EDITORIAL

Tuberculosis preventive therapy uptake barriers: what are the low-lying fruits to surmount this?

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Closing the tap—the 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 TB 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 the WHO.² However, global coverage has been low, just 49% among people newly enrolled in HIV care in 2018, with South Africa accounting for 60% of this enrolment.¹

So why is TPT coverage suboptimal? Why are millions being ‘missed’? A PEPFAR (US President’s Emergency Plan for AIDS Relief) supported review of 42 countries showed that TPT national guidelines were available 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 and commodity insecurity due to stock outs.³

In this issue of *Public Health Action*, Odume et al. provide some insight into 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 the HIV programme led to increase in coverage by 69% in 2016–2017. Although overall coverage remains sub-optimal, this is a step in the right direction to ensuring improved coordination between HIV-TB programmes. Similarly, Kenya in 2014–2017 enrolled over 640 000 PLHIV on TPT by securing high-level political commitment that ensured financial support, dedicated healthcare workers to implement the programme, and stakeholder involvement. By using existing platforms to integrate TPT implementation, the costs of implementation were minimised (e.g., roll out of dolutegravir).⁵

There is currently an unprecedented global momentum to accelerate TPT and interventions such as those described by Odume et al. as ‘low lying fruits’ that address barriers to scale-up. The UN High-Level Meeting 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 the 3HP regimen (3 months of weekly isoniazid and rifapentine) and the likely adoption of the 1HP regimen (1 month of daily isoniazid and rifapentine) could improve the adherence and roll out of TPT.⁷ The Global Fund has 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 programmes have stepped up TPT implementation as an essential component of the care package for PLHIV in high TB-HIV 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 30 million people eligible for TPT? Let’s focus on addressing the low-lying barriers!

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