Research Article

Prevalence of smear positivity, hiv co-infection, trend and treatment outcome among tuberculosis patients accessing care at faith alive foundation, Jos, Nigeria

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Abstract

Background: Tuberculosis (TB) in the African sub-region, is still a public health problem, heightened by its synergy with HIV. Sputum smear positivity which is diagnostic indicator often gives a lower prevalence of the disease that may be give a false burden of the disease thus leading to varied treatment outcomes that may add to the vicious cycle of the magnitude of the disease. Thus, the prevalence of sputum positivity and co-infection with HIV; trend and treatment outcomes of TB were assessed.

Methods: Secondary data of TB patients from 2012 (commencement of TB care at this centre) - 2018 at Faith Alive Foundation Jos, a renowned faith-based hospital with approximately a large monthly patient turn-out rate. Software SPSS version 18 was used for data analysis.

Results: Females adults were more affected; prevalence of sputum positivity/HIV co-infection were 15.1% (14% in adult; 1.1% in children) / 62.0% (57.4% in adults; 4.6% in children) respectively. The 7-year trend spiked in year 2015 and 2017, with an observed downward pattern in 2018 in all the ages. Cure after treatment was 6.3% (5.7% in adults and 0.6% in children).

Conclusion: Efforts will need to be put into TB diagnosis considering the low sensitivity of sputum smear microscopy in instituting treatment. TB is still a leading opportunistic infection in persons infected with HIV.

Introduction

Tuberculosis (TB) is amongst diseases that have affected mankind from time immemorial, whose causative agents and cure were initially obscured thus contributing significantly to morbidity and mortality [1-3]. Compared with diseases caused by a single infectious agent, it is the second biggest cause of mortality globally [4,5]. A third of the world’s population has been exposed and being infected with the organism with varying degrees of severity[6]. Globally, TB is currently responsible for more years of healthy life lost (2.5 percent of all disability-adjusted life years, or DALYs) than any other infectious disease [7], primarily infecting the lungs. The TB may be at the latent or active phase among persons infected [8].

Efforts have been made to curtail TB such as the Bacillus Calmette Guerin (BCG) vaccine administered to babies at birth [9,10]. In addition, the World Health Organization (WHO) designates a day annually to create awareness aimed at minimizing its global burden. Despite all these efforts, TB burden is still a problem in the African sub-region. Now with the advent of Human Immunodeficiency Virus (HIV) infection, there is a dramatic resurgence of TB with more than 8 million new cases each year worldwide and more than 2 million persons dying from it [11]. The emergence of HIV has made all the battles aimed at reducing these predisposing factors to TB infection fruitless. Mainly because TB is the most common opportunistic infections of persons infected with HIV. Additionally, the sub-Saharan countries have
barely curtailed the double burden of diseases imposed by the infectious diseases (diarrhoea disease, measles, etc.) and non-infectious diseases (diabetes, hypertension, obesity, cancers due to epidemiologic transition) then the advent of HIV and some re-emerging diseases, thus creating a triple burden on the health system and a further weakening of the already frail system. The synergy of TB and HIV co-infections poses particular diagnostic and therapeutic challenges e.g. infection with HIV is the most powerful known predisposing risk factor for Mycobacterium tuberculosis infection and progression to active disease, which increases the risk of latent TB reactivation to about 20-folds. Tuberculosis on the other hand is the most common cause of AIDS-related death in persons infected with HIV. Thus, they act in synergy, accelerating the decline of immunological functions and leading to subsequent death if untreated though the mechanisms behind the breakdown of the immune defense of the co-infected individual are not well known [12]. The HIV like many diseases affecting mankind in a pandemic proportion has not spared any age group and has brought a lot of setbacks [13–17], and the Nigerian health system had suffered several infectious disease outbreaks year after year [18,19], which has continuously weakened the system and contributing to the increasing trends of diseases despite numerous health interventions. It is estimated that each day there are about 1,000 new infections of HIV in Nigeria and 2011 WHO report on other health problems in the country has shown that the number of reported cases of malaria is on the increase [20]. In spite of the various reforms to increase the provision of health to the Nigerian people, many still find it extremely difficult to afford the high cost of health care Figure 1 [21].

Among the 30 high TB burden countries who accounted for 87% of the new cases; Nigeria is one of them. Ending the TB epidemic by 2030 is among the health targets of the United Nations Sustainable Development Goals (SDGs) [23]. According to the WHO, mortality from TB is seen among HIV-negative people and additionally from HIV-associated TB [24]. More than 95% of TB deaths occurred in low and middle-income countries [23,25]. The two synergic partners (TB and HIV) pose a threat to a desired healthy population especially in sub-Saharan Africa which provides other enabling factors to these diseases Figure 2.

The World Health Organization estimates that 9 million people a year get sick with TB, with 3 million of these “missed” by health systems [22,27]. The contribution of TB to child mortality is undetermined, particularly in TB endemic areas and a substantial number of children dying from meningitis, presumed sepsis, HIV/AIDS, or severe malnutrition may have had TB as its underlying cause [28], thus, the real burden of childhood TB in Sub-Saharan Africa is not known. A Malawi study found that 12% of all registered TB cases were children less than 15 years of age [9,29]. In the United States, a total of 9,582 cases of TB were reported in 2013, of which 485 (5%) cases were among children less than 15 years of age. In high TB burden settings outside of the United States, children account for an estimated 15–20% of TB cases [29], Children with latent infections become reservoirs for future transmission following disease reactivation in adulthood, thus fueling future epidemics [30].

The study determined the prevalence; trend and treatment outcome of patients who received TB treatment at the health centre.

The study was framed on the Donabedian health care model with a framework for examining health services and evaluating the quality of health care based on organizational structure, process and outcomes [31].

