Workshop to Accelerate the Implementation of the Three I's Principles for HIV & TB in East Africa

November 28th- December 1st 2011, Sarova Panafric Hotel, Nairobi

KELIN
KENYA LEGAL AND ETHICAL ISSUES NETWORK ON HIV & AIDS

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical & Research Foundation
ARASA	Aids Rights Alliance of South Africa
ART	Antiretroviral therapy
BCG	Bacille Calmette- Guerin
CBO	Community Based Organizations
CSO	Civil Society Organization
CXR	Chest X-Ray
DLTLD	Division of Leprosy, Tuberculosis and Lung Disease
DOT	Directly Observed Therapy
DR	Drug Resistant
TB	Tuberculosis
DST.	Drug Susceptibility Testing
EAC	East African Countries
EALA	East African Legislative Assembly
HIV.	Human immunodeficiency virus
HRBAP	Human Right-Based Approach to Programming
IC	Infection Control
ICF	Intensified Case Finding
IEC	Information, Education and Communication
INH	Isoniazid
IPT	Isoniazid Preventive Therapy
IT	Information technology
KELIN.	Kenya Legal and Ethical Issues Network on HIV and AIDS
M & E.	Monitoring and Evaluation
MCH	Medical Center Hospitals
MDR	Multi-Drug Resistant
MOH	Ministry of Health
NACC.	National AIDS Control Council
NASCOP	National Aids and STI Control Programme
NEPHAK	National Empowerment Network of People Living with HIV & AIDS in Kenya
NETMA	Network of Men Living with HIV in Kenya
NGO	Non-governmental Organizations
NTP	National Tuberculosis Programme
PLHIV.	Persons Living with HIV
PPD	Purified Protein Derivative (Tuberculin Test)
PPP.	Public-Private Partnership
SADAC	Southern Africa Development Region
TALC	Treatment Advocacy & Literacy Campaign
TB	Tuberculosis
TST	Tuberculosis Skin Test
WHO	World Health Organization
XDR	Extensively Drug-Resistant
ZAMSTAR	Zambia / South Africa TB and AIDS Reduction

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ABOUT KELIN

KELIN is a legal NGO working to protect, promote and advance health related human rights in Kenya. We do this by:

- Providing legal services including legal advice and litigation to people who have suffered health related human rights violations – especially people living with HIV and other vulnerable groups – using KELIN staff and our network of probono lawyers.
- Strengthening and Building Capacity of health professionals, lawyers, community workers and people living with HIV on health and other related human rights including working from a rights-based approach in service provision.
- Engaging in advocacy campaigns that promote awareness of human rights issues in national laws and policies to governments, organizations and communities.
- Research on areas relating to human rights, legal issues and health, contributing to new legislation and supporting evidence-based change.

KELIN's current main programme areas are around: promoting alternative dispute resolution in securing justice for vulnerable groups like widows and orphans, campaigning for sustainable funding for health services, ensuring the government effectively supports the rights of TB patients and facilitating various people in Kenya to know and use their human rights. We continue to ensure government accountability in guaranteeing the progressive realization of the provisions of the right to health as envisioned by the Constitution of Kenya 2012.

For more information on KELIN and its work visit HYPERLINK "http://www.kelinkenya.org"www.kelinkenya.org.

Workshop to Accelerate the Implementation of the Three I's Principles for HIV & TB in East Africa

NAME OF HOSTING INSTITUTIONS	KELIN		
COUNTRY/SITE OF MEETING	SAROVA PANAFRIC HOTEL, NAIROBI, KENYA		
MEETING	WORKSHOP TO ACCELERATE THE IMPLIMENTATION OF THE THREE I's PRINCIPLES FOR HIV AND TB IN EAST AFRICA		
DATE OF MEETING	NOVEMBER 28TH TO DECEMBER 1ST 2011		
TOTAL NUMBER OF PARTICIPANTS	**MALE** 14	**FEMALE** 15	**TOTAL** 29

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1.0: EXECUTIVE SUMMARY

The Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN - www.kelinkenya.org) with support from World Health Organization (WHO) and in collaboration with the AIDS and Rights Alliance for Southern Africa (ARASA - www.arasa.info), hosted a four days' workshop to strengthen the capacity of civil society advocates, senior government officials and organizations of People living with HIV (PLHIV) to engage effectively in advocacy for improved access to HIV and TB prevention, diagnosis and treatment services within the region of East Africa.

Tuberculosis is the leading cause of death among PLHIV. The risk of developing TB is estimated to be between 20-37 times greater in PLHIV than among those without HIV. This makes TB treatment in PLHIV an urgent priority for both HIV and TB programs. The Three I's; Isoniazid Preventive Therapy (IPT), Intensified Case Finding (ICF) for active TB, and TB Infection Control (IC), are key public health strategies to decreasing the burden of TB among PLHIV. Despite the considerable benefits, both HIV and TB groups have been slow to implementing these TB-reducing services resulting in missed opportunities to prevent many unnecessary cases of TB related deaths1.

The workshop was aimed at familiarizing participants with the 2011 WHO guidelines for ICF and IPT for PLHIV in resource constrained settings for effective advocacy towards accelerating implementation of the 3Is within Eastern Africa. The objectives of the forum were to facilitate:

- Overview of the WHO TB/HIV collaborative activities policy, global and local situation and current implementation and challenges
- Introduction to the WHO Guidelines for intensified TB case finding and isoniazid preventive therapy for people living with HIV in resource constrained settings (Three Is for HIV/TB - intensified TB case finding, isoniazid preventive therapy and infection control for TB)
- Introduction to the ARASA/WHO toolkit for HIV/TB
- Introduction to models of integration of HIV and TB services
- Better understanding of the concerns and needs of the community around HIV/TB and how best to respond to these needs.
- Network with each other and build momentum to catalyze implementation of a fully integrated approach based on the needs of people in their countries and regions.
- Discuss strategies to enhance community mobilization for implementation of HIV/TB services and demand generation for the services

The forum was held from the 28th of November to 1st of December 2011 at the Sarova Panafric hotel, in Nairobi. Regional participants included, people working in non-governmental organizations (NGOs), TB activists, people living with HIV, people working on health policy, journalists, government officials, and a representative from WHO.

The forum began on Day 1 with a word of prayer, followed by participant introductions facilitated by Mr. Allan Maleche. Opening remarks were given by Dr. Joseph Sitienei of the Division of Leprosy, Tuberculosis and Lung Disease (DLTLD)2 of Ministry of Public Health and Sanitation, and Lucy Chesire of TB Action Group. In a power point presentation, Dr. Sitienei highlighted the need to re-invent the tools in dealing with TB. He talked about regional countries being in different stages of implementing the Three I's, but was quick to point out that the lag in integrating the Three Is was as a result of common challenges observed within the region such as financial constrains and lack of acceptable

1 *WHO 3Is meeting Report http://www.who.int/entity/tb/publications/2009/who_3Is_meeting_report.pdf*
2 *http://www.nltp.co.ke/tbcontrol.html*

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approaches that brings together communities and governments collaboration. He noted that Kenya had made significant progress working with the Five I's3 as compared to the other countries in the region whose efforts were limited to the Three I's, but the Five I's as well. He urged other countries to put extra effort and begin implementing not only the Three Is but the Five I's. He also mentioned the need for WHO to support TB programs like they have HIV programs. Lucy Chesire encouraged those in attendance to go beyond and roll out IPT program for people living with HIV. She elaborated on the WHO TB/HIV model that shows we can prevent 1,000,000 people living with HIV from dying from.

