ISONIAZID PREVENTIVE THERAPY in HIV-INFECTED PERSONS

IMPLEMENTATION ISSUES

STEP 1: HIV TESTING

Screening of potential recipients (PLHIV)

in

HIV testing and counseling services:

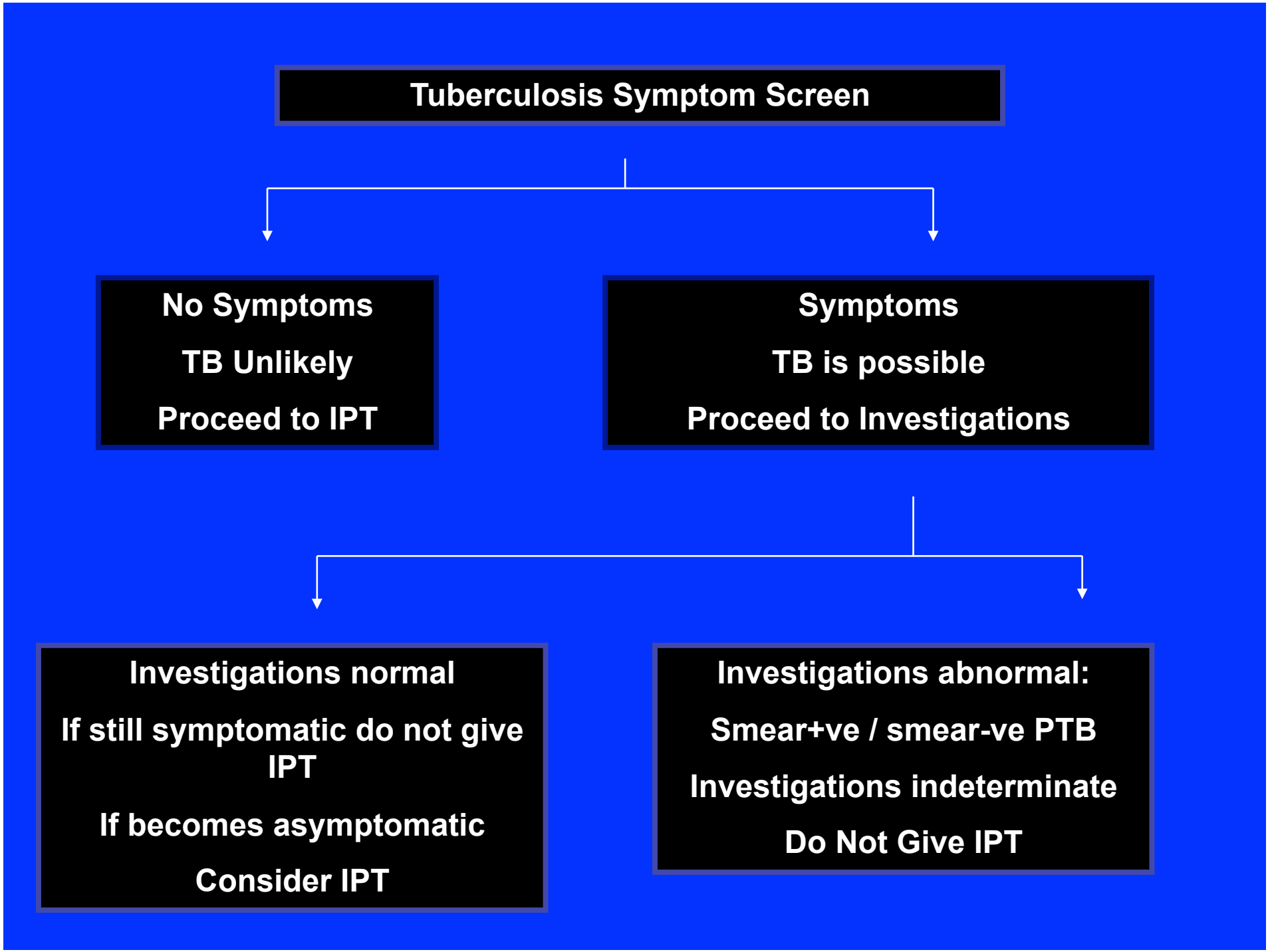
either

VCT sites

or

PITC sites

2. SCREEN FOR ACTIVE TB


Tuberculosis Symptom Screen
No Symptoms
TB Unlikely
Proceed to IPT
Symptoms
TB is possible
Proceed to Investigations
Investigations normal
If still symptomatic do not give IPT
If becomes asymptomatic
Consider IPT
Investigations abnormal:
Smear+ve / smear-ve PTB
Investigations indeterminate
Do Not Give IPT

STEP 3: CONTRAINDICATIONS

- Patient with suspected or active TB
- Patient with hepatitis
- Use with caution in those who consume alcohol on a daily basis

STEP 4: IPT ADMINISTRATION

- Daily, self-administered therapy for 6 months at 5mg/kg (max. 300mg)
- One monthly check-up and give one month supply of medication

STEP 5: MONITORING

- Monitor for adherence to therapy - those who interrupt should take at least 6 months isoniazid during a 12-month period
- Monitor for drug toxicity, especially hepatitis
- Monitor for signs of active TB

STEP 6: EVALUATION

Effectiveness regularly assessed (quarterly?):

- **no. clients HIV-positive**
- **no. who start IPT**
- attendance at regular appointments
- adherence to therapy
- toxicity and patient withdrawal from therapy
- **no. who complete PT**

PROGRESS WITH IPT SCALE UP

Global Plan to STOP-TB:
IPT Target for 2006 = 1,200,000 PLHIV
Results for 2006:

- 84 countries have IPT policy
- 24 countries reported IPT activity
- 27,056 PLHIV started on IPT

- 70% of IPT patients from Botswana
- 63% of IPT patients in Botswana did not complete treatment

WHY LACK OF PROGRESS?

- Countries do not know who should take responsibility or how to do it
- Concern that IPT being given to many PLHIV who do not have latent TB infection and therefore an ineffective intervention
- Fear of inadvertently placing TB patients on IPT and therefore creating drug resistance
- Fear of INH toxicity

WAY FORWARD?