



Providing TB Preventive Treatment (TPT) to People in CARGs Feasibility & Acceptability in Zimbabwe

Background

Tuberculosis (TB) is a leading cause of death among people living with HIV, for whom TB incidence is 2–10-fold higher than their HIV-negative peers. TB preventive treatment (TPT) has been shown to markedly reduce the risk of illness and death from TB among people living with HIV, but low coverage and completion rates are challenging in many settings. Zimbabwe is a high burden TB country with a substantial HIV epidemic, but coverage of TPT is low, with only 11% of people newly enrolled in HIV care receiving TPT in 2017. The anticipated introduction of new, shorter TPT regimens is a promising opportunity to improve TPT coverage and completion for people living with HIV, as are new HIV treatment models such as differentiated service delivery (DSD).

Zimbabwe's Ministry of Health and Child Care (MoHCC) has strongly endorsed the use of DSD for HIV treatment, and has scaled up multiple DSD models including community antiretroviral groups (CARGs) in which small groups of people on antiretroviral therapy (ART) meet regularly in the community to review their

health status and provide mutual support. After each meeting, one CARG member visits the health care facility on behalf of the entire group to report back and pick up a supply of ART for each CARG member.

Because TPT coverage is so low in Zimbabwe, there are now hundreds of thousands of people receiving ART via CARGs who have not received TPT. Integrating TPT into the CARG model could leverage the mutual support provided by CARG members and the convenience of delivery of both ART and INH/pyridoxine. This may increase demand for TPT amongst recipients of care, leading to enhanced coverage and completion of TPT regimens.

In order to explore the potential of providing TPT services to people in CARGs, ICAP partnered with MoHCC and the Zimbabwe National Network for People Living with HIV (ZNNP+) to conduct a rapid assessment of the feasibility and acceptability of integrating TPT into the CARG model.

Assessment Design & Methods

The assessment was designed to explore existing TPT guidelines and implementation, current CARG practices, and attitudes towards integrating TPT into CARGs. Data collection took place between March 2019 and September 2019 with 'central level' informants and 'site level' participants from 4 urban and 3 rural health facilities.

Data collection included:

- 25 key informant interviews (KIIs) with 'central level' informants, including members of the MoHCC HIV, TB and pharmacy/logistics teams, ZNNP+ members, PEPFAR staff, program implementers, and clinicians;

- 20 KIIs with CARG leaders in rural and urban settings
- 16 focus group discussions (FGDs) with 136 CARG members in rural and urban settings; 8 FGDs with CARG members who had previously received TPT and 8 FGDs with those who had not received TPT
- 8 CARG field observations/time motion studies

KIIs and FGDs were transcribed and analyzed using Dedoose™ software. Thematic coding and content analysis were performed. Closed-ended questions from KIIs and FGDs and the field-based observations were analyzed using STATA.

Key Findings

Overall, the integration of TPT into CARGs was accepted by participants among all cadres. 24/25 (96%) central-level informants and 17/20 (85%) CARG leaders felt it was a “very good” or “good” idea. The perceived advantages to integration were that it would utilize a system already in place, provide psychosocial support for members, promote adherence to both TPT and ART, save time and money as well as reduce workload for health facility staff due to less clinic visits. The perceived disadvantages to integration included potential coordination challenges, potential medication stockouts, the unknown impact on TPT adherence and safety, and the need for additional training and education for CARG leaders and members as well as health facility staff.

In the KIIs, central level informants and CARG leaders were presented with two TPT demand generation strategies. In approach #1, CARG members who had not had TPT would be encouraged to ask for it at their next scheduled clinic visit. In approach #2, CARG members who had not had TPT would be encouraged to return to the clinic right away to request TPT. Central level informants slightly preferred approach 1 and CARG leaders slightly preferred approach 2.

Model #1

(leave the CARG for the duration of TPT)

Once a person in a CARG initiated TPT, s/he leaves the CARG and is seen at the clinic monthly for the duration of TPT. S/he would receive one month of TPT and ART at a time, with monthly clinical examinations while taking TPT. Once s/he completes the full course of TPT, s/he returns to the CARG model.

Model #2

(hybrid)

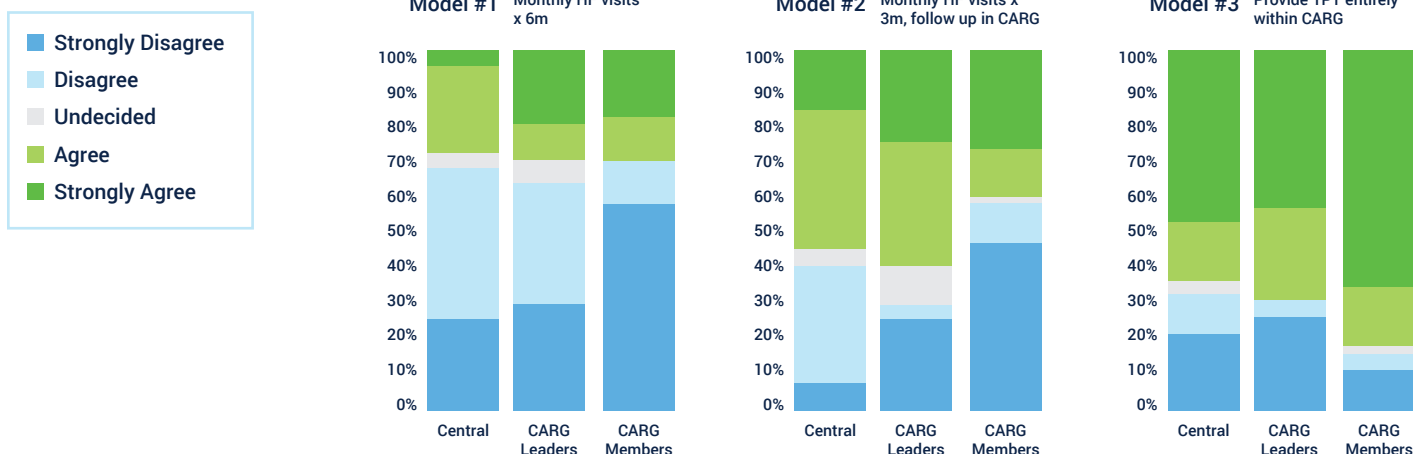
Once a person in a CARG initiates TPT, s/he makes monthly visits to the clinic for the first three months. Then, if doing well, s/he receives three months of TPT and three months of ART and returns to the CARG model

Model #3

(TPT given entirely within the CARG)

TPT is initiated at the clinic but administered entirely within the CARG. The person would not be seen at clinic following initiation but would receive 3 months of TPT and ART at a time and be monitored by the CARG leader

Preferred TPT Delivery Model



Model 3 was generally preferred by central level informants, CARG leaders and CARG members (see Figure), although all noted some concerns about safety.

Trained data collectors observed 8 CARG meetings:

- CARG leaders asked each participant if they were taking their ART as instructed in 7/8 meetings
- CARG leaders asked each participant if they had any new health issues in 5/8 meetings
- CARG leaders asked each participant about TB symptoms (cough, fever, night sweats, weight loss) in 2/8 meetings

Conclusions

Policymakers, implementers, CARG leaders and CARG members agreed that provision of TPT via CARGs would be a feasible and acceptable approach to increasing TPT coverage and completion in Zimbabwe. The perceived need for additional training and supervision of CARG leaders was reinforced by the observation that only 25% screened CARG members for TB symptoms.