Participants from Rwanda, Burundi and Tanzania keenly listen to the presentation

Objectives of interest on Day 1 were: An overview of HIV & TB- History, current global and local context and Introduction to the 2011 WHO Guideline for intensified TB case finding and isoniazid. The workshop commenced with power point presentations on overview of HIV & TB history, challenges in the prevention, diagnosis and treatment of TB and ICF in TB, facilitated by Reuben Granich, Lucy Ghati and Francis Apina. Later in the day, participants were divided into three groups and presented with different case scenarios. Groups members were allocated ample time to brainstorm and come up with strategies for implementing ICF in different scenarios. Day 1 concluded with a Q & A session, which allowed participants to ask questions and engage in a free discussion.

Day 2 started out with a review of day 1. A continuation of the objective Introduction to the 2011 WHO Guideline for intensified TB case finding and isoniazid was facilitated through power point presentation on TB infection control, isoniazid preventive therapy and Human Rights Based Approach to TB and HIV. These were facilitated by Lucy Ghati, Nelson Otwoma and Allan Maleche respectively. The Case study discussions focused on strategy development for accelerating implementation and mass education. There were also Case Studies on advocacy and incorporating Rights Based Approach in TB/HIV interventions.

3 Intensified tuberculosis case-finding, Isoniazid preventive therapy, Infection control for TB, Initiate earlier ART and Integrate HIV and TB services

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The objectives of interest on day 3 were: Adapting WHO policy and guidelines to local environments (The ARASA example) and Introduction to Models of service integration. The forum started with a review of the ARASA HIV/TB toolkit facilitated by Ms.Khairunisa. This was followed by country delegates' deliberations on policy recommendations for localizing the toolkit in their respective countries. During the subsequent country presentations, an intense debate ensued around possible challenges that may arise in implementing the toolkit. The day's objective was finally concluded with a power point presentation and discussion on challenges in integrating antiretroviral therapy (ART) in different communities.

Day 4 objective of focus was discussing strategies to enhance community mobilization for implementation of collaborative HIV/TB services and demand generation for the services. Francis Apina presented on developing strategies for PLHIV in the communities and getting involved in the implementation. This was followed by a group discussion, centered on advocacy strategies at national and community levels.

At the conclusion of the sessions, participants made specific recommendation calling for community, national and regional levels interventions which would complement their advocacy towards the acceleration of implementation of the 3Is. At the community level they plan to take an inventory of what exists in the communities with regards to TB/HIV activities, distribute the report from the workshop with TB/HIV stakeholders to create awareness on current TB/HIV issues and put in place a simple tool to help monitor and measure activities or indicators to hold countries accountable. At the national level, they plan to engage policy makers and involve media in TB issues. At regional level, they agreed to hold joint regional forums for experience and sharing.

As a way forward each country developed a plan of action that would facilitate achievement of their recommendations on adaptation of WHO policy recommendations and localizing the ARASA toolkit.

The participants' overall evaluation of the workshop conveyed that most of them were content with the discussants and the topics covered. The participants were confident that they would be able to carry out most of their recommendations within the minimal resources available to them. They however felt more time was required for exhaustive experience sharing and detailed interrogation of the best practices presented at the workshop. The major concern raised at the meetings was how to mobilize additional resources for the realization of the major recommendations targeting the broader regional advocacy.

All in all, the objectives of the workshop were met. In light of the theme of "Getting to Zero4" several media houses interested in covering the workshop attended the last day and conducted interviews with a couple of the participants. Annexed is an article published by the Standard Newspaper - one of the leading National media houses.

Mr. Innocent Habimana of Rwanda ended the workshop by pledging to host a follow-up meeting in Rwanda with the objective of facilitating the participants' wishes for exhaustive experience sharing and detailed interrogation of the best practices presented at the workshop. Reuben pledged his technical support and promised to share any opportunities to mobilize resources with the group. The host organization undertook to hold participants accountable for achievement of the agreed plan of action.

DAY ONE

The forum began with a word of prayer, followed by participant introductions facilitated by Allan Maleche. The participants shared their expectations; which in summary were as follows:

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1. Gain a deeper understanding of the Three I's and their implementation
2. Understand the relationship between TB/HIV and Human Rights Issues
3. Learn from the experiences of others within East Africa on how to manage and integrate TB/HIV programs
4. Share best practices within the region on how to address challenges faced in the implementing TB/HIV collaborative activities
5. Receive an account of the progress made by governments in implementing WHO guidelines on the 3Is
6. Learn more about ARASA tool kit and how it can be adapted to help address implementation issues arising due to limitations of resources
7. Explore how to involve communities in TB/HIV intervention programs
8. Network and strengthen collaborative efforts by CSOs in regional advocacy

2.0 OPENING REMARKS

Opening remarks were given by Dr. Joseph Sitienei of the Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) at the Ministry of Public Health, and Lucy Chesire of TB Action Group.

> In a power presentation, Dr. Sitienei highlighted the need to re-invent the tools in dealing with TB, considering that it is the most likely to lead to death for most people living with HIV. He talked about regional countries being in different stages of implementation of the Three I's. He pointed out that the integration of TB services was lagging perhaps due to common challenges observed in the region such as financial restrain and inability to get communities and governments more involved. He discussed the fact that Kenya was ahead of the other countries in the region because they have not only initiated the intervention of Three I's, but the Five I's5 as well. He urged other countries to put extra effort and start the intervention of the Five I's6. The last two I's being the integration of services for TB and HIV and the immediate provision of ART. He also mentioned the need to ask WHO to take lead in TB programs like they have HIV programs.

Lucy Chesire encouraged those in attendance to go beyond and roll out IPT program for people living with HIV. She elaborated in the WHO TB/HIV model that shows we can prevent 1,000,000 people living with HIV from dying.

5 Intensified tuberculosis case-finding, Isoniazid preventive therapy, Infection control for TB, Initiate earlier ART and Integrate HIV and TB services
6 Ibid

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3.0 SUMMARY OF SESSIONS

3.1 SESSION ONE: Overview of HIV & TB – History, current global and local context

Session Chair: Evelyne Kibuchi (Kenya)

3.1.1 HIV & TB: HISTORY AND CURRENT GLOBAL CONTEXT

PRESENTER: REUBEN GRANICH

The first presentation was an overview of WHO 2011 HIV/TB collaborative activities policy update, presented by Reuben Granich who is the Medical Officer (HIV/TB), Antiretroviral Treatment and HIV Care, Department of HIV/AIDS, World Health Organization – Geneva.

