



AIDS Community



AIDS COMMUNITY Consolidated Reply

Query: TB and HIV synergies, from Medical & Health Services, Daman & Diu, (Experiences/Advice).

**Compiled by E. Mohamed Rafique, Resource Person and Moderator; research provided by Seema Kochhar, Research Associate
21 April 2006**

Original Query: Dr. Devendra Kumar Makwana, Medical & Health Services, UT of Daman & Diu.

Posted: 24 March 2006

Today, March 24 2006, is the 25th World TB Day.

HIV kills around three million people every year. TB kills two million. HIV has been for a quarter of a century. TB has been much longer. The above sentences reflect how we still think of TB and HIV separately. There is an urgent need to change this type of thinking, because a third of the 40 million people living with HIV today are also co-infected with TB. We have with us today the knowledge of how TB and HIV interact with one another. We also know what the programmes are to address these diseases. We know they should also work together. Yet, we continue to think and work about HIV and TB: Separately

Let us use this day and the next few ones to find out what we in India have done for HIV and TB collectively as well as in isolation through two simple questions:

- 1) What are the ways we are working presently to stop TB and HIV jointly?
- 2) What are the areas that members think need synergy between TB and HIV?

Responses were received, with thanks, from:

1. [E. Thiruralluvan](#), ICMR/TB Research Centre, TB Government Rajaji House, Madurai
2. [K. Ramakrishnan](#), ICMR/ TB Research Centre, TB Government Rajaji House, Madurai
3. [Sugata Mukhopadhyay](#), RACHNA Program, CARE India, New Delhi
4. [Abha Jha](#), Catholic Relief Services, Lucknow
5. [A. Sankar](#), EMPOWER, Tuticorin

6. [Gopal Krishnan](#), SHELTER, Calicut
7. [Gautham MS](#), Dept. of Community Medicine, MSRMC MSRIT, Bangalore
8. [Avnish Jolly](#), Chandigarh AIDS Hotline, Chandigarh
9. [Chandrakant Lahariya](#), Department of Community Medicine, Lady Hardinge Medical College, New Delhi
10. [A. Raja S. Solomon](#), SHADOWS, Chirala
11. [Ravi Nayse](#), Ambuja Cement Foundation, Chandrapur

Summary of Responses

The members unequivocally agreed with the query's supposition that there needs to be greater synergy between TB-HIV programming and policy. Members shared several examples of current joint TB-HIV prevention and treatment activities and outlined areas that they felt still required coordination. The Union Health and Family Welfare Minister, Mr. Anbumani Ramadoss's statement on the future of India's efforts to control TB, summed up the thrust of member's discussion. The Minister said, "India has achieved 100% coverage under [the] Revised National TB Control Programme (RNTCP). The focus will now be on addressing the TB-HIV co-infection and tackling multi-drug resistant (MDR) cases."

Current TB and HIV Coordination

Members noted that the spread of TB has increased due to the rise in the numbers of HIV infections. They contended the community must adopt a horizontal approach to address TB-HIV through common strategies. At the same time, the members cautioned, that when determining whether TB or HIV should take the programmatic lead, population and culture specific considerations should be included.

Members argued that the two primary objectives of HIV and TB coordination programs is to improve TB surveillance among People Living with HIV (PLHIV) and make HIV testing and counselling services more accessible in TB affected areas. In addition, members said, the six components of the World Health Organisation's [Stop TB Strategy](#) should be included in all TB-HIV programming and policy development.

The National AIDS Control Organisation (NACO), members mentioned, is in the process of implementing a HIV-TB coordination program, with financial assistance from the Global Fund for AIDS, TB and Malaria (GFATM) and technical support from the WHO. Phase I of the programme, started in six high HIV prevalence states- **Andhra Pradesh, Tamil Nadu, Karnataka, Maharashtra, Manipur and Nagaland**. The second phase extended the reach of the programme to include eight additional states- **Delhi, Gujarat, Himachal Pradesh, Kerala, Orissa, Punjab, Rajasthan and West Bengal**.

Members also noted a project in **Uttar Pradesh**, working with Catholic Relief Services (CRS), which is successfully implementing a joint TB-HIV program. The program involves the community specifically affected by TB and HIV. Its strategies attempt to coordinate TB-HIV control and treatment through the setting of norms and standards for care, creating an enabling environment, training healthcare providers, mobilizing resources and joint monitoring and evaluation of existing TB-HIV programmes.

As of April 2006, the RNTCP had covered the entire country. Based on this fact, members recommended involving the same providers dispensing Directly Observed Treatment Short-Course (DOTS) through RNTCP to give free anti-retroviral treatment (ART) to TB patients participating in the 6-8 month programme. Members argued that unless ART is free, there is no point in diagnosing new HIV cases. Thus, members urged for universal access to existing TB-HIV

diagnosis and treatment and accelerated research to develop new and better tools to address both diseases.

Areas TB and HIV Synergy is Necessary

Members emphasized some areas, which still require synergy between HIV and TB activities. At the macro level, they said, it includes a number of things:

- Service delivery coordination and cross-referrals
- Optimal and comprehensive use of community out reach
- Joint efforts at IEC focussing on de-stigmatization
- Monitoring and evaluation at the district, state and national level to assess the coordination

At the micro level, members contended, the areas requiring coordination include:

- Infection control to prevent the spread of TB in HIV care facilities
- Preventing the spread of HIV among TB patients through use of safe (sterilized or new) needles
- Increased awareness and sensitization of programmes and providers

Members also reported that collaborations between public and private healthcare providers hold considerable potential to improve tuberculosis control in India, due to the fact that the majority of TB patients use private sector services. They contended mixed public-private activities jointly addressing TB-HIV will lead to increased case notification, while maintaining acceptable treatment outcomes.

