EDITORIAL

Extending the reach of integrated TB-HIV services with community health workers

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The integration of tuberculosis (TB) and human immunodeficiency virus (HIV) services is a cornerstone recommendation for both diseases, but in practice it is difficult to achieve.¹ Active case finding for TB among household contacts of TB patients can serve as a platform for both TB and HIV screening,² and home-based HIV testing conducted by trained lay counselors has been shown to be an effective way to achieve high testing uptake and linkage to care.³ The World Health Organization (WHO) recommends TB contact tracing in all settings, but significant implementation gaps remain in many low-income, high-TB burden settings.⁴ Community health workers (CHWs) are increasingly engaged to conduct HIV screening and outreach activities, but few evaluations of integrated TB-HIV programs employing CHWs are available to inform this strategy.

In this issue of *Public Health Action*, Ochom and colleagues report on a CHW-delivered HIV counseling and testing (HCT) program integrated into TB household contact tracing in Uganda.⁵ CHWs conducting TB contact screening conducted home-based HCT for TB contacts while conducting home visits for TB screening, achieving a modest uptake of HIV testing among adult contacts (53% accepting HCT) and, importantly, 100% linkage to care with antiretroviral therapy (ART) initiation among persons testing positive for HIV (4% of tested contacts). Quality assurance found high agreement with CHW and laboratory-based testing, and qualitative findings identified increasing CHW confidence and satisfaction with providing HIV testing and treatment linkage as part of TB contact tracing.

There are limitations to the study, including a lack of reporting on the performance of the TB component of the program, and a relatively intensive training and supervision program for CHWs that may not be fully scalable where resources are limited. Also absent was any mention of TB prevention options for household contacts, especially those found to be HIV-infected. Nonetheless, this study contributes important information on operational feasibility of integrated CHW TB-HIV activities, and provides valuable preliminary costing data, which are of primary concern to program managers. In addition, the evaluation demonstrates the significant potential for value-added services conducted as part of TB contact tracing, which

should further motivate an already underutilized component of TB control.

The technical and logistical successes of CHW-delivered HIV testing and linkage through household contact tracing suggests this is a viable platform to provide an expanded package of integrated TB and HIV service and prevention delivery. Next steps could include implementing new WHO guidelines for TB and HIV prevention: referral for PrEP or male circumcision for eligible HIV-uninfected persons, isoniazid or other short-course TB preventive therapy for TB-negative household contacts,⁶ as well as continued referral for further diagnostic evaluation and treatment for persons screening positive for HIV or TB.

To meet the ambitious UNAIDS 90-90-90 targets for HIV testing, ART initiation, and virologic suppression,⁷ as well as improving HIV-TB integration in practice, significant scaling up of case-finding strategies (for both TB and HIV) outside of traditional facility-based testing and robust linkage to care are necessary. As shown in this study, CHW-led integrated TB-HIV screening can serve as a mechanism to improve testing coverage, linkage to care, and TB-HIV integration. The full potential of CHW-delivered interventions on the trajectory of both TB and HIV epidemics may only be fully realized by including comprehensive prevention as part of integrated service delivery.

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