Reuben presents the participants with data supportive of the WHO guidelines on TB/HIV collaborative activities

He started by reviewing the general purpose of the WHO 2004 interim policy on collaborative TB/HIV activities, explaining that it was to create a mechanism of collaboration

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between TB and HIV&AIDS programs. He covered how in April of 2008, in collaboration with other key partners, the WHO - HIV&AIDS and TB departments, hosted a meeting of international stakeholders where they developed recommendations and guidance for national programs and their partners for implementation of the Three 'I's for PLHIV. The participants were presented with the updated 12 point policy package of the recommended collaborative TB/HIV activities including establishing Intensified TB case-finding (ICF) and quality TB treatment, Introducing Isoniazid prevention therapy (IPT) and ARVs, and Infection control (IC) in health care and congregate settings. He finally updated the participants on new developments since the release of the WHO policy guidelines.

Reuben's recommendations from a global perspective included increased support by WHO to support country level adaptation of policy guidelines, broadening the approach to tackle Drug use in addition to HIV and TB, ART for all HIV positive TB patients, access to ART at CD4 <350 for all PLHIV to prevent TB, decentralization and integration of national HIV and TB programs.

3.1.2 HIV/TB: SPECIFIC CHALLENGES IN PREVENTION, DIAGNOSIS AND TREATMENT FOR PEOPLE LIVING WITH HIV (THE PATIENTS' PERSPECTIVE)

PRESENTER: LUCY GHATI

Lucy Ghati; the Program Officer on TB at NEPHAK delivered a presentation that covered the patients' perspective of specific challenges in prevention, diagnosis and treatment of TB for PLHIV. She described the risk factors for TB infection in Eastern Africa which included poor housing, overcrowding, poor ventilation, malnutrition, HIV prevalence, poor access to health care and poor quality of health care. She raised concern about the limited available vaccines for TB and their efficacy. She discussed the unreliability of the available diagnostic and challenges patients encounter as a result of poverty and the double stigma associated with TB and HIV which affects treatment adherence.

Her recommendations included strengthening TB diagnostic services for PLHIV, research on new drugs and treatment regimens that would effectively address the duration of treatment and the pill burden for PLHIV co-infected with TB.

3.1.3 HIVTB: SPECIFIC CHALLENGES IN PREVENTION, DIAGNOSIS, TREATMENT FOR PEOPLE LIVING WITH HIV (CLINICAL PERSPECTIVE)

PRESENTER: REUBEN GRANICH - WHO

Reuben's next presentation looked at the clinical perspective of specific challenges in prevention, diagnosis and treatment of TB for PLHIV. He began by drawing the participants' attention to the new evidence that supports ART for prevention of HIV transmission. He thereafter highlighted the major challenges with implementation of IPT elaborating on inconsistency in regime and duration administered, efficacy and durability of effect, diagnosis of active TB before administering IPT, the role of tuberculin skin test, IPT and drug resistance, toxicity of IPT, impact of ART and IPT, adherence to IPT and drug supply management.

In his concluding remarks he re-emphasized the need to scale up IPT intervention recommending the development of simplified algorithms for IPT delivery, generating demand for the integration of IPT as part of the comprehensive HIV treatment and care package, ensuring effective drug supply system and access and establishing efficient monitoring and evaluation systems.

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3.1.4 TB & HIV SITUATION IN EAST AFRICA: IMPLEMENTATION OF HIV & TB SERVICES AND OPERATIONAL CHALLENGES

PRESENTERS: COUNTRY DELEGATES

RWANDA:

Presentation was made by Mr. Innocent Habimana. The group gave a brief description of the pilot phase of IPT currently ongoing in Rwanda. They said that Rwanda plans to start implementation of IPT in 2012. They listed some challenges so far encountered during the pilot phase such as difficulty in collaborating TB & HIV programs, rotation of staff, limited space and accurate recording of information. They plan to address the challenges by integrating TB and HIV services, reinforcing implementation of one-stop services, rolling out the IPT implementation and strengthening the infection control.

TANZANIA:

Presentation was made by Dr. Peter Mugosha. The team stated that implementation of IPT in Tanzania had not commenced either. They outlined some challenges faced in implementing of HIV & TB services. These include; weak coordination between TB and HIV programs, inadequate TB screening at clinics, inconsistent availability of supplies, few referrals, limited funding and less community involvement. Their strategy to address the challenges involves strengthen community involvement, fostering Public-Private Partnership (PPP) initiatives (including Faith-Based Organizations) and decentralization of collaborative activities into regions/districts.

UGANDA:

Presented by Ms. Namata Kevin; the group informed forum members that implementation of IPT had not started in Uganda. They listed challenges faced by HIV &TB groups as leadership issues, policy, inadequate human resources, stigma for both HIV/TB, inadequate diagnosis for both HIV and TB, limited access to health facilities, inadequate financing and inaccurate and incomplete data. The group stated that strategies to implement IPT would need to include initiatives to improve funding and human resources for health, increase access to diagnosis services and collaboration with other health sectors.

KENYA:

Presentation was made by Ms. Katindi. The Kenyan team listed challenges in implementing of integrated HIV & TB services in Kenya as inadequate funding, lack of qualified staff, lack of quality and up-to date diagnosis methods, inadequate data on demand and slow progress in implementation of national policies. They outlined strategies for effective implementation to include deliberate efforts towards community involvement, more aggressive Direct Observed Therapy (DOTs) strategy and extra support during TB treatment to encourage adherence by patients (e.g. financial and nutritional support), improved screening of prisoners especially upon release, reviewing of the HIV strategic plan to among other things incorporate human rights issues and incorporate regularly updated TB information into the training curriculum for health workers.

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Plenary:

During the discussions, forum members agreed upon the significance of community sensitization in addressing majority of the challenges highlighted. Lack of TB treatment literacy was identified as the greatest hindrance to demand for integrated TB and HIV services. It was agreed upon that deliberate efforts to ensure education and additional support (Financial and psychosocial) was needed to ensure treatment adherence by patients. One major issue that came up for discussion was the punitive nature of the strategy adopted by the Public Health Officers in Kenya to criminalize non-adherence to TB drugs and imprison TB patients for the duration of treatment. The participants agreed to schedule a session to discuss how best to strike a balance between human rights issues of patients and public health care concerns as efforts are enhanced to control infection.

3.2 SESSION TWO: Introduction to the 2011 WHO Guidelines for intensified TB case finding and Isoniazid preventive therapy for PLHIV in resource constrained settings

Session Chair: Moses Mulumba (Uganda)

3.2.1 INTENSIFIED CASE FINDING

PRESENTER: FRANCIS APINA

The session started with a power point presentation on the overview of TB Intensified Case Findings (ICF) facilitated by Francis Apina; the TB/HIV Advocacy Manager of NETMA. He began with a brief background of IPF emphasizing its importance in increasing the early identification of TB disease. He discussed in detail the goals of ICF including the reduction of morbidity and mortality and reduction of transmission. He also analysed the TB screening algorithm. His discussion on the challenges covered poor treatment outcome, diagnostic approaches, overwhelmed health system and the wanting community approach.