Some members pondered whether the fear that a combined HIV-TB programme will divert money from one organisation to another or worry that stigma of HIV would negatively affect TB programmes was hindering the coordination of HIV and TB programmes. To counter this concern, members are doing a couple of things:

- Use available DOTS network with minor infrastructural and staffing modification to combine Voluntary Confidential Counselling Testing Centres (VCCTC) with existing TB centres
- Employ IEC to address jointly issues and topics relating to HIV and TB
- Renaming existing treatment centres- "Awareness and Treatment" Centres to denote their broader purpose

All the members articulated their belief that synergy between TB and HIV activities is an essential component for achieving the successful eradication of TB and effectively treating HIV. Moreover, they noted that there is coordination between existing HIV and TB programmes. However, members contended, policy makers and professionals need to do more to ensure all affected communities have access to the full range of DOTS and ART options.

Comparative Experiences

Uttar Pradesh

Targeting TB and HIV Co-Infections through Community-Based Intervention (from [*Dr. Abha Jha*](#), Catholic Relief Services, Lucknow)

CRS acknowledged the need to adopt an integrated approach to TB and HIV programming. Therefore, it has been supporting a community-based program in Lalitpur District, aimed at reducing the number of deaths caused by TB and HIV co-infection and to increase life

expectancy. In order to achieve its objectives, the project adopted five key strategies to address issues of poverty, incomplete treatment, premature deaths, and sex work in the project area.

New Delhi

Providing TB Patients HIV Counselling and Testing (from [Seema Kochhar](#), Research Associate)
'Ashraya' Care Home started a TB DOTS center for the adjoining areas of Mahipalpur and Kapashera. TB patients coming to the Care Home are counselled and encouraged to have an HIV test. If found positive they are provided care and support services and given appropriate treatment under the DOTS strategy of RNTCP.

Linking Existing TB Treatment to Allied Disease Control (from [Seema Kochhar](#), Research Associate)

LRS Institute of TB and Respiratory Disease provides patient care for TB and other respiratory diseases. The Institute engages in teaching, training and researching in the field of TB and allied diseases. The Institute is also working with the government to develop and implement strategies for TB control.

Related Resources

Recommended Documents

International Standards for Tuberculosis Care (ISTC) (from [E. Thiruralluvan](#), TB Government Rajaji House, Madurai)

Tuberculosis Coalition for Technical Assistance; The Hague; January 2006.

www.who.int/tb/publications/2006/istc_report.pdf (Size: 1.89 MB)

Describes the widely accepted level of care that all practitioners (public and private), should seek to achieve when managing TB patients.

The Patients' Charter for Tuberculosis Care (from [E. Thiruralluvan](#), TB Government Rajaji House, Madurai)

Tuberculosis Coalition for Technical Assistance; The Hague; January 2006.

www.who.int/tb/publications/2006/istc_charter.pdf (Size: 992 KB)

Outlines the ways patients, the community, health providers and governments can work as partners in a positive, open relationship to improve TB care.

RNTCP Performance Report India Fourth Quarter (from [Dr. K. Ramakrishnan](#), TB Government Rajaji House, Madurai)

Central TB Division, Directorate General of Health Services, Ministry of Health and Family Welfare; Nirman Bhavan, New Delhi, 2005.

www.tbcindia.org/pdfs/Perf4q05.pdf (Size: 947 KB)

Documents DOTS services under RNTCP are accessible to 97% of the country and that population coverage has increased from 1059 million to 1080 million.

Towards a Revolution in TB Prevention, Care and Treatment (from [A. Shankar](#), EMPOWER, Tuticorin)

World Congress on Lung Health; Paris, France; October 2005.

www.plwha.org/Parismanifesto%2017th%20Nov.pdf (Size: 24 KB)

Stresses the need for universal access to existing TB diagnosis and treatment and for accelerating research to develop new and better tools.

Improving TB Control through Public-Private Collaboration in India (from [Dr. Gautham MS](#), MSRMC MSRT, Bangalore)

By Dewan, P.K., Lal, S.S., Lonnroth, K., Wares, F., Uplekar, M., Sahu, S., Granich, R., and Chauhan, L.S; BMJ ;332:574-578 (11 March), 2006.

For abstract [click](#) For full text [click](#)

Documents the characteristics of mixed public-private projects in India and their impact on case notification and treatment outcomes for tuberculosis.

India Reports Progress in Fights against TB (from [Avnish Jolly](#), Chandigarh AIDS hotline, Chandigarh)

By Kamil Zaheer; Reuters; March 2006.

www.alertnet.org/thenews/newsdesk/DEL157169.htm

Reports that DOTS projects have successfully put 5.45 million people on treatment and tripled the treatment rates from 25% in 1998 to 86% by 2004.

India to Implement National Action Plan against TB-HIV (India) (from [Ravi Nayse](#), Ambuja Cement Foundation, Chandrapur)

By MedIndia; March 27, 2006.

www.medindia.net/news/view_news_main.asp?x=8861

Documents that 50-60% of the HIV positive in India are susceptible to TB and outlines the measures being taken by the Health Minister to address TB/HIV and MDR- TB.

