NAP & NTP SPECIAL SESSION

FRIDAY 17th October: 14:00-16:00, ROOM 351

Chair: Dr. Saidi EGWAGA, Director of the National TB and Leprosy Control Programme, Tanzania

Panel: Prof A.D HARRIES, Senior Technical Adviser, IUALTD, France
Ms. Cindy KELEMI, Treatment Literacy Officer and Community Activist, BONELA, Botswana
Dr. Woldemariam MULUGETA, National AIDS Programme Manager, Ethiopia
Mr. Ezio T SANTOS FILHO, Senior Programme Officer& Community Activist, TB/HIV Social Mobilization Expert, CCM Brazil
Dr. Vishnu KAMINENI, Technical consultant, India Resource Centre, IUATLD, India

Rapporteur: Ms. Cathriona MC CAULEY, Technical Programme Officer, IUALTD, France

Presentations: Attached in zip format

I. TB-HIV Collaborative activities- Prof A.D Harries-10 mins
II. India Country Presentation: Focus ICF- Dr. Vishnu Kamineni (on behalf of Dr. Ajay Khera, MOH)-10 mins
III. Commentary from Mr Ezio T Santos Filho 5 mins
IV. Ethiopia Country Presentation: Focus IC- Dr. Woldemariam Mulugeta- 10 mins
V. Commentary from Ms Cindy Kelemi 5 mins
VI. IPT overview: Prof A.D Harries- 10 mins
VII. Commentary from Ms Cindy Kelemi & Mr Ezio T Santos Filho - 5 mins
VIII. Facilitated discussion open to the floor

Commentaries Presentation II: Key issues are how to improve the referral mechanism between public and private sector and how to measure this using reliable data?

Commentary Presentation IV: There is clearly a need for isolation of infectious TB cases in health care facilities, however this may be a challenge in resource limited settings, and it is difficult to talk about infection control when wards contain 30 patients in close proximity with increased risk of cross infection. (Important to note that isolation is only one of many components of infection control measures, albeit a particularly complex one). Patients should be treated at home where at all possible, rather than bringing them to hospital, and they could be followed by contact tracing. At community level, the link between TB and TB/HIV needs to be emphasized, and facilitated by both programmes working together. This could be achieved through the establishment of regular channels of communication between AIDS and TB programmes, enabling a trickle- down effect to local structures.

Commentary Presentation VI: (Ezio): In the implementation of IPT, it is important to consider when it is appropriate to re-implement the course of preventive therapy, as the chance of re-infection still exists when

IPT has finished. IPT is a responsibility of the AIDS programmes and this idea needs to be made clearer- the NTPs need to convince the NAPs of this.

Toxicity is an issue with IPT but it should not be a reason for not prescribing it.

(Cindy): IPT is effective but as the presentation indicated, it's a problem if patients did not complete. We need to understand why patients do not complete treatment. At community level, there are often issues about taking a drug when one is not actually sick. There is need to empower PLWHA with information through treatment literacy to attain improved treatment outcome

For the elimination of active TB amongst PLWHA, screening may need to be more active.

There is low activism in TB, and more is needed to win the war against TB

KEY POINTS ARISING FROM FLOOR DISCUSSION

Acceptance and use of IPT: an important part of the prescription process depends on the explanation given to the patients. They need to clearly understand that this intervention saves lives, and the dialogue between physician and patient needs to clearly outline this.

Oftentimes the reluctance to use IPT comes from physicians, not patients. The earlier IPT is offered the better.

Use of IPT with vulnerable patients (pregnant women and children): if eligible for ART, patients should enter the ART system; if not eligible, there needs to be a package of care for these patients, i.e. pre-ART.

Ethiopia is trying to integrate TB/HIV screening in hospitals, health centres out patient and inpatient departments including ante-natal and postnatal services.

Infection Control: In congregate settings, i.e. prisons, masks are often not available for prison guards and other prisoners. We need to find ways to manage IC in such settings. Also there is little consideration of protecting health workers from TB infection in resource limited settings

Role of Global Fund in promoting 3Is: In high burden countries, the 3Is need to be included in the proposals, and Civil Society Organisations should be included in CCMs.

TB Programmes and Activism: There is not enough activism on ground level- is there any mechanism which can be put in place whereby these voices can be heard? The Show Off Gang, Taiwan is one such group which is

working on social mobilisation at school level in a highly effective way- a key element to ensuring an impact is that group is very well educated about the subject matter before they go out to the wider public.

The capacity of activists needs to be built so they can communicate messages accurately and with a sufficient degree of uniformity so that patients are getting a clear message.

Collaboration on TB/HIV activities is a political issue which starts within the programmes themselves and which must be promoted by NTP and NAP managers. In this way it can be built up within the health services.

There has been a marked evolution in the direction in which the Union conference has moved in the past few years. We need to continue to increase the participation of the HIV community, and have their voices heard in the symposia.

The TB community has transformed in the 5 years but still has a long way to go. IPT is still under the control of NTP managers but needs to be under the control of NAP managers.

SUMMARY POINTS

- **We need to increase the focus on social mobilisation and activism. The treatment literacy approach is one such approach which empowers patients to demand Three I's (infection control, IPT and ICF) as well as ART**
- **There needs to be a scale up of the basic elements of the package of HIV care for pre-ART patients (which includes IPT, nutrition, cotrimoxazole etc) and this needs to be done in a standardized fashion**
- **Global Fund: include 3Is in high burden countries, and CSO need to be mentioned on CCMs. In other words, we need to be sure that TB/HIV is meaningfully a part of each HIV AND TB proposal in heavily impacted countries via collaborative activities and meaningful budget line.**
- **IC, ICF and IPT all need to be implemented together as a package of interlinked interventions for people living with HIV**
- **The TB programme needs to let go of isoniazid and leave it in domain of NAPs. The 3Is need to be used in congregate settings**