

## Highlights: 37<sup>th</sup> Union World Conference on Lung Health

Paris, November 1-4, 2006

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### Introduction

**This year’s Union meeting** was characterized by the steadily increasing level of dynamism in the “TB world” due to the growth of TB, the new STOP TB strategy, and interactions between the fields of TB and HIV/AIDS control and treatment.

This was the first year CORE has had a Union booth (as with several other organizations). We were able to connect with representatives of National Tuberculosis Programs (NTP), NGO staff and patients/ex-patients from around the world. The word “*community*” has become omnipresent in the TB world, and people are curious about what that really means in terms of TB programming. “*Treatment Literacy*” is also an emerging tool, based on the concept as used with people living with HIV/AIDS (PLWHA); it means patients should understand what their illness is, and how their treatment works.

As your representative, I shared information about CORE and CORE members, the CORE Community Listserv, and the TB Working Group, as well as the TB Case Studies, the TB Technical Reference Materials, and the TB Facilitator’s Guide description. I met with dozens of TB managers, program staff, and patients from government and NGOs, from Albania, Bangladesh, Brazil, Gambia, Ghana, Haiti, India, Indonesia, Iraq, Kenya, Malawi, Malaysia, Namibia, Nigeria, Pakistan, Nepal, Uganda, Viet Nam, and Zambia, among other countries.

CORE member Doctors of the World presented a well-attended one-day workshop on *Advocacy, Communication and Social Mobilization for TB*. The event was well attended, including eight members of the Pakistan NTP.

## **TB Control Programming Rapidly Changing** (as described by the STOP TB Partnership)

In 1994, the top-down, clear-cut **DOTS strategy** was introduced. This initially called for government management of TB control, primarily passive case finding, standardized short-course chemotherapy for sputum smear positive cases, regular drug supply system, and monitoring of program supervision and evaluation.

Now the **recently developed STOP TB strategy** envisions national programs based on an expansion of DOTS to include community-based strategies; public, private and NGO involvement; involvement of multiple stakeholders, including patients; and TB/HIV collaboration. Other relevant factors include MDR and XDR TB, impact assessment, and new tools (drugs, diagnostics) under development.

### **The six principal components of the STOP TB Strategy are:**

1. Pursue high-quality DOTS expansion and enhancement.
2. Address TB/HIV, MDR-TB and other special challenges
3. Contribute to health system strengthening
4. Engage all care providers
5. **Empower people with TB, and communities** (Elena, TB WG co-chair, is representing CORE within the STOP TB partnership on the development of this component.)
6. Enable and promote research

The strategy (available in seven languages), and more details about each component:

[http://www.stoptb.org/news/archives/stbstrategy/assets/documents/STOPTB\\_STRATEGY\\_ENGLISH.pdf](http://www.stoptb.org/news/archives/stbstrategy/assets/documents/STOPTB_STRATEGY_ENGLISH.pdf)

Many presentations and booths addressed aspects of TB programming relevant to the work of TB WG members.

### **Did You Know?**

#### **The Conceptual Framework of TBCAP** (USAID's TB Technical Assistance Mechanism)

Addressing TB control through...

1. Political Commitment
2. Strengthen DOTS
3. Public Private
4. HIV/TB
5. Human Resource Development

**Popular or new acronyms (PNA)** offer insight into emerging trends...

CDT—center for diagnosis and treatment (decentralizing?)

CM—cough monitor (local person hired to perform community cough screening/sputum collection)

CTP—community treatment partner

LPT—late patient tracers

PMTM—programmatically multidrug resistant TB management

PPMD—public private mix DOTS

## Hot Off the Press!

***International Standards for Tuberculosis Care.*** Seventeen “standards” of TB diagnosis, treatment, and public health responsibilities. Clearly written (non-clinical language), and short with basic explanations of each standard. **A must for any TB control program.** Available for customization by country/region. (e.g. change the photos). Developed by TBCTA, funded by USAID. 2006. English, French, and Spanish. <http://www.nationaltbcenter.edu/international/>

