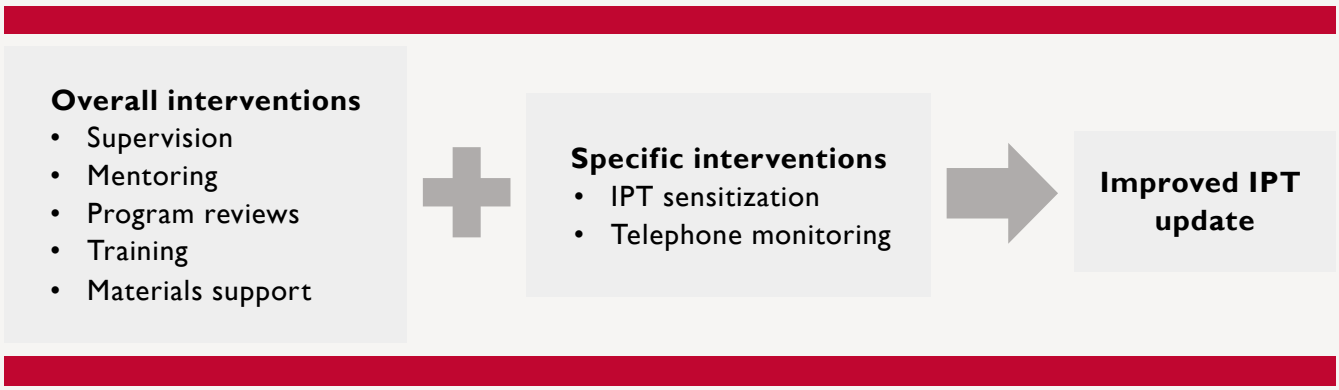
IMPLEMENTATION

A comprehensive package of program support has been provided that includes mentoring and supportive supervision, regular quarterly program review meetings, and providing TB/leprosy-related formal trainings and material support (figure 1). On-site supportive supervision has been conducted at antiretroviral therapy (ART) sites every quarter, jointly with RHB and/or woreda TB experts using the standards of care to improve TB (SOC/qual TB) checklist. This practice has been routinely applied during mentorship and one-to-one meetings.

Specific interventions

- Sensitization workshops to create awareness on IPT in Tigray: IPT sensitization was given to 228 health professionals, consisting of facility- and woreda-level TB staff and ART focal persons. All seven zones were covered through the sensitization workshops that fully engaged the CTB-Tigray staff and experts from the Tigray RHB.
- Patient monitoring and support: The regional team was determined to improve IPT coverage and decided to institute monthly patient-level monitoring and support through phone calls. In preparation for the telephone-assisted monitoring, the regional CTB team initially enumerated the phone numbers of all ART focal persons in their catchment.
- Checking for newly enrolled patients: Quarterly supportive supervision focused on checking the ART register to determine if there are patients who are newly enrolled in chronic care. If so, health care staff and the ART focal person would discuss the situation and screen patients for eligibility and provide IPT for those fulfilling the criteria. The regional CTB staff and the focal person discuss any challenges working against provision of IPT and make every effort to solve them.
- Tracking patients: A regional team member gives a unique identifying number to each patient who is a candidate for IPT. The team member makes follow-up phone calls to the ART focal persons at least once a month to make sure that all eligible, newly enrolled, and recorded PLHIV are put on IPT in a timely manner.

