

KYRGYZSTAN **X**PERIENCE AND CHALLENGES CONTROLLING TUBERCULOSIS IN DETENTION



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Country situation

- KG has a population of about 5.42 million.
- TB incidence rate 159 PER 100,000 population.
- KG is one of 10 countries with high MDR TB burden worldwide
- detection of cases 66 %
- The treatment success for new pulmonary smear positive was 84%, for SS- and EP 92% and retreatment 70% (2008)
- In 2009, 6358 TB cases were notified (total, new and relapse)
- MDR
 - 13 % among new TB cases
 - 42 % among retreatment cases
- Other DR: not reported, not treated...
- Concept of “chronic TB” is alive: most likely XDR?

Country situation

- Prison population in KG is about 7100 in 2010
- TB rates in penal system:
 - 4600 per 100 000 notification, 2009
 - 499 per 100 000 annual mortality
- Country HIV prevalence 0.3%
- However: HIV prevalence among:
 - IDUs 14.7% 2009 (7% in 2007)
 - Prisoners 6.6% (3% in 2007)
- Co-infection rate 1%, reported in WHO TB report 2010 (data accuracy issue?)
- HIV testing coverage reported 104 per cent, however VCT is not always done
- Hep C prevalence among prisoners 39% (2009 data)

MSF OCG programme

- Started in two facilities:
 - SIZO (pre-trial detention center with TB ward)
 - Colony 31 (Sensitive and PDR TB hospital)
 - ICRC active in Colony 27 (MDR TB hospital)
- Primarily concentrated on Centralization of TB care for the poor outcomes of previously decentralized TB Rx
- Case Finding
 - “active” case finding based on CXR (fluoroscopy)
 - “passive” case finding (patients come with the symptoms)
- Diagnostics – supporting microscopy labs and NRL
- Treatment
- Infection control
- Social follow up after release
- Addressing comorbidities

Case finding

- Screening of all incoming inmates, and regular screening of prevalent inmates with chest Fluorography
 - Cost effectiveness issues
 - Lack of supporting evidence
 - Risk of over-diagnosis (and perhaps under-diagnosis for HIV+)
- Start introducing symptom-based clinical screening
- Concentrate on screening “prevalent” inmates, especially in SIZO
- Introduce molecular method (Xpert MTB/Rif)
 - More patients soon
 - More TB diagnosis among HIV+, more EPTB
 - Issue of reporting
 - Need to adjust treatment plan

Laboratory Diagnostics

- Microscopy Lab network in Penal system: Good performance
- NRL:
 - Introduction of liquid media in 2007
 - Plan to introduce HAIN in 2011
- Quality: high contamination rates
- Quality: high levels of devergence on DST1 between NRL and SNL
- NRL: lack of leadership and managerial capacity!
- Insufficient HR
- Biosafety issues in 2009/2010 (3 new TB cases in staff)
- Lack of coordination between NRL and penal system (financing)

Treatment

- MSF is a sole supporter of PDR/mono-DR TB treatment
- Cases of MDR and XDR at SIZO1
- DR TB treatment
 - SL TB drugs shortages - inadequate planning
 - Centralized prescription through “MDR-TB committee” (paper work is a negative incentive for the staff)
 - Exclusion criteria (e.g. HIV, substance abuse)
 - Patient support and education not systematically tackled
 - side effects not always addressed
- HIV and Hepatitis
 - Improve HIV counseling and testing
 - New ART initiation thresholds – more pts on ART
 - HepC screening
 - Hep B vaccination

Infection Control

- Lack of Up-To-Date National or institutional Policy
- Security considerations override medical
- Informal hierarchy among prisoners
- Current approach:
 - Environmental Controls (UV lamps and ventilation installations)
 - Personal protection (high filtration masks)
 - Early separation by infection pattern (AFB pos/neg, resistance)
- To be more systematically addressed:
 - Managerial/Administrative controls
 - G SIN institutional capacity (e.g. HR issue)
 - Timely transfer to the Colony and timely Rx initiation for those detected in periphery

Transitional Case Management

- Poorer outcomes among released patients
 - Success 84% finished in vs 40% finished out
- Need for better collaboration btw GSIN and NTP (at the moment MSF is main supporter of after-release follow up)
- Need to foresee handover:
 - Hand over to local partners
 - Social HR in MoH payroll?
- Need to better integrate with drug treatment programmes
- Many released patients drop off treatment for unwilling to be inpatient (Treatment guidelines adjustment needed!)

Challenges

- Commitment by the related ministerial and health bodies – (MoH, NTBI, GSIN and NRL)
- Allocation of adequate financial resource: penitentiary system got only 15 per cent of requested funds in 2009
- Inequality of TB treatment provision and existence of exclusion criteria in both sectors (penal and civil)

Challenges

- Inadequate follow up and support mechanisms for patients on MDR-TB treatment
- Inadequate contact tracing mechanisms for contacts of MDR-TB patients
- Capacity issues (human resource, high turnover of medical staff, lack of motivation)
- Lack of patient support and education (clinical standards, HR)
- Comprehensive Infection control implementation

Challenges

- Lack of explicit national guidelines with identified roles and responsibilities (between the partners) and which are complied with
- Comprehensive DR TB Guideline does not exist
- Need for Context adapted DR TB guidelines for penal system
- Lack of diagnostic care and integration of care/treatment for co-morbidities - HIV, Viral Hepatitis
- Drug treatment services: issue of methadone availability for identified cases within two TB colonies.

Thank you!