His recommendations for effective implementation of ICF included the redouble strategies to reach high risk population which will address the high rate of TB morbidity and prevalence. Looking at the Zambia / South Africa TB and AIDS Reduction (ZAMSTAR) model he proposed adopting the same strategies in scaling up access to the general community and encouraging their involvement. Finally he recommended better management of smear negative TB.

Plenary:

During the discussions, concerns were raised with regard to the cure rate with members inquiring about availability of relevant statistics from WHO. Participants also expressed apprehension at the large numbers of patients that are lost between screening and diagnosis. The capacity of laboratories in the region was also an issue of concern meaning it takes longer to get results and patients get exhausted of the tedious follow-up. They restated the necessity for governments to embrace community-based mechanisms to help support patients through the treatment process. HIV programs especially need to be more proactive towards TB.

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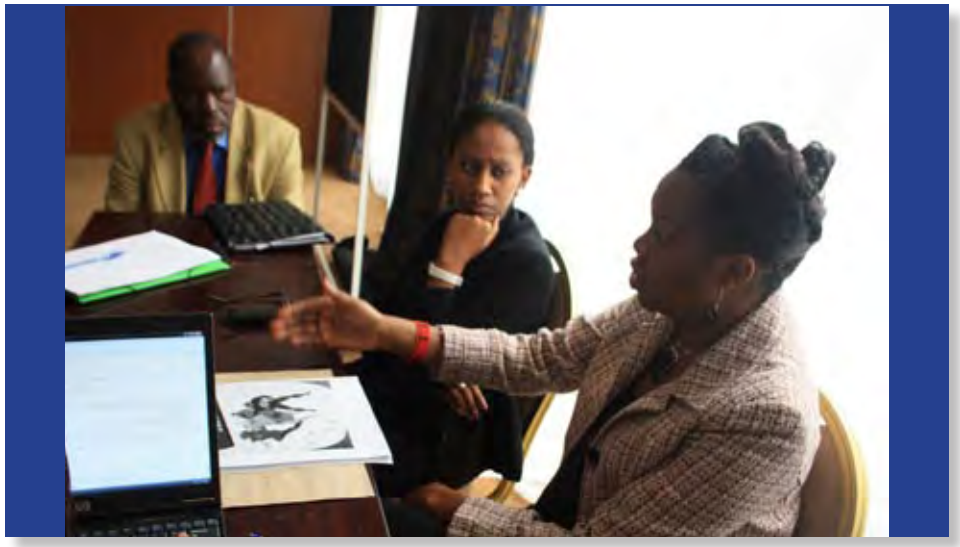

Dr. Kichari (MCHI), Ms. Katindi (KELIN) and Ms. Chesire (TB Action Group) deliberate with others on the TB/HIV national policy in Kenya.

3.2.2 GROUP WORK

GROUP 1:

Their task was to come up with an advocacy strategy in collaboration with health care workers associations, to scale up ICF from 20% to 100%. The group identified two opportunities; existence of the facility and the willingness of workers. Barriers included lack of human resource, ICF and low infrastructure. The strategy was to put up a policy champion for TB/HIV, motivate the community workers, approach the government for resources, put up Information technology (IT) , promote cure through TV and radio and get health care providers who couldadvocate.

GROUP 2:

Was tasked with developing a pilot plan for community driven ICF in a low– income community. Their challenges included; high mortality rate of TB/HIV, 70% co-infection rate, low reporting rate on TB cases screened HIV positive clients, lack of community awareness, lack of infrastructure and more. Their strategy was to get the community gate keepers to own the problem, identify those who could ICF, hold meetings with health care workers to map out ways of addressing the challenges, develop an effective referral system for those diagnosed with TB, develop Information, Education and Communication (IEC) materials targeting the community and the available TB/HIV services.

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GROUP 3:

This group was tasked with developing an educational toolkit aimed at increasing demand and uptake of ICF in health care facilities. After identifying the barriers to uptake of ICF in health care facilities, the tool developed by the group focused on sensitization which would highlight the benefits of ICF and facilitate standardized knowledge by the service providers. It also included strategies of improving infrastructure within the health care facility and improving quality of human resource through regular trainings, staff motivation and allowing flexibility in terms of operational hours by encouraging us of volunteers such as community health workers.

3.3 WRAP UP OF DAY ONE

Day 1 ended with a conclusion on the importance of disseminating information and sensitizing communities on TB issues. This was seen as the most powerful tool emerging from the day's deliberations. Forum members proposed adaptation of an effective community-based model with TB survivors and PLHIV at the forefront. Media engagement was considered another powerful weapon in creating public awareness. Human Rights were identified as an existing gap in policy guidelines and the national response which needs to be recognized and incorporated in TB/HIV strategies.

DAY TWO

3.4 SESSION THREE: Introduction to the 2011 WHO Guidelines for intensified TB case finding and Isoniazid preventive therapy for PLHIV in resource constrained settings (Continued)

Session Chair: Tobias Kichari (Kenya)

3.4.1 SCALING UP INFECTION CONTROL FOR TB

PRESENTERS: EVELYNE KIBUCHI & LUCY GHATI

Forum started with a word of prayer, followed by a review of Day 1 by Ms. Mariam Abdulrahaman Maulid.

Ms. Ghati delivered the first presentation of the day via power point (Prepared by Evelyne Kibuchi the Senior TB Project Manager at KANCO), on scaling up of TB Infection Control. She described how TB infection occurs and distinguished its control from that of other diseases. She described the significant role of ICF in preventing transmission within the health care settings. The presentation highlighted factors that increased the risk of infection discussing the patient, recipient, bacterial and institutional factors. The steps involved in implementing TB infection control at all levels were explained and the contents of the 2009 national guidelines for TB infection prevention in Kenya shared.