***The Patients’ Charter for Tuberculosis Care: Patients’ Rights and Responsibilities.*** **Rights**, eight categories: Care, Dignity, Information, Choice, Confidence, Justice, Organization, and Security. **Responsibilities**, four categories: Share Information, Follow Treatment, Contribute to Community Health, and Show Solidarity. **Another must in TB programming**—yet just a few pages long. English, French, and Spanish. <http://www.nationaltbcenter.edu/international/>

***The STOP TB Strategy: Building on and Enhancing DOTS to Meet the TB-Related Millennium Development Goals.*** Another short but sweet publication with the basics of TB control, with short explanations. 2006. <http://www.stoptb.org/news/archives/stbstrategy/>

***Social Mobilisation of NGOs in TB Control.*** Reports from workshops in Brazil and Bangkok, with case studies and recommendations. Short and chock full of ideas and brief recommendations. 2004.  
[http://www.uatld.org/upload/home\\_news/social\\_mobilisation\\_uk\\_143.pdf](http://www.uatld.org/upload/home_news/social_mobilisation_uk_143.pdf)

## Session Snippets

### **Role of Community Health Organizations for TB (Latin American examples)**

Case finding, community DOT to improve treatment adherence, increasing community awareness, social support, and lobbying local governments.

**TB Infection Control among staff.** A Nairobi hospital study found “hospital exposures and HIV status were associated with TB among staff.” To protect staff, health care facilities should improve: early detection and treatment of TB, infection control practices, ventilation, and encourage staff testing for HIV and offer reassignment for HIV+ staff away from high TB exposure. (Global AIDS Program, CDC)

In Latvia, three approaches appeared to decrease infection rates: 1. Administrative (reduce exposure, infection, and disease through policies and practices, e.g. rapid isolation, treatment of patients, early detection of MDR, IC practices, and supervision), 2. Engineering/ environmental (dilution and removal of infectious droplet nuclei), and 3. Personnel respiratory protection.

**Urban/slum TB programs** seeing increasing emphasis as urbanization trend continues and urban conditions foster spread of TB and HIV.

**Peer Patient empowerment.** “An increasing source of interest for policy makers...Patients supporting each other become able to demand participation in the treatment...” Norwegian Heart and Lung Association

**Stigma** feeds denial, contributes to delayed and interrupted treatment, and harms psychological well-being. Women may be especially vulnerable due to harmed prospects of getting or staying married and sterility fears. In high HIV setting, TB association with HIV may heighten stigma. ZAMBART project, Zambia.

**Improving TB/HIV Collaboration through Advocacy.** The experienced, well-established world of HIV/AIDS activism is fertile ground for TB advocacy efforts. The STOP TB partnership has also shown how global institutions can support in country advocacy efforts, through the strategy and direct connections with key stakeholders.

The **Armenian National AIDS Foundation** targeted the country coordination commission, medical institutions, NGOs, and affected communities, promoting better information exchange between TB and HIV National Programs. Methods: awareness raising workshops including NGOs, doctors, others; treatment literacy materials; roundtables. With local NGOs, successfully pushed for the commission to form a working group on HIV and TB program coordination.

In **Mexico** a multisectoral TB-HIV national committee including policy makers, PLWHA, civil society representatives was formed to increase awareness and advocacy. Held satellite session during an AIDS conference, developed regional and national strategies, created bimonthly electronic bulletin, and developed health care worker training.

In **Georgia and Uganda** community-led advocacy raises awareness of TB amongst HIV+ and communities at risk through production and dissemination of treatment literacy information, workshops, and drama groups. AIDS NGOs and networks serve as a platform for addressing TB drug stock outs, developing policy, and advocating among district health officials.

**Human Resource Issues in High Burden Countries.** This ever-growing problem has no easy solution. Presentations called for governments and NGOs to respond by increasing efforts to recruit, train, and retain quality staff through established management tools, including employee friendly workplaces, clearly defined responsibilities, incentives and benefits, defined career structures, supportive supervision, good practice dissemination, human resources forecasting, and vacant position review and monitoring. A proactive long-term view is also urgent.