The HIV-TB Co-Infection (from [Seema Kochhar](#), Research Associate)

National AIDS Control Organisation (NACO); New Delhi

www.nacoonline.org/guidelines/HIV-TB_guidelines.pdf

Outlines program coordination guidelines for clinicians and standard operating procedures for care of patients with TB/HIV.

Recommended Tools

Shanta: Model Community Mobilizers (from [Ravi Nayse](#), Ambuja Cement Foundation, Chandrapur)

Bob Madey, Stop TB Partnership, India; 2000.

http://www.stoptb.org/resource_center/assets/documents/VideoSeries.htm#Video%201

To avail copies of the video: info@stoptb.org

Illustrates how social and community mobilizers contribute to the success of TB programme; highlights the role of IEC in mobilizing TB patients, families, communities.

DOTS and Public-Private Partnerships (from [Ravi Nayse](#), Ambuja Cement Foundation, Chandrapur)

Bob Madey, Stop TB Partnership, India; 2000.

http://www.stoptb.org/resource_center/assets/documents/VideoSeries.htm#Video%201

To avail copies of the video: info@stoptb.org

highlights a private hospital in Hyderabad efforts to serve as a link between local private practitioners and the government to provide DOTS.

Recommended Organisations

Catholic Relief Services (CRS), Lucknow (from [Abha Jha](#), Catholic Relief Services, Lucknow)

D-1, HAL Township, Lucknow, Uttar Pradesh

www.catholicrelief.org

CRS uses a multi-pronged strategy to increase HIV and TB awareness and promote safe behaviours, create enabling environment, and support home based care

'Ashraya' Holistic Care Centre (from [Seema Kochhar](#), Research Associate)

Dr. N.I Singh at 'Ashraya,' M.P.C.C. Building, Village Rajokri, NH-8 New Delhi; Phone: 9810398059
actionindia@vsnl.net ; www.actioninida.org.in

It has a TB DOTS center working in close coordination with the AIDS Care center to tackle HIV and TB.

Lala Ram Sarup Institute of Tuberculosis and Respiratory Diseases (from [Seema Kochhar](#), Research Associate)

Sri Aurobindo Marg (Near Qutub Minar), New Delhi, 110030

www.lrsitbrd.nic.in www.mohfw.nic.in

It is actively involved in treating, teaching, training and researching in the field of T.B. & allied diseases such as HIV.

[E. Thiruralluvan](#), ICMR/TB Research Centre, TB Government Rajaji House, Madurai.

On 22 March 2006, WHO has released a set of *International Standards for Tuberculosis Care* http://www.who.int/entity/tb/publications/2006/istc_report.pdf (1.89 MB) describing a level of care that all health practitioners should follow, together with a new document at http://www.who.int/entity/tb/publications/2006/istc_charter.pdf called the *Patients' Charter for Tuberculosis Care* outlining for the first time the rights and responsibilities of people with TB.

The two documents are important inclusions in a new six-point Stop TB Strategy,* developed by WHO and published in the Lancet medical journal last week. Both the International Standards and the Patients' Charter are also highlighted in the Stop TB Partnership's Global Plan to Stop TB, 2006–2015, which was launched in January 2006.

*** The six components of the new Stop TB Strategy are:**

- Pursue high-quality DOTS expansion and enhancement
- Address TB/HIV, MDR-TB and other challenges
- Contribute to health system strengthening
- Engage all care providers
- Empower people with TB, and communities
- Enable and promote research

India's Position:

As to the question where does India stand in implementing the previous Stop TB Strategy, we have to look to the *Global Tuberculosis Control 2006 report* at http://www.who.int/tb/publications/global_report/en/index.html. This report confirms that 26 countries had already met the targets a year ahead of time, two of them being the high TB burden countries of the Philippines and Viet Nam. The report also indicates that five other high-burden countries – Cambodia, China, **India**, Indonesia and Myanmar – should have reached the targets within the 2005 time frame, though final confirmation will come at the end of 2006.

The Time is now for India:

It therefore appears that there is a good chance for India to meet the targets provided it adheres to the new Stop TB strategy. Needless to say, if these components are not in our National strategic document for control of TB then a revision to include these will attain the top most

priority. I feel that it is the last four components of the new Stop TB Strategy that should require good financial support as well as top commitment from political leaders and program managers in the near future. This way good ground can be covered so that India could achieve its targets within stipulated time frames.

References:

<http://www.who.int/mediacentre/news/releases/2006/pr15/en/index.html>

Dr. K. Ramakrishnan, ICMR/TB Research Centre, TB Government Rajaji House, Madurai.

E. Thiruralluvan has made a strong plea for the inclusion of the new Stop TB Strategy in the National strategic document for control of TB. I would like to add that at the web site of TBC India <http://www.tbcindia.org/pdfs/Perf4q05.pdf> the RNTCP Performance Report, India for the Fourth Quarter, 2005 is available. This tells the latest tale of how much India has done in National TB Control.

Dr. Sugata Mukhopadhyay, RACHNA Program, CARE India, New Delhi.

I am Dr. Sugata Mukhopadhyay a Medical Doctor, presently working in CARE India and based at New Delhi as Technical Specialist-HIV/AIDS. I have had some ground level working experience in HIV-TB coordination program.