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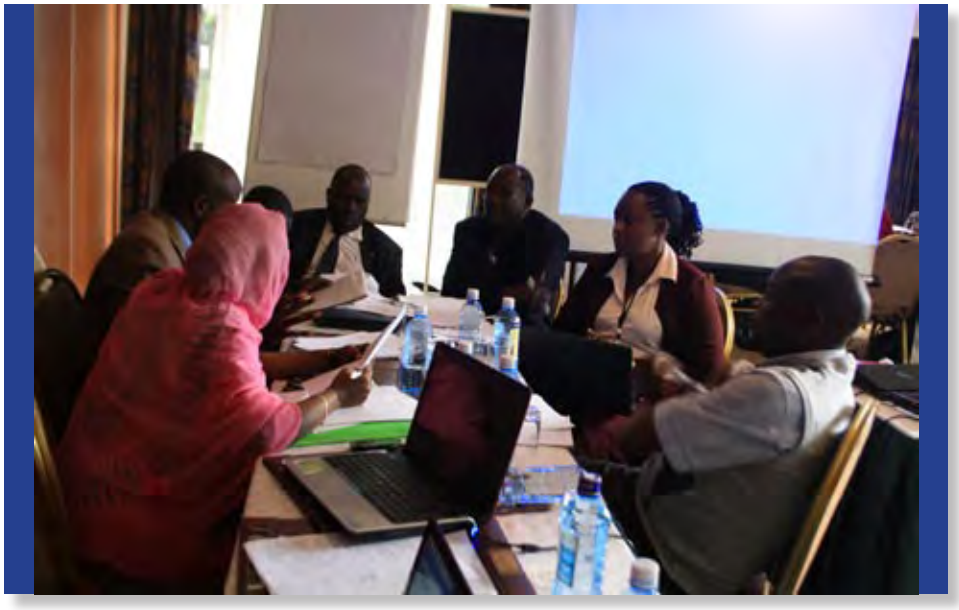
Plenary:

The question of interest was how best to address factors that increase infection rate within health facilities; dealing with the overburdened health care system, human resource, long waiting times for patients and people with different ailment all kept together. They proposed several strategies to address these challenges. They suggested taking administrative measures as a first step such as ensuring staff are well trained, waiting time at facilities is shortened and proactive steps to identify TB suspects and keeping them separately from other patients in the facility particularly pregnant women and children. Iinfrastructural challenges could be helped by carrying out some of the work in tents to avoid congestion and to facilitate maximum ventilation and sunlight. It was also proposed that public transport service providers should be targeted with TB information.

3.4.2 GROUP WORK



A group of participants explore strategies of accelerating implementation of infection control within East Africa

GROUP 1:

Their task was to implement mass education strategies in a country that had seen increased Multi-Drug Resistant tuberculosis (MDR TB) especially among PLHIV. Data also showed that close to 50% of them had died of Extremely Drug-Resistant tuberculosis (XDR) TB in the past 6 months. The team's strategy was to form a committee to include government and community

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leaders, pastors, traditional healers and chiefs and educate all groups. They planned to use media personalities and former TB patients in spreading the word and ask community members to come out for screening. They intended to target general public, especially the young and the elderly, work places and transportation means such as Matatus and buses for education.

GROUP 2:

Their task was to accelerate implementation of infection control strategies in a country that has high rate of TB/HIV co-infection, 70%. They planned to target implementation at the national, provincial/district and facility levels. They would identify focal point persons, supervision and mentoring at all levels of interventions. They would also develop a committee to include people from the community and reinforce effective referral systems.

GROUP 3:

The group was tasked with implementing advocacy strategies for TB infection control in correctional facilities where incident rates were 18 times the national rate. From government standpoint, providing treatment to prison population first was viewed by the team as a strategic political move for those in politics. For the purpose of advocacy, they decided to look for a policy ally on the inside and use diplomatic approaches to push for the issue among their peers at policy level. The team also planned to look for media personnel who were interested in the issues of TB, mobilize prisoners, their families and prison staff and sensitize them on issues of TB, as well as have them share personal experiences of leaving with HIV and TB or with PLHIV.

3.4.3 ISONIAZID PREVENTIVE THERAPY (IPT) FOR PLHIV

PRESENTER: NELSON OTWOMA

Mr. Nelson Otwoma; the Executive Director of NEPHAK gave a presentation on Isoniazid preventive therapy (IPT) to reduce the burden of TB among PLHIV. He began his presentation with statistics on the burden of TB among PLHIV. He stated the methodology and criteria of implementation of IPT upon the release of the WHO policy guidelines and updated the participants of the recent developments. He discussed the challenges in implementing IPT expounding on the views that of some that chronic cough alone was perceived as an insensitive predictor of TB. He highlighted the lack standardized screening tools and the overreliance on chest x-rays (CXR) only. Nelson explored the taking IPT for thirty six months as compared to the recommended shorter course of six months. He addressed concerns that administration of IPT among PLHIV was resulting in drug resistance in patients who already have undiagnosed active TB.

Plenary:

The session was extremely heated with conflicting views regarding the enrolment criteria of patients on IPT, the appropriate duration of the therapy and the efficacy in preventing TB infection. The longer course for IPT in setting with a high burden of TB raised concerns with regard to the financial implication with questions of the ideal course of the therapy, how long the protection would last and how regularly the therapy would have to be repeated. It was observed that globally different countries were using their own discretion to determine the applications of IPT.

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Participants take note of statistics on the burden of TB among PLHIV as presented by Mr. Otwoma (NEPHAK)

3.4.4 RIGHTS BASED APPROACH TO THE TB AND HIV RESPONSE

PRESENTER: ALLAN MALECHE

The session started with a video documented by KELIN sharing the plight of two residents of Kapsabet in Kenya who upon suspicion that they had defaulted on their MDR-TB treatment were arrested and incarcerated for allegedly posing a threat to the health of the Public. The two were imprisoned for eight months, a period that was meant to coincide with the length of their TB treatment. The video gave a detailed account of the negative effect this had on the individuals their families and the Kapsabet community in general. This necessitated the intervention of KELIN and NEPHAK; applying both legal measures and social interventions.

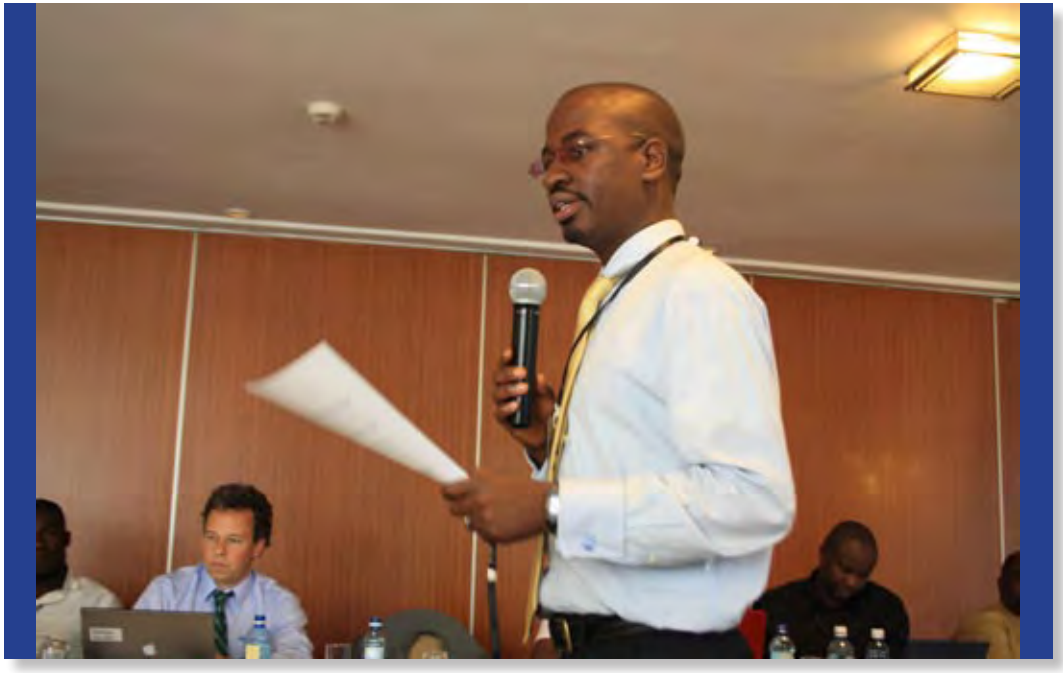
Mr. Allan Maleche; the Coordinator of KELIN delivered a presentation on incorporating a rights based approach in HIV and TB prevention and management. He elaborating on the rights based concept that is well enshrined in the Constitution of Kenya and in numerous international instruments by defining it and explaining the principles involved. In addressing the controversial issue of public health concerns occasioned by the two epidemics he explained the application of the siracusa principles7 reiterating that any compulsory measures needed to

