



Tuberculosis mortality targets off-track

Many countries are on target to meet UN goals for tuberculosis mortality among people with HIV, but many more are not. Talha Burki reports.

For UNAIDS report on progress towards the 2020 goal see http://www.unaids.org/sites/default/files/media_asset/tuberculosis-and-hiv-progress-towards-the-2020-target_en.pdf

The 2016 High-Level Meeting on Ending AIDS saw UN member states commit to cut mortality from tuberculosis among people living with HIV (PLWHIV) by 75% by 2020, relative to 2010 levels. In March, 2019, UNAIDS reported its progress towards this target. It noted that 23 low-income or middle-income countries have already achieved mortality reductions of at least 75%, or are expected to do so by the end of 2020. But it cautioned that most nations are not on track to attain the target. Indeed, in some countries and regions, deaths are rising.

The report is based on WHO mortality estimates. Given the dearth of vital registration data from Africa, which is home to three-quarters of the global burden of HIV–tuberculosis co-infection, the estimates necessarily involve a degree of speculation, particularly when it comes to extracting information on those who are HIV positive. Nonetheless, WHO reckons that around 1.6 million people died from tuberculosis in 2017, the most recent year for which records are available. 300 000 of these deaths occurred in PLWHIV. That amounts to a reduction in mortality of 42% since 2010.

There were 464 633 registered cases of tuberculosis among PLWHIV in 2017. 84% of the registered patients were on antiretroviral therapy. “The tuberculosis programmes are doing well, with many exceeding the first two 90–90–90 targets with 90% or more tuberculosis patients aware of their HIV status and 90% or more on HIV treatment”, said Alasdair Reid (UNAIDS, Geneva, Switzerland). Around two-thirds of tuberculosis patients in the 30 countries with a high burden of co-infection know their HIV status. Sharp increases in antiretroviral therapy coverage in southern Africa

have contributed to a dramatic drop in tuberculosis incidence in the region over the past few years.

India has cut the number of deaths from tuberculosis among PLWHIV by 84% since 2010. The reduction, which is the largest in the world, is testament to the country’s drive to tackle co-infection. In 2017, Indians made almost 11 million visits to antiretroviral therapy clinics; 83% of attendees were evaluated for tuberculosis, 6% of whom were found to have symptoms of the disease. 3500 HIV-positive Malawians died from tuberculosis in 2017, down from 16 000 in 2010. The impoverished southern African nation has rapidly scaled up the roll-out of antiretroviral therapy, which it provides free of charge, alongside screening, testing, and treatment for tuberculosis.

“The number of PLWHIV receiving preventive treatment for tuberculosis has plateaued”

Elsewhere, progress is mixed. Ethiopia and Kenya are expected to make the target. South Africa, widely considered a model for tuberculosis control, is more or less on course. Mozambique, Lesotho, Rwanda, Tanzania, and Zimbabwe have all seen reductions in mortality of 25–49%. “They are doing well, but tuberculosis and HIV programmes need to rapidly scale-up joint activities if they are to get to 75% by the end of 2020”, said Reid. Angola, Chad, Congo, and several western and central African nations, have seen increasing mortality. This is also the case in much of South America, although the numbers there are much smaller. Deaths are also rising in Russia and Pakistan.

“The problem is the people that we are missing—the ones who are not

diagnosed with either tuberculosis or HIV”, said Reid. The total burden of tuberculosis among PLWHIV is thought to be around 920 000 per year, which implies that half of cases are going undetected. “Around one-third of tuberculosis cases are not in the system, and although in Africa especially it is systematic to do HIV testing on tuberculosis patients, there are still gaps”, explains Mario Raviglione, former director of the WHO Global TB Programme. He stresses the importance of integrated HIV and tuberculosis services. “If the programmes are not integrated, you have to ensure that they are collaborating very closely”, Raviglione concluded. A concerted effort to track down the millions of missing patients is also crucial, which can only be done if health programmes work in tandem.

The number of PLWHIV receiving preventive treatment for tuberculosis has plateaued at just under 1 million. This is suboptimal. WHO recommends prophylactic treatment for all PLWHIV who do not have active tuberculosis. Only half of the 30 countries with a high burden of co-infection report providing such treatment. “It is one area where we really need to make a big push”, said Reid. “We have new preventive, shorter, more effective regimens available, and although the price is still something of a barrier, we expect it to come down as more and more countries take up the drugs.” He points out that preventive treatment reduces tuberculosis incidence and mortality, and that the mortality effect is independent of antiretroviral therapy. “We should be doing all we can to ensure as many patients as possible are benefiting”, Reid told *The Lancet Infectious Diseases*.

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