Background:

There are many global evidences that clearly demonstrate close association between the two deadly infections of HIV and TB. HIV increases the possibility of full-fledged TB disease in TB infected individuals by 50% where without HIV the possibility remains as low as 10%. Similarly more than 33% HIV positive people are affected by TB in their life time which is the commonest Opportunistic Infection in PLHIV. At the same time presence of TB in a HIV infected person enhances the progression to the full blown stage of AIDS. In India more than 60% of the PLHIV suffer from TB while the HIV prevalence among selected groups of TB patients is about to be 11%. However, it is evident from various studies that TB in HIV infected persons can be fully cured by DOTS.

Objectives of HIV and TB coordination program:

- 1) To improve TB surveillance among PLHIV and ensure their appropriate treatment under the DOTS strategy of RNTCP
- 2) To make HIV testing and counselling services more accessible to TB affected cases

Basic Program strategy:

Developing strategic linkage between VCTC and TB Microscopy Centers at the district and sub-district level so that HIV infected persons with suspected TB symptoms can be promptly examined, tested and avail ATT under the district RNTCP and persons detected to be suffering from TB can be referred to VCTC for the counselling and HIV testing under the district NACP.

Program Approaches:

The basic purpose of HIV-TB coordination is to ensure optimal synergy between the two programmes for the prevention and control of both diseases.

Key areas include:

1. Commitment to HIV-TB coordination, through sensitization;
2. Service delivery coordination and cross-referral, through training, provision of additional services, and coordination at the local level;
3. Optimal and comprehensive use of the community reach of both programmes through the sensitization and involvement of NGOs and private practitioners who are involved in both programmes;
4. Infection control to prevent spread of TB in facilities caring for HIV-infected persons, and to prevent spread of HIV through safe injection practices in the RNTCP;
5. Joint efforts at IEC particularly with regard to de-stigmatization, TB being treatable; HIV being preventable; DOTS prolongs life of HIV infected persons and ensuring confidentiality of HIV and TB-related information.
6. Monitoring and evaluation at district, State and National level to assess the co-ordination between both these programmes. Coordinators would be posted in all the states identified for implementing the HIV-TB action plan.

Progress so far:

NACO is already in the process of implementing HIV-TB coordination with the financial assistance of Global Fund for AIDS, TB and Malaria (GFATM) and technical support of WHO. In Phase I of the programme, coordination started initially in the six states with high prevalence of HIV/AIDS, namely Andhra Pradesh, Tamil Nadu, Karnataka, Maharashtra, Manipur and Nagaland. Phase II of the programme has been extended to eight additional States of Delhi, Gujarat, Himachal Pradesh, Kerala, Orissa, Punjab, Rajasthan and West Bengal.

For more detailed information and critical documents, I would suggest to take help from WHO, TB India and NACO websites.

Dr. Abha Jha, Catholic Relief Services, Lucknow, UP.

We in CRS have already acknowledged the growing need to adopt integrated approach wherein the issue of TB and HIV co-infection can be addressed. Given the current scenario, any stand-alone project on HIV in high TB prevalence area will not be the right operational strategy from any point of view. In light of the above, I would like to share my experience as Coordinator-Health & HIV/AIDS in CRS (Catholic Relief Services-Lucknow).

CRS has been supporting a program in the District of Lalitpur in collaboration with H.B.M. Hospital, with an aim to reduce the number of deaths caused due to TB and HIV co-infection and increase the life expectancy. It is a community-based intervention targeted towards sand mine workers, where the prevalence rate of Silicosis/tuberculosis is very high.

Lalitpur district is located in Bundelkhand region at the South-western tip of UP. The National Highway (NH) traverses through Lalitpur district and the total length of NH is 85 kms. There are many sand stone mines; where people from about 90 villages earn their livelihood from stone mine work. The life expectancy of males in these villages is 35-40 yrs. Generally at 35, males become invalid due to Silicosis/Tuberculosis. The sand mine worker on an average get Rupees forty a day. Intermittent treatment from private practitioners add to debt and resistant tuberculosis. The male dies leaving behind wife and children. The widow then becomes the head of the family and earns more to repay the debt and commercial sex becomes a lucrative option for them. The entire belt is known for high-risk behaviours and prevalence of tuberculosis. A study by HBM hospital in twenty villages reveals that out of 4210 households, there are 788 widows and 532 persons (mostly men) are Tuberculosis patients. Although there are a number of

Primary Health Centers within the district, these are not easily accessible to villagers. 90% rural people depend on the services of local practitioners and traditional healers.

To address the issue, CRS has adopted 5-key strategies:

- Setting norms and standards for providing skilled care attendance.
- Deployment, development and management of human resources to ensure quality of care provided by trained local health service providers.
- Creating an enabling environment and capacities both within the health sector and with in communities.
- Mobilization of resources (human, financial and technical knowledge)
- Monitoring & Evaluation of program.

A. Sankar, EMPOWER, 107J / 133E, Millerpuram, Tuticorin.

The Voice of the Community must be taken into account for need-based planning in any program. So, please find appended the Statement from Communities affected by TB.