7 *United Nations Economic and Social Council UN Sub-Commission on Prevention of Discrimination and Protection of Minorities: The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, Annex (1985). U.N. Doc. E/CN.4/1985/4*

protect the public from severe health threats should be such that they withstand the scrutiny that

- the restrictions are provided for and carried out within the law e.g. procedural safeguards are complied with e.g., notice, hearing before an impartial tribunal, access to representation, & opportunity to appeal,
- the objective is legitimate (evidence of an actual risk to the public),
- the limitation is strictly necessary, and
- that there exists no less intrusive and restrictive means available to achieve the same objective.

Mr. Maleche explored some challenges that may face incorporation of the Right-Based Approach in national programs and concluded by reiterating that the application of human rights principles in HIV and TB programs ensures acceptable, desirable and sustainable outcomes.



Mr. Maleche (KELIN) emphasizes on the importance of incorporating human rights in the TBHIV response

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Plenary:

Participants were shocked at the approach adopted in Kenya sharing that the other countries in the region had not encountered this issue. They however noted that their laws contained similar broad provisions that could be abused in the same way. They were curious to learn more about what was doing in supporting such human rights violations. Allan updated the participants on several approaches including probono cases they were undertaking to represent these clients individually in court. They were also applying strategic litigation on behalf of TB patients to secure an order compelling the Government to issue clear guidelines. Allan explained that community sensitization which KELIN was conducting in partnership with NEPHAK was empowering the public on their rights and responsibilities and facilitating meaningful engagement with policy makers at national level.

3.4.5 GROUP WORK

Below is a summary of the case studies discussed by the participants during the afternoon sessions

GROUP 1: SELF-DETERMINATION

Bahati has recently been diagnosed with MDR TB. He had TB five years ago and was successfully treated even though he experienced very unpleasant side effects. He has heard of many patients in his local hospital who had lost their hearing because of taking MDR TB drugs and therefore, he is refusing to take MDR TB treatment, and plans to get remedies from his local traditional healer instead. He is also afraid of stigmatization. The local health authorities wanted to arrest and forcibly isolate him to administer treatment.

After deliberations, the group's presentation proposed that Bahati be given appropriate information to help him understand the nature of MDR TB and the benefits that outweigh the side effects of the treatment. Proper counseling was recommended and reassurance of the precautions the doctor's will take to reduce the side effects of the treatment. As a last resort he may be held in isolation in a separate room within the health facility until he completes his medications to avoid transmitting the disease to others.

GROUP 2: INFECTION CONTROL

Halima is a nurse who provides testing, counseling and treatment for TB. She is one of the only two nurses in her small rural town where there are extremely high incidences rates of TB, including MDR and XDR TB. There are no masks in her facility and ventilation is poor. Halima is worried about getting Drug Resistant tuberculosis (DR TB). One day, she decides to stop reporting to work and requests a transfer to another facility. The request is refused and she is instructed to return to work or face dismissal. The case is taken to court.

After deliberations, the group ruled that Halima was wrongfully dismissed and should be compensated. They proposed her reinstatement upon establishing that the necessary precautions had been taken to address the risks she is exposed to at work.

GROUP 3: ADHERENCE

Cankuzo is a small settlement in a poorly serviced rural area, and the nearest clinic is 3km away. TB patients are required to report to the clinic on a daily basis in order to receive their directly observed treatment from the health care worker. Frustrated at the long distance that they have to walk back and forth, the patients in the village have made a collective decision to interrupt their treatment in protest. They want to be able to take a full month's supply of treatment and administer it to themselves at home. The Cankuzo community is taken to court for refusing to take TB medications and for spreading TB to others.

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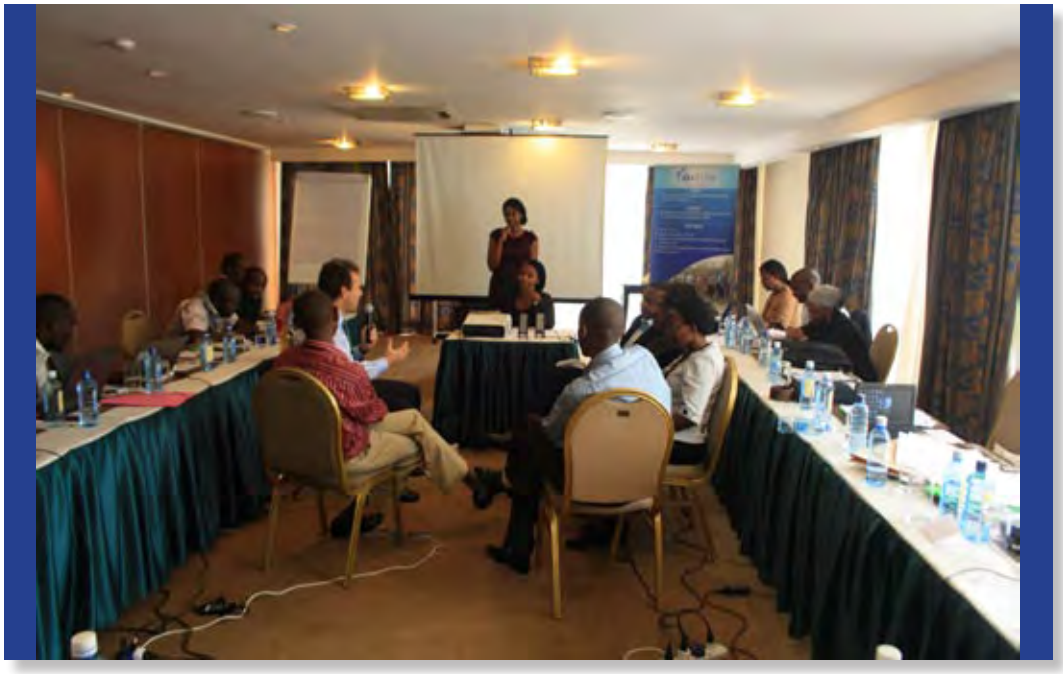

Participants present a skit demonstrating the complex balance between individual rights and community health care concerns

After deliberations, a skit was presented that revealed a judgment that was able to strike a balance between community concerns and health care providers' obligations. An order was made for the community to select reliable members to be trained as community health workers to go collect medications from the hospital and bring to the community members. These community health workers would be responsible to ensure that everyone takes their medications and would be accountable to the health care workers. A mobile clinic was a proposed feasible solution to bringing services closer to the people.