FIGURE 1. Types of interventions that lead to increased uptake in IPT



RESULTS AND ACHIEVEMENTS

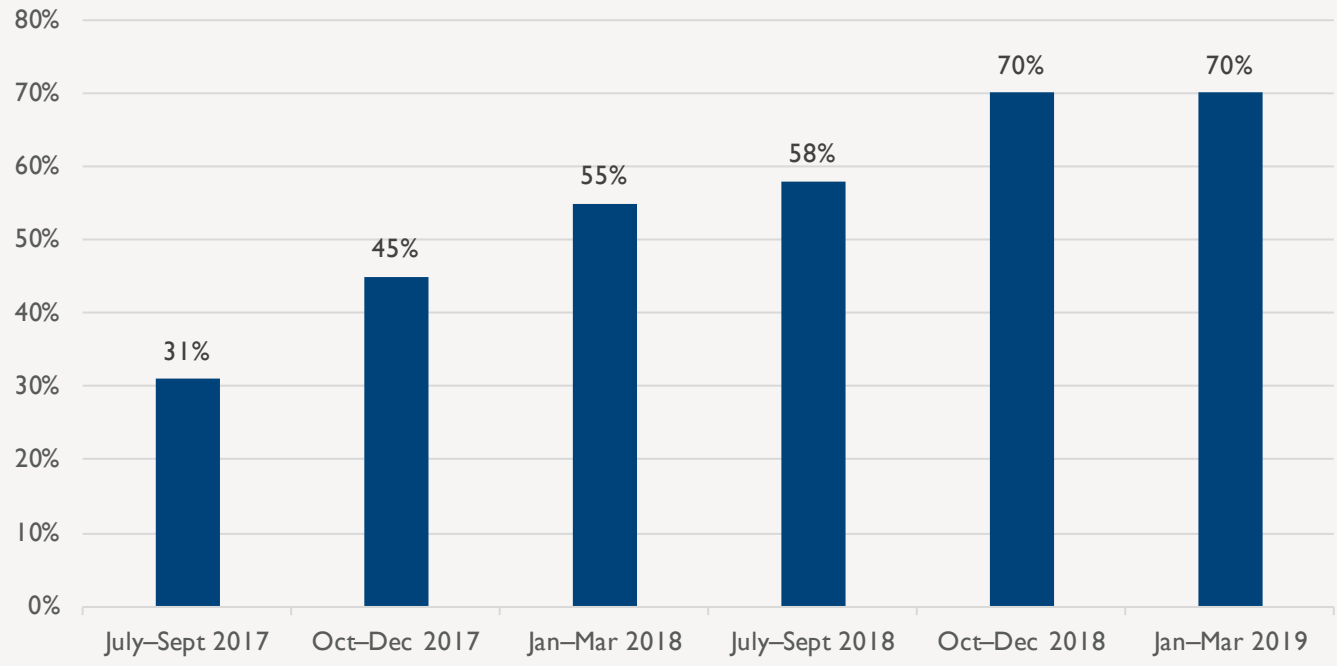
As the routinely collected, quarterly HMIS (health management information system) data for the period July 2017–June 2018 were analyzed, improvement in IPT uptake by PLWHA (table 1 and figure 2) was noted.

IPT coverage for PLWHA has improved from 31% in July-September 2017 to 70% in Jan – Mar 2019. Thus, nearly a two-fold increase in IPT uptake was evident compared to the baseline (figure 2).

TABLE 1. Number of PLWHA newly enrolled in chronic care that accessed IPT, by quarter, Tigray region

PLWHA IPT COVERAGE	JULY–SEPT 2017	OCT–DEC 2017	JAN–MAR 2018	JULY–SEPT 2018	OCT –DEC 2018	JAN–MAR 2019
# new PLWHA enrolled	1,012	991	889	878	638	406
# new PLWHA on IPT	310	443	488	513	448	282
IPT coverage	31%	45%	55%	58%	70%	70%

FIGURE 2. IPT coverage among PLWHA newly enrolled, by quarter, Tigray region



WAY FORWARD

Persistently low performance of IPT in the region has been well addressed as evidenced by an improvement in IPT coverage from a baseline level of 30.6% in quarter 1 to 58.4% in quarter 4.[1] This translates to increased PLWHA enrollment, leading to reasonable protection from TB and a better quality of life. The tailored sensitizations corrected misconceptions and brought health care workers to the forefront of TB prevention, coupled with innovative patient-level monitoring– by telephone.

The USAID/CTB Tigray office and the Tigray RHB discussed sustainability issues and finally reached an agreement so that the RHB will continue the telephone monitoring by integrating the intervention into routine care.

Acknowledgment

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Authors

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[1] It was later noted that the project target of 70% was achieved in Q1 of 2011 Ethiopia fiscal year.

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