Towards a Revolution in Tuberculosis (TB) Prevention, Care and Treatment

Statement of Individuals from Communities Affected by Tuberculosis (TB)

36th World Congress on Lung Health

23 October 2005

Paris, France

We are individuals from communities affected by the worldwide pandemic of tuberculosis (TB). We have seen the unnecessary suffering and death that TB causes, amplified by the overlapping HIV/AIDS pandemic. Up to two billion people worldwide are infected with the bacteria which causes TB. Each year, eight million people develop TB disease and two million die from it. Yet TB is preventable, treatable, and curable. The suffering and death it causes are unnecessary and unacceptable.

No one should die of a curable disease because of poverty or under-funded health systems. Human rights, public health, and social justice approaches all demand a better global response to stopping TB.

Universal access to existing TB diagnosis and treatment, and massively accelerated research to develop new and better tools are both urgently needed.

We can reduce the suffering caused by TB to 80 million people over the next ten years, prevent 20 million unnecessary deaths, and accelerate the day when tuberculosis – one of humanity's most ancient diseases – is finally stopped.

What has been lacking is the political will, the scientific determination, and the popular support.

We call upon leaders, governments, and all sectors of society to take the following steps:

1. **Recognize the importance of community participation in TB control efforts.** People living with TB must be at the center of all TB awareness, prevention, care and treatment programs. Their rights and dignity must be respected. People living with TB have the right to participate fully in all organizations concerned with their care, at all levels including governance, planning, implementation, and evaluation of TB research, prevention, care, treatment, and advocacy programs.
2. **Increase investment to support community participation.** Community activism is essential to ensure the growth and sustainability of TB control programs. Massively increased resources are needed to support community mobilization, awareness, education, literacy, and participation in TB control programs worldwide by people living with or most vulnerable to TB.
3. **Ensure expanded access to TB treatment.** All people with active TB – not just those with sputum smear positive pulmonary TB – must be promptly and properly diagnosed, treated, and cured. This includes those with smear negative pulmonary TB, extra pulmonary TB, paediatric TB, HIV-related TB and multi-drug resistant (MDR) TB.
4. **Provide TB services to vulnerable populations.** All affected communities must have full access to TB prevention, care and treatment, including women, children, homeless people, the unemployed, the uninsured, the incarcerated, populations regardless of immigration status, drug users, people living with HIV, and those with other life-threatening diseases.
5. **Incorporate TB program expansion into stronger health systems.** TB control programs should be expanded in the context of strengthening health systems.
6. **Provide universal access to high-quality TB services.** TB preventive measures, diagnosis, treatment, and cure must be made universally accessible, available, and free at the point of use to persons being screened or treated for TB, including those with multi-drug resistant (MDR) TB or with TB/HIV.
7. **Expand use of existing TB prevention methods.** More emphasis is needed on use of existing tools to reduce TB transmission and treat latent infection, including administrative measures to reduce transmission in confined settings and isoniazid preventive therapy in people at high risk of progression to active TB, including those with TB/HIV.
8. **Scale up research on new tools to stop TB.** Massively accelerated and greatly increased research funding is needed for new tools to prevent, diagnose, treat, and cure TB. Funding for this research should come from all countries from both public and private sectors. Community activism is needed to secure full funding of and community involvement in all stages of this research.
9. **Disseminate existing TB diagnostics and develop new ones.** New diagnostic tests to accurately diagnose TB – pulmonary and extra pulmonary, drug-sensitive and drug-resistant, adult and paediatric, and HIV-negative and HIV-positive – are urgently needed. These tests must be usable where the vast majority of people with TB get their care, in district hospitals, private providers, and health centers. Optimally, these point-of care assays must be rapid, require little technical training, not require electricity or refrigeration, able to withstand high heat and humidity, and be affordable for all public health systems. Currently available diagnostics such as culture and drug susceptibility testing (DST) must be made much more broadly available in resource-poor settings to increase the ability to diagnose smear-negative, extra pulmonary, paediatric, and drug-resistant TB.
10. **Develop shorter TB cures.** New drugs and combination treatment regimens for TB are urgently needed which will fully cure over 95% of drug-sensitive and drug-resistant cases of TB within two months. These drugs must be affordable, available, safe, and effective especially for persons infected with MDR-TB or TB/HIV.

11. **Discover new TB vaccines.** New vaccines for TB are needed which will prevent TB infection or disease in over 75% of those vaccinated without side effects, ideally in a single dose given once a lifetime.
12. **Stopping TB is a job for everyone.** Governments around the world must commit the full resources, leadership, and long-term effort necessary to make TB a disease of the past. We call for strong, vocal, and persistent commitment by political leaders and systems worldwide, and by all sectors of society and community, to provide the resources needed to make TB a disease of the past.

For the past ten years, governments around the world have stated their commitment to stop TB. Now is the time to intensify this commitment by turning declarations into deeds, promises into programs.

Community activism and advocacy are essential to ensure the growth and sustainability of TB programs. We commit to redouble our efforts to mobilize communities to respond to the TB epidemic by increasing our efforts in education, information dissemination, advocacy, support, and participation. We call for the same commitment from all with the power to help make the future one free of TB.

Dr. Gopal Krishnan, SHELTER, I. G. Road, Calicut.

Quoted below is the text of Dr. Mathew's posting at <http://health.groups.yahoo.com/group/AIDS-INDIA/message/5601> of AIDS-INDIA e-forum.