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DAY THREE

3.5 SESSION FOUR: Adapting WHO policy and guidelines to local environments

Session Chair: Shamsi Kazimbaya (Rwanda)

Day 3 began with a recap of Day 2 by Dr. Martin Ruhweza. Dr. Kichari brought a sample of the mask used in health care facilities to control infection and was passed around for participants to see.

3.5.1 INTRODUCTION OF THE ARASA HIV/TB TOOLKIT FOR THREE IS

PRESENTER: KHAIRUNISA SULEIMAN

Introduction of the ARASA HIV/TB toolkit was facilitated by Ms. Khairunisa; the TB Research Project Coordinator at ARASA. She started by giving a brief history of the toolkit's development and the process involved in its development. She pointed out that it had been piloted in 4 countries; Swaziland, Botswana, Lesotho and Zambia. She emphasized the need to integrate the toolkit into both national TB/HIV integration efforts and existing community based-programs for sustainability. She said that the toolkit was a diversified kit and could be used in different settings as it addresses various needs including most of those identified during the sessions.

She informed the forum that ARASA was targeting various ministries including those of Health and Education to rollout the tool within South Africa. She added that ARASA had established a small grants project to enable integration of the toolkit into their partners work in other countries within the SADAC region like Botswana, Zambia and Mozambique.

Plenary:

Discussions after this session were focused on how to incorporate the toolkit within the Eastern Africa region with deliberations around the regional needs and the suitability of the tool to address these. The participants agreed that the tool appears to satisfy needs that will help address the gaps and accelerate implementation of the 3Is. However it was agreed that they needed to read the toolkit themselves and circulate it widely to facilitate a broader stakeholder consultation process. This participatory process would encourage buy-in as the stakeholder will be involved in analyzing suitability of the tool to address the needs within eastern Africa and welcome any adaptations that will allow its localization in each of the countries.

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Groups work hard to develop advocacy strategies

3.5.2 GROUP WORK: ADAPTING POLICY RECOMMENDATIONS AND LOCALIZING THE ARASA TOOLKIT

PRESENTERS: COUNTRY DELEGATES

Picking up from the consensus reached during the plenary sessions the participants sought to develop country strategies to localize the tool by initiating interventions that would target its incorporation within national TB/HIV integration efforts and existing community based-programs.

BURUNDI: Presented by Felix in French (translated to English). The team explained that Burundi had started the implementation of ARASA toolkit. They stated that the Burundi government was fully involved and they planned on reviewing and making any further improvements. The Burundi team said they planned to have consultations at all levels including prison groups when they returned home.

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KENYA

PRESENTED BY MS. MELBA KATINDI

They Kenyan team started by highlighting areas that need consideration which included; National policy currently in place with regards to TB/HIV emerging issues, e.g. IPT implementation, stakeholders in TB/HIV integration and how to get their buy in and tools already being used by government and other implementing partners. The team's strategy was to have an exhaustive audit of relevant laws and existing policies, develop evidence-based information on implementation gaps, influence action by policy makers and implementing partners in accelerating implementation of the 3Is Principle and media engagement for public awareness.

RWANDA

PRESENTER: MR. INNOCENT HABIMANA

The Rwanda group started by listing the various TB/HIV tools in place including a handbook for TB control & TB/HIV, community health workers handbook and a handbook for TB infection control. Their strategy was to have TB national programs organize a TB and HIV consultative meeting to review and harmonize the ARASA toolkit with Rwanda's existing tools, establish a technical committee to finalize the harmonization of the toolkit, approval and disseminate the toolkit, hold an orientation meeting for stakeholders on toolkit and put in place a Monitoring and Evaluation framework (M & E).

TANZANIA:

PRESENTER: MR. DICKENS ELIASATH

The Tanzanian team described the strategy for implementing the ARASA toolkit. They stated that Tanzania already has a comprehensive toolkit in place that they had started using. However, they were planning to review and compare the two toolkits, hopefully by end of December 2011. They set their time line of implementation between December 2011 and December 2012. Some toolkits they have in place include a booklet with life experiences of people who have been treated, a handout for TB (Dalili za kifua kikuu), a handout for infection control, handout on TB and HIV transmission and a national book on HIV.

UGANDA

PRESENTER: MS. NAMATA KEVIN

The groups plan is to review the toolkit first, understand its aspects and who they will be targeting i.e. policy makers, health professionals and civil society? The team plans to integrate the tool kit with the Uganda existing guidelines and then roll-out the domesticated toolkit among partners to work with at community level, start implementation from Mubende and Kiboga

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Districts on a/c of already established networks, make a follow up / update of the progress of the tool, identify other partners to involve, have feedback mechanism to review the progress either annually or semi-annually. The team set a timeline for review to feedback between first quarter to fourth quarters of 2012, and scale up in year 2.

Plenary:

The day ended with a discussion on the need for each country to do a policy analysis and find out any gaps that exist so that the information will inform suitable adaptation of the toolkit. Country delegates shared with each other materials and tools already being used in their countries. Forum members agreed to each other updated on progress in the different countries and share opportunities for regional engagement.

3.6 SESSION FIVE: Models of service integration

Session Chair: Peter Mgosha (Tanzania)

3.6.1 ART FOR PREVENTION: WHY IS IT IMPORTANT FOR HIV/TB?

PRESENTER: REUBEN GRANICH

A power point presentation on ART in prevention of HIV and TB was presented by Reuben Granich. He shared the WHO statistics (2003-2011) which evidenced support for the use of ARTs as prevention of HIV transmission. He continued to explain that viral load was the single greatest risk factor for HIV transmission and that ARTs worked to lower this viral load down to undetected levels, making the risk of getting TB much and TB mortality much lower. He recommended ART for all HIV patients co-infected with TB patients regardless of CD4 count.

He discussed the importance of counseling and testing in a wide variety of settings, and the use of innovative campaign approaches to expand access; for example testing the public during an activity to distribute mosquito nets or food to community members. He stressed that the ideal goal is to move ART for all PLHIV to an earlier start time of CD4 cell count <500.

Plenary

One forum member raised concerns over the allegation that premature aging was a side effect of ART. After a lengthy discussion, forum members concluded that information on ART side effects was very limited given the fact that ARTs have not been around long enough to inform reliable studies on their long term side effects. Another question raised during the discussion was the level of engagement by WHO in developing ART guidelines calling for more involvement. Forum members were informed that updated WHO guidelines were still under development and when completed, countries would be allowed to adapt them to fit their needs.

The participants were challenged by the examples given of US, Zambia and South Africa that have developed their own ART guidelines beyond WHO recommendations.

