## Tuberculosis Preventive Therapy Uptake barriers: What are the low-lying fruits to surmount this?

 “Closing the tap”: Prevention of new infections and their progression to TB disease is critical to reduce the burden of ill health and death caused by TB (1). Tuberculosis preventive therapy (TPT), a high impact intervention critical to reducing the burden of TB among people living with HIV (PLHIV) has been recommended since 1998 by WHO (2) . The global coverage has been low; 49% among people newly enrolled in HIV care in 2018, with 60% of this enrolment being accounted for by South Africa(1).

So why is TPT coverage so suboptimal? Why are there “missed” millions for prevention? A review of 42 countries supported by the US President's Emergency Plan for AIDS Relief (PEPFAR) showed availability of TPT national guidelines in 33 (94%) countries, but only 21 (60%) reported nationwide programmatic TPT implementation (3). Various barriers to high coverage of TPT have been highlighted including lack of health care worker buy-in(4), commodity security with stock outs (3).

In this issue of PHA, Odume et al provide some insights on how some bottlenecks to scale-up TPT can be resolved through simple, practical and context specific solutions implemented in Nigeria. Streamlining the supply chain system to ensure last mile delivery of commodities by HIV program led to 69% change in coverage in 2016-2017. Though overall coverage is remained sub-optimal, this is a step in the right direction in ensuring improved coordination between HIV/TB programs. Similarly, Kenya in 2014-2017 enrolled over 640,000 PLHIV on TPT through securing high level political commitment that ensured financial support , dedicated healthcare workers implementing the program, stakeholder involvement and using existing platforms to integrate implementation of TPT hence minimizing the cost of implementation(e.g roll out of Dolutegravir)(5).

Currently, there is an unprecedented global momentum to accelerate TPT and interventions like those of Odume et al identify “low lying fruits” that address barriers to scale-up. The UNHLM Political Declaration on TB sets ambitious targets for TB prevention for those most at risk of falling ill, including rapid scale-up of access to testing and provision of preventive treatment for at least 30 million people by 2022 including 6 million PLHIV(6). The recent WHO guidance on use of 3 months of weekly isoniazid and rifapentine (3HP) and the likely adoption of one month of daily isoniazid and rifapentine (1HP) could improve the adherence and roll out of TPT(7).The Global Fund to Fight AIDS, Tuberculosis and Malariahas recently expanded the scope of its catalytic investment for finding missing people with TB to include TPT for PLHIV and contacts of people with infectious TB in 20 high burden countries. In addition, PEPFAR HIV care programs have stepped-up implementation of TPT as an essential component of the care package for PLHIV in the TB/HIV high burden countries.

To cover the millions of people in urgent need, an extension of service delivery points beyond the traditional health facilities will be required. Depending on the setting, this approach will require effective use of community systems and community-based health workers. In addition, differentiated models of care facilitated by digital adherence technology should be considered.

Can we reach the 30million people with TPT? Let`s focus on addressing the low-lying barriers!

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