*"My personal opinion regarding the public health approach in co-infection management:
The tri weekly DOTS regimen for TB is borrowed from it's poorer cousin -Leprosy, where they had a monthly supervised pulsed dose of RMP/RMP+CLOF, which has been in vogue since 1982 and also has successfully brought down the prevalence of leprosy globally and nationally down to < 1/10,000. Now that the country has been entirely covered by RNTCP this month is it not possible to involve the same DOTS providers to give ART also supervised for the 6-8 months they are in the TB programme. Unless ART is given free of charge, there is no point in diagnosing new HIV/AIDS cases, come on health providers tell me one disease where you diagnose the patients and don't treat them with appropriate drugs. Who are we to diagnose them and then brand them for them to suffer the stigma and discrimination, if we cannot provide the appropriate treatment. In leprosy we had a political commitment (Indra Gandhi-1977 World Health Assembly), we had a tool in MDT (Free to the patient) patients of leprosy came to get diagnosed and get treated. At least let us begin with Co-infection"*

It is very much similar to what Dr. Rafique had proposed during the discussion on IEC Strategy for Health Sector:

"In 1991, WHO and its member States committed themselves to eliminate Hansen's Disease [Leprosy] as a public health problem by the year 2000. Almost similar is the history of the Control Programs for Venereal Diseases, which became known as Sexually Transmitted Diseases and now we use the terms Sexually Transmitted Infections and Reproductive Tract Infections. All along we also had our TB control programs. Two decades after the advent of HIV, we now see the need for refocusing, redefining, reviewing and now integrating. Stigma and Discrimination to varying extents, is one of the common denominators in all these four diseases. There are other similarities and associations too. Yet, we still do not have a unified IEC strategy, common plans, or any kind of integration for these inter-related diseases which are dealt by just a couple

of departments in the Medical Colleges Hospitals and other Government Hospitals above the Taluk level. Integration is brought about easier in the Sub-Centers, Primary Health Centers, and Community Health Centers where there is mostly a single-window approach."

Looks like there is lot of talk on integrating TB-HIV co-infection, lots of opportunities, which are not yet lost.

Dr. Gautham MS, Dept. of Community Medicine, MSRMC MSRIT, Bangalore.

Please find appended below an abstract from PubMed on Improving TB Control through PPP. This is relevant in our country as many patients are seen by the private sector.

BMJ. 2006 Mar 11; Volume 332, Number 7541: 574-8. Epub 2006 Feb 8; **Improving Tuberculosis Control through Public-Private Collaboration in India: Literature Review**; Dewan, P.K., Lal, S.S., Lonnroth, K., Wares, F., Uplekar, M., Sahu, S., Granich, R., and Chauhan, L.S.

Click here for PubMed abstract: [PubMed](#)

Click here for full text: [PubMed](#)

OBJECTIVE: To review the characteristics of public-private mix projects in India and their effect on case notification and treatment outcomes for tuberculosis.

DESIGN: Literature review.

DATA SOURCES: Review of surveillance records from Indian tuberculosis programme project, evaluation reports, and medical literature for public-private mix projects in India.

DATA EXTRACTION: Project characteristics, tuberculosis case notification of new patients with sputum smear results positive for acid-fast bacilli, and treatment outcome.

DATA SYNTHESIS: Of 24 identified public-private mix projects, data were available from 14 (58%), involving private practitioners, corporations, and non-governmental organisations. In all reviewed projects, the public sector tuberculosis programme provided training and supervision of private providers. Among the five projects with available data on historical controls, case notification rates were higher after implementation of a public-private mix project. Among seven projects involving private practitioners, 2796 of 12 147 (23%) new patients positive for acid fast bacilli were attributed to private providers. Corporate based and non-governmental organisations served as the main source for tuberculosis programme services in seven project areas, detecting 9967 new patients positive for acid-fast bacilli. In nine of 12 projects with data on treatment outcomes, private providers exceeded the programme target of 85% treatment success for new patients positive for acid-fast bacilli.

CONCLUSIONS: Public-private mix activities were associated with increased case notification, while maintaining acceptable treatment outcomes. Collaborations between public and private providers of health care hold considerable potential to improve tuberculosis control in India.

Avnish Jolly, Chandigarh AIDS Hotline, Chandigarh.

India Reports Progress in Fight Against TB

Reuters, March 24, 2006, by Kamil Zaheer

For full report: <http://www.alertnet.org/thenews/newsdesk/DEL157169.htm>

India has the world's highest TB caseload: The nation accounted for 370,000 of the 1.7 million TB-related deaths worldwide in 2004. In recognition of World TB Day, India highlighted its progress against the disease. "India is on the right track," Health Minister Anbumani Ramadoss said, announcing "there has been a dramatic surge in treatment, and the whole country has been brought under Directly Observed Therapy, Short-course (DOTS)." "Treatment rates have tripled from 25 percent in 1998 to 86 percent in 2004," said a statement from the ministry, which noted that India is detecting 66 percent of TB cases. This is shy of the UN target of a 70 percent detection rate, but Ramadoss said the higher figure will be attained "very soon." DOTS is the cornerstone of the Revised National Tuberculosis Control Program, which India undertook in 1997. As a result, the nation has put 5.45 million people on treatment and saved almost a million lives, the ministry said. Still, advocates say much remains to be done in the country that is home to about one-fifth of the world's new TB infections. "Often, the free treatment benefit is negatively offset by the invisible cost of accessing the treatment in the form of transport costs and loss of earnings for accompanying family or community members," said Bobby John, president of the Swiss-based group Massive Campaign Effort.