**Keys to effective TB control, Peru.** “The main factors to reduce the TB problem are political support, regular and free supply of diagnosis and treatment cases, sensitive and qualified health personnel who are continuously trained. Strategic articulation and coordination with the different health institutions and community actions with active participation of the affected people.”

**Prisons.** Reports from the United States, Ghana, and Bangladesh focus on the difficulty of having patients finish treatment once they are released from prison.

### **TB-HIV at Community Level**

For full video of these presentations, and/or podcast, visit

[http://www.kaisernetwork.org/health\\_cast/hcast\\_index.cfm?display=detail&hc=1946](http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1946)

### **Tony Moll, S. Africa: Data on TB/HIV integration.**

*Features of this “ideal” test program:*

- Literacy sessions for TB/HIV.
- Rx Buddy (family/community volunteer) also attend literacy sessions.
- Initial meeting arranged btw Rx buddy, patient, other health personnel.
- Patients are linked to nearest clinic.
- A supervisor manages Rx Buddies.

- Use of DOT for treatment initiation for both ARV and TB for 3-6 months—DOT supporter observed ARV single daily dose (for dual dose ARV DOT supporter didn't see second dose).
- One-stop monthly follow up.
- Easy-to-use medication presentation (Calendar on cardboard: Each day has plastic bag attached with all meds for that day inside.)

*Outcome:* 199 patients enrolled: 99 successful TB treatment, 98% appointments kept, excellent response to ARV, and treatment well tolerated. Five cases: MDR/XDR, so treatment failed. Ten more died due to MDR/XDR.

*Reflection:* There exists an imbalance between TB/HIV resources and lacking human resources. **This approach enabled HIV resources to strengthen the TB program and to improve outcome for HIV patients.** Media attention re: XDR TB helped facilitate this.

**Dr. Opart Karnkawinpong, Thailand:** Every community hospital had separate TB and HIV clinics. There was a high early mortality rate of TB patients. Didn't have TB/HIV guidelines, or hospital level collaboration. This project developed hospital policy dictated that all TB patients receive VCT, but who to do counseling, within what structure?

The project developed guidelines for:

- intensified TB case finding in PLWA
- subsequent joint treatment
- HIV VCT for TB patients
- cross training, and coordinating activities at the hospital level
- codisease care
- supervision, M& E via accountability, on the job training, lessons learned

*Problem emerged:* M&E revealed a lack of collaboration between TB and HIV staff. In response, added regularly scheduled meetings.

*Outcomes:* Death and default rates decreased. ART reduced mortality during TB treatment.

**O. Motsamai, Botswana:** *The Big 5 Comprehensive Approach.* (Borrowed term "Big 5" refers to African wildlife.). For nationwide TB/HIV integration, focused on these specific WHO recommendations: Conduct HIV surveillance among TB patients. Provide VCT. Introduce ART.

*Five Steps:*

1. TB/HIV training needs assessment.
  - a. Consistent staffing issues at all levels (turnover, multiple job responsibilities, etc)...consistent training needed
2. Baseline evaluation (routine HIV testing) TB patients tested for HIV, TB patients that are HIV+, TB patients on ART
3. Made changes to Recording & Reporting forms, and developed curriculum, using TOT approach
4. One-year rollout of training and R&R forms: 72 trainers trained over 1000 staff in all districts.
5. Follow-up process evaluation. Increase in TB patient HIV testing, new registers in use but not new treatment cards as much, due to distribution delays

**Sara Stulac, Partners in Health, Rwanda.** *Accompagnateur program* based on one in use by PIH in Haiti. Rapid scale up of HIV and TB diagnosis and ART treatment for HIV+ children. Active TB case finding in pediatric and malnutrition wards, through contact tracing, mobile VCT and more.