**Materials and methods**

Secondary data of TB patients seen from 2012 (commencement of TB care at this centre) – 2018 at Faith Alive Foundation Jos, a faith-based hospital with approximately 10,000 patients seen monthly were assessed. A minimum sample size of 300 was calculated [32].

\[ N = \frac{Z^2pq}{d^2} \]

Where \( N \) = minimum sample size

\( Z = \) alpha level corresponding to the 95% confidence interval = 1.96

\( P = \) Proportion of TB cases co-infected with HIV in African countries was 39% = 0.39 [26,33].

\( q = 1 - p \)

\( d = \) maximum acceptable error margin = 5% or 0.05
N = (1.96)^2 X 0.39 X 0.5 / (0.05)^2
= 3.8416 x 0.195 / 0.0025
= 299.64
= 300

Inclusion criteria
Data of all registered TB patients was assessed.

Ethical consideration
Written consent was sought for and obtained from the Health Research Ethics Committee of Faith Alive Centre, Jos (Appendix I).

Limitation of the study
Treatment outcome is usually influenced by factors that may affect the external validity of the data collected.

Results
Tables 1,2, Figures 3–5.

Discussion
Many problems have been attributed to the spread of TB in the sub-region; such are immune suppressive conditions like HIV/AIDS, malnutrition, overcrowding, non/poor utilization of health facilities, etc. Smear positivity in making a working diagnosis of TB is still of utmost concern; even in HIV negatives, this may be high[34]. The burden of TB was observed more among adults than children with a smear positivity of (14%) in the adults and (1.1%) in the children, similar (14%); [35], lower than that obtained from a pooled meta-analysis with prevalence of sputum smear positive TB of (52%) in adults and (6.8%) in children; [36] whose findings may have being influenced by the massive data pooled from 14 countries. Lower prevalence were compared with an Ethiopian study among homeless adults (2.6 %) [37]; (5.4%) [38] in another Ethiopian study (10%) [39] TB infection was higher among the female gender as against the male preponderance from other studies, this may be due to the peculiarities in most Africans where cultural restrictions on nutritious foods may predispose more females to lower immunity with a higher risk of TB than her male counterpart. Polygamy which may fuel the spread of HIV (the synergistic partner of TB) may indirectly account for the female prevalence and the higher TB/HIV co-infection seen in more than half of the adult population. Heterogeneity of smear positivity was recorded from the different study assessed with marked disparity among age groups and gender [39–42] in Table 1:

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>898</td>
<td>45.01</td>
</tr>
<tr>
<td>Female</td>
<td>1097</td>
<td>54.99</td>
</tr>
<tr>
<td>Age Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults ≥18 years</td>
<td>1895</td>
<td>94.99</td>
</tr>
<tr>
<td>Children &lt;18 years</td>
<td>100</td>
<td>5.01</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>369</td>
<td>19.47</td>
</tr>
<tr>
<td>Married</td>
<td>1198</td>
<td>63.22</td>
</tr>
<tr>
<td>Divorced/Widowed</td>
<td>328</td>
<td>17.31</td>
</tr>
</tbody>
</table>

Table 2: Prevalence of smear positivity and HIV Co-infection among TB patients.

<table>
<thead>
<tr>
<th>Age</th>
<th>TB Positive</th>
<th>Smear positive</th>
<th>HIV Positive</th>
<th>TB/HIV Co-infection</th>
<th>TB Positive/HIV Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>1895 (95%)</td>
<td>280 (14%)</td>
<td>1145 (57.4%)</td>
<td>1145 (57.4%)</td>
<td>750 (37.6%)</td>
</tr>
<tr>
<td>Children</td>
<td>100 (5%)</td>
<td>22 (1.1%)</td>
<td>91 (4.6%)</td>
<td>91 (4.6%)</td>
<td>9 (0.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>1995 (100%)</td>
<td>302 (15.1%)</td>
<td>1236 (62%)</td>
<td>1236 (62%)</td>
<td>759 (38.1%)</td>
</tr>
</tbody>
</table>
addition, the disparities might have been influenced by the presence of lung cavities seen more in adults, ease of sample collection/diagnosis, rapid progression from infectivity to disease, factors related to skilled manpower, low case finding in children due to misconceptions etc.

TB/HIV is the most common co-infection which still carries high mortality and morbidity worldwide [43,44]. The TB/HIV co-infection was (57.4%) in adults and (4.6%) in children similar to (55.5%) [37] HIV positive individuals are more susceptible to TB infection and disease [38,45]. All the HIV positive (1145) had TB, the HIV/TB co-infection brought about by the immune suppressive state of HIV and the reactivation of latent TB infection has totally reversed the gains of programs aimed at reducing/eliminating the scourge of tuberculosis especially in Africa. The impact of these diseases on one another is bidirectional, with HIV increasing risk of TB infection and disease progression and TB slowing CD4 recovery and increasing progression to AIDS and death among the HIV infected [46].

The downwards pattern signifying a reduction may be attributed to better detection techniques that may have coincided with the introduction of more sensitive means of detecting smear positivity. The existence of a good TB Prevention and Control Program is essential to fight against TB [44]. The trend will provide a basis for effective monitoring and supervision, and an indirect audit of the many efforts that is/has been put into reducing the disease in the state through regional and national efforts.

The desired treatment outcome is a complete cure; this wasn’t the case in the 7 years under review. TB–HIV co-infected people are facing multifaceted problems like high lost to follow up rates, poor treatment adherence, high TB recurrence rate, and high mortality risk [47]. The observed treatment outcomes with defaults, treatment failures, death; has re-emphasized the need for detecting smear positivity. The existence of a good TB diagnosis by health workers should not only be placed adequate medical intelligence and surveillance systems. J Pharm Bioall Sci 3: 219-227.

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