Dr Chandrakant Lahariya, Department of Community Medicine, Lady Hardinge Medical College, New Delhi.

I am really pleased that you raised this query here at this forum. I think one action which needs to be taken immediately in India is coordination of HIV and TB activities at all the levels. I have advocated it in the past and at presently am working on it. I am actually unable to understand why people are hesitant of coordination of these two programs? Is it money which will be diverted from one organization to another? Or is it that the so called stigma of HIV will negatively affect TB program if we combine both?

As far as the issue of money is concerned, I know it's a sensitive issue, and I have been told that there is no dearth of it for both the programs. So it may be people with vested interest or may be one powerful lobby which doesn't want to lose its hold from the finances it has control of. I am afraid if it is so, its a dangerous sign. I wish I am wrong. The issue should be dealt with at all possible fora.

People often say there is stigma with HIV which will negatively affect RNTCP. It depends how you are going to combine these two programs. One could start using the infrastructure available for DOTS for NACP's various activities like IEC, Lab services or may be VCCTC where ever feasible. I don't think people are so ignorant that they would not know the difference. At the same time if DOTS facilities or microscopy centers are used as surveillance units for HIV than we might get closer to the actual estimates of HIV prevalence in the country. When 40% of the population is infected I think we can easily assume this as representative of general population. The step might be started in high HIV prevalence states first.

Immediate priority should be coordination in rural areas where there are poor health infrastructure and lack of information about both the disease. Sadly, the Sentinel sites for HIV are also fewer in rural areas when we know that prevalence of both the disease is reaching to same

levels in urban and rural areas. CHC or similar health facilities can be identified to utilized for both HIV and TB activities.

Here I am enclosing one write up I had prepared for distribution at HIV and TB conference between 13-15th Jan 2006 at AIIMS, New Delhi having the same title as my presentation:

DOTS facilities as surveillance units for curbing AIDS Epidemic

India with 5.13 million HIV infected people is home to the world's second largest infected population. Country has a prevalence of the 0.91% which classifies it as a low prevalence. Government reacted early in the wake of the HIV and the slow rise in it may be attributed as one of the success of this. The data which is collected on probable numbers are through sentinel surveillance at ANC, STD and IDU sites, a few MSM and FSW are also involved. This methodology probably gives very close result of the prevalence in the community.

HIV prevalence in our country may not be best projected by only these surveillance units as large part of our population is rural, illiterate and ANC and STD sites are poorly attended (inadequate sample size from number of sites in sentinel surveillance is the proof.) A strategy or methodology which may be successful elsewhere in the world might not produce the same result in our country. Polio eradication campaign is a testimony to this. There are HIV positive people amongst TB patients (5.5% of total 8.5 million TB case in India). They need information on HIV and AIDS and should be informed about diagnosis and treatment facility at the nearest.

HIV is usually associated with number of co-infections, TB being the commonest. 400 million of the Indians are already infected with M. Tuberculosis. 10% of them will develop TB disease in lifetime which is a mind-boggling 40 million. On the other hand, 25% of the HIV positive people are co-infected with TB in the world and need immediate attention. TB is the only presenting complaint in the half of the African HIV positives. Developing countries have different problems as 9 out of 10 positive people are not aware about their status. (WHO report on AIDS, 2005.) TB itself is not a risk factor for HIV but there are confirmed HIV positive people amongst TB patients. India due to heavy TB load added to it is poor knowledge and awareness about HIV and presence of risk behaviour in this group (as found in this study) makes them even more vulnerable for HIV infection.

People need to be educated about HIV/AIDS but TB patients need special attention. if ignored, not only the rise in TB will undo the gain we have made through RNTCP but there would be epidemic of AIDS in future also. The world has recognized the urgent and immediate need for HIV and TB collaboration and to and fro referral is being discussed at various fora. India with vast network of DOTS centers with existing infrastructure can used for AIDS control activities. Considering limited number and uses of ANC and STD facilities in comparison with DOTS centers and their vast network, these center as surveillance units of HIV (in form of anonymous testing) can give better picture of its prevalence and may help us in monitoring epidemiological trends. DOTS centers network can also be used for VCCTC and IEC on both HIV and TB with minor infrastructural and staffing modifications and renaming such as 'Awareness and treatment centers' might be considered.

RECOMMENDATION:

1. DOTS centers for Sentinel surveillance (anonymous testing for HIV).
2. VCCTC may be started at these sites.
3. IEC center for both HIV and TB.

A. Raja S. Solomon, SHADOWS, Chirala, Andhra Pradesh.

Strategizing:

In India, we have varied co-factors to accelerate HIV and TB spread. The TB DOTS program, which is a great gift to the PLHIV on treatment for HIV. However, one must be cautious with using TB treatment as prophylaxis it gives increased chances of developing resistance. Studies have proved that adherence to treatment is very high when patients have seen the ill effects of the infection. While there are different schools of thought on when to begin ARV, it is known that prescriptions when symptoms start has better treatment adherence. All the PLHIV who are given non-allopathic treatment at a reputed care facility at Tamil Nadu are also given TB treatment along side. This also matches with the observation at the field level from feedback received of patients who go to that institute. Now, is it good to use the treatment as prophylaxis ? I am working in a community based care and support program, where the Volunteers and support groups are taking the task of TB care.