- *Accompagnateur model:* Before starting medications, patient chooses a trusted community member: literate, adult, not in family, who lives nearby. Accompagnateur is then trained and attends ongoing meetings/trainings on signs and symptoms, side effects, confidentiality, importance of DOT and adherence, and how medications work.
- *Accompagnateur tasks:* Observe and record medication taking, monthly clinic visit, receive pills, respond to concerns, and moral and social support.
- *Program provides to patients* health education, free transport, nutritional support, social worker services, education assistance, and addresses other underlying factors.
- *Benefits of model:* Supportive relationship, assess household needs and other health problems, patients get transport and free health care so rarely miss appointments; when they do, a team visits patient. An Accompagnateur sometimes works with multiple family members who are on medications.
- *Concerns:* Confidentiality, stigma, and cost of paying Accompagnateur incentive (who may work with a maximum of five households) but these haven't proven to be major barriers.
- *Ultimate Benefits:* prevents treatment failure, avoids costly inpatient care, and provides employment.
- *Now in Rwanda:* 157 children on ART, excellent adherence, no patients lost to follow up, excellent clinical results.

**Looks interesting: Patient Perspectives in TB Control and Care.** Video and podcasts available at:

[http://www.kaisernetwork.org/health\\_cast/hcast\\_index.cfm?display=detail&hc=1952](http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1952)

**And much more—easy to access videos, etc, from the conference at**

<http://www.kaisernetwork.org/paris2006/>

## **Resources**

**TB Education and Training Resources.** One-stop site to search for, order and submit TB resources, including materials, funding opportunities, events, web links, etc. CDC.

[www.findtbresources.org](http://www.findtbresources.org).

**Engaging All Care Providers.** Examples of this component of the STOP TB strategy include projects in the Philippines (coalition), Indonesia (hospitals), Bangladesh (village doctors), Kenya (private chest specialists) and India (mainstreaming PPM). Powerpoint presentation on the topic: [www.stoptb.org/cb/meetings/20050503\\_Addis\\_Ababa\\_Ethiopia/assets/presentations/Agenda%20Item%209%20PPM.ppt](http://www.stoptb.org/cb/meetings/20050503_Addis_Ababa_Ethiopia/assets/presentations/Agenda%20Item%209%20PPM.ppt)

**QUOTE-TB (Quality of care as seen through the eyes of the patient).** TB Program assessment tool: measures *structure quality* (availability, accessibility, continuity, costs, accommodation), and *process quality* (attitude, information, autonomy, professional competence). A quality impact score based on importance and performance quantifies where the most gains can be made. This tool is disease and setting specific.

Research using this tool in urban Uganda found nine important quality of care dimensions for TB, according to patients: Good patient/provider interaction/counseling; info, availability and accessibility of TB services; payment for TB services; TB/HIV relationship; support from TB services; and TB health care provider professional competence and procedures. Other QUOTE research has turned up issues of gender, age, ethnicity, and stigma.

## **Organizations**

**Asthma Drug Facility.** Low cost, reliable source of asthma drugs, available to NGOs, public and private health services, etc. (Clinical manual available as well.) [www.globaladf.org](http://www.globaladf.org).

**India Resource Center.** A regional office of The International Union Against Tuberculosis and Lung Disease. Provides technical support to NGOs (and NTPs) in planning, implementation, logistics, and resource mobilization. [www.iatld.org](http://www.iatld.org)

**The World Care Council.** “A new initiative to raise the standards of care for people with Tuberculosis, HIV/AIDS, and Malaria...For and by people threatened by these pandemics, the World Care Council is a new NGO that is mobilizing to turn approved recommendations for the standards of care into accountable, implemented practices, to improve health programs and community well being.” [www.worldcarecouncil.org](http://www.worldcarecouncil.org)

## **Upcoming Events**

**Powering up Political Will for TB Control** Feb 22-24, 2007 Vancouver. Presented by the Union (North America). Includes “Promoting Community Empowerment for TB Care and Prevention,” “Empowering Patients,” “Community-based Model of MDR TB treatment,” Latin American sessions, etc. WEB ADDRESS

**Advanced Training Courses on TB and TB/HIV management.** Italy, 2007. PPM April. TB and TB/HIV management, May and October. TB/HIV Collaboration in Europe July. WEB ADDRESS