The synergy:

- TB and HIV are common in India. TB is the major co-infection in HIV. Control should include, focus on TB first, because, people dying with TB including PLHIV with TB co-infection is high.
- There is increased spread of TB due to the increase in the HIV infection in the community. So, both needs to be dealt carefully and a vertical approach does not yield results. Hence, Horizontal approach through common strategies needs to be adopted.
- Population specific and cultural sensitive approaches determine whether the TB campaign should take lead or the HIV infection.
- TB is major concern for paediatric AIDS care because, we are facing a lot of problem to get accurate dosage for TB DOTS and ART apart from the nutritional care and socio-economic cofactors.

Ravi Nayse, Ambuja Cement Foundation, Chandrapur.

One point that favours the synergy of TB and HIV is the cost of these medications. Until the PLHIV is given these together under a single window free scheme, treatment adherence in both the diseases would give low returns. Moreover, we have to remember that the poor sections of the society are the ones more affected by TB especially. In addition, knowing well that one cannot afford to ignore either of these diseases, please find appended an abridged version of the National Action Plan against TB-HIV from the MedIndia website as well as some information of Indian videos available at the Stop TB one. The point is the National Plan and the videos still do not clearly articulate the kind and levels of synergy required. So, in order to make up, more has to be done by us at the grass root level to provide friendlier services.

India to Implement National Action Plan Against TB-HIV (India)

For Full text: http://www.medindia.net/news/view_news_main.asp?x=8861
MedIndia, March 27, 2006

The Revised National TB Control Programme (RNTCP) in India plans to widen the scope for providing standardized, good quality treatment and diagnostic services to all TB patients. Approximately 50-60 percent of HIV-infected persons in India are more susceptible to contracting TB. In the 2006 RNTCP Status Report for India, Anbumani Ramadoss, Union Health and Family Welfare Minister, outlined various measures to address TB/HIV and multidrug-resistant TB. Maharashtra, Tamil Nadu, Andhra Pradesh, Karnataka, Manipur, and Nagaland, six states with a

high incidence of HIV infection, were identified for implementation of services for HIV-infected patients through Voluntary Counselling and Testing Centres, the RNTCP Designated Microscopy Centres, and nongovernmental organizations. The Ministry is conducting community-based surveys in Gujarat and Maharashtra states to determine the number of persons who have become resistant to drugs and other states will be monitored for drug resistant cases. According to the statistics for India, drug resistance in new cases is less than three percent and in old cases, about ten percent.

http://www.stoptb.org/resource_center/assets/documents/VideoSerieshtm

Video 4 - SHANTA: Model community mobilizer

"Go to the people. Live with them. Learn from them. And what is more, respect them. Talk with them in the language they understand..." - Shanta Raye, IEC Adviser, DANTB - Orissa, India

Summary: Community mobilization and education are key to the success of the DOTS strategy. Profiling the work of model community mobilizer Shanta Raye, a health educator working in Orissa, India, this video illustrates how social and community mobilizers contribute to the success of the TB programme in India, even in remote areas. Shanta's story highlights the crucial role of IEC (Information, Education, and Communication) in effectively mobilizing TB patients, families and communities to support and sustain DOTS and stop TB.

Audience: General, Training, Educational (Community/India)

Length: 14 min. [NTSC/PAL]

Ref.: CDS/STB/Video/2000.4

Director/Producer: Bob Madey

Executive Producer: Heidi Larson

Project Manager: Binod Mahanty

Discussion guide prepared by: Healthlink Worldwide

Video 5 - DOTS and public-private partnerships

"If it is as successful as it has been in Hyderabad City, this could be a way for the future for a truly successful government and private partnership..." - Rechu Chatterjee, Sec. Dept. of Family Welfare - Andhra Pradesh, India

Summary: The private sector is the first point of contact for most TB patients. DOTS and public-private partnerships showcases how the Mahavir Trust Hospital, a private hospital in Hyderabad City, India, serves as a link between local private practitioners and the government in the provision of DOTS. The Mahavir Trust Hospital has gained the trust of the local private practitioners and works closely with them to ensure that TB patients are effectively treated and cured using the DOTS treatment strategy-achieving cure rates of ninety percent and more. This video shows that by building a relationship of trust between the public and the private sector, outstanding treatment results may be achieved.

Audience: General, Training, Educational (Community/India)

Length: 14 min. [NTSC/PAL]

Ref.: CDS/STB/Video/2000.5

Director/Producer: Bob Madey

Executive Producer: Heidi Larson

Project Manager: Binod Mahanty

Discussion guide prepared by: Healthlink Worldwide

Many thanks to all who contributed to this query!

If you have further information to share on this topic, please send it to Solution Exchange for the AIDS Community in India at aids-se@solutionexchange-un.net.in with the subject heading **'Query: TB and HIV synergies, from Medical & Health Services, Daman & Diu, (Experiences/Advice).'**

Disclaimer: In posting messages or incorporating these messages into synthesized responses, the UN accepts no responsibility for their veracity or authenticity. Members intending to use or transmit the information contained in these messages should be aware that they are relying on their own judgment.



Copyrighted under Creative Commons License "Attribution-NonCommercial-ShareAlike 2.5". Re-users of this material must cite as their source Solution Exchange as well as the item's recommender, if relevant, and must share any derivative work with the Solution Exchange Community.



Solution Exchange is a UN initiative for development practitioners in India. For more information please visit www.solutionexchange-un.net.in