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3.6.2 GROUP WORK: OVERCOMING INTEGRATED SERVICE DELIVERY CHALLENGES

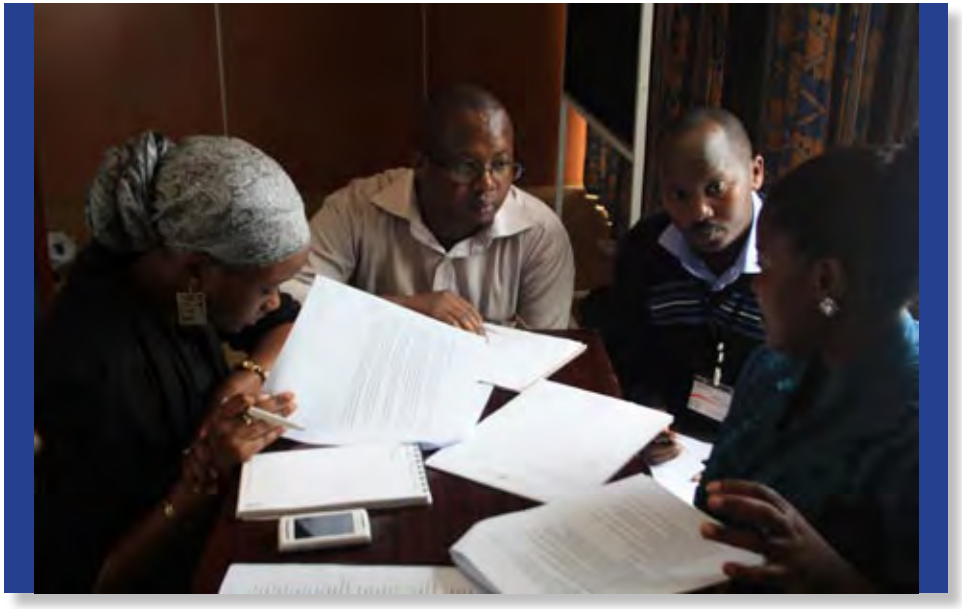
PRESENTERS: COUNTRY DELEGATES

BURUNDI

Country delegates listed challenges in ART integration as drug stock out, decentralization of services, task sharing and policy and long time for people in rural areas to receive CD4 count results. After discussion, the team came up with solutions to help alleviate these problems, that is, advocacy to shorten drug procurement procedures, to increase the number of CD4 count, advocacy for policy to allow nurses to initiate ART within policy, of facilitation of results transportation, for income generating activities and to build capacity in focusing (procedures in drug procurement)

UGANDA

Challenges listed by Uganda team during integration of ARTs were; lack of a universal access hence they are going to have problems integrating programs. Other problems listed included ART treatment rates having risen to 53.5%, failure of some government programs or suspension, sex workers is an issue, stock-out of medications and more. Their strategy was to put in place explicit policies, enhance service delivery at public health clinics, advocate for funding at the district level programs, address system issues, and introduce health literacy for community health workers and involve government bodies that are concerned.



A group of participants study the ARASA toolkit

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RWANDA

The Rwanda team described implementation of the One-Stop TB/HIV services. The team stated that TB/HIV national policy in Rwanda was developed, approved and disseminated in 2005. The National TB/HIV working groups were then established and meetings are held on regular basis. They said that TB and HIV technical manual and training materials had been revised to include TB/HIV chapter, and the recording and reporting tools revised to include information on TB/HIV. The group listed challenges to TB/HIV integration as problems in communication between the two traditionally vertical programs, difference in approach to site support, space, rotation of staff, lack of effective referral between TB and HIV programs, inaccurate recording and reporting of TB/HIV data and more.

TANZANIA

The group started by highlighting challenges faced by Tanzania during integration of ARTs; that is, high patient turnover, increased demand for commodities, lack of infrastructure, adherence maintenance, monitoring and evaluation issues, high administrative cost, and financial constraints to sustain the programs. The team's strategy was to increase medical professionals, have comprehensive care/treatment, involve the community and improve health facilities, monitoring and evaluation systems to include tools.

KENYA

Challenges encountered by Kenya during implementation of ARTs were presented by Ms. Lucy Ghati. The team listed challenges as resource or funding problems, patients not being able to access ARTs (Kenya is at 47% in ART coverage, yet with 140,000 new infections yearly), and most Kenyans not knowing their HIV status (Almost 80%). The Kenyan group discussed possible solutions to include innovative ways to get funding, ensuring availability and affordability of quality drugs, scaling up testing to put more people on ARVs to prevent transmission of HIV and utilizing inter-ministries opportunities to include counseling and testing.

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DAY FOUR

3.7 SESSION FIVE: Adapting WHO policy and guidelines to local environments Discuss strategies to enhance community mobilization for implementation of collaborative HIV/TB services and demand generation for the services

Session Chair: Faith Macharia (Kenya)

Forum started with a word of prayer by Dr. Kichari. Participants were asked to name a person or persons they knew had died of HIV related complications in commemoration of World Aids Day.

3.7.1 DEVELOPING STRATEGIES FOR PLHIV TO CALL FOR SERVICES AND GET MORE INVOLVED IN IMPLEMENTATION OF COLLABORATIVE/INTEGRATED SERVICES FOR TB AND HIV

Presenter: Francis Apina

A power point presentation on developing strategies for PLHIVs community call for services and getting involved in the implementation was presented by Mr. Apina. During the presentation, he discussed community's knowledge of their social fabric which created TB vulnerability. He stated that communities were not voiceless or powerless expounding that they are dynamic and autonomous, have an identity that needs respect, poses abilities beyond "the patient role" and understand TB beyond the microscope. Mr. Apina discussed strategies on how to get a the community involved in TB control, for example, getting the community involved in case detection, adherence to counseling and defaulter tracing, planning, implementation, evaluation and monitoring of the TB local response, fighting stigma associated TB and so forth. He also discussed advocating for a round table approach where everyone is an equal partner and how all key players could all get involved.

Plenary:

Group discussion focused on how to ensure civil groups did not duplicate interventions. It was agreed that before conducting an activity or intervention in an area, the CSO should find out what other interventions were already in place whether by civil groups or government groups. They encouraged collaboration between civil society and government to complement the others efforts.

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3.7.2 ADVOCACY STRATEGIES TO ENHANCE DEMAND AND IMPLEMENTATION

Community levels

GROUP 1:

The team members outlined their strategy as follows; to develop partnership and use the media to educate the communities, and then engage the communities at all levels.

GROUP 2:

Started by identifying areas that would need advocacy and service. Their strategy was to define the need, empower the people at the community and National levels, reaching the people who make things happen through dialogue, consultation meetings, use of media, and come up with a framework, have precise statistics.

GROUP 3:

Their strategy included strengthening the existing programs and interventions, formulating a single strong voice organization, synergizing civil society to help avoid duplication at the community level, signing the memoranda for TB/HIV from community perspective to represent affected groups in policy and decision making, mapping out existing interventions to see who was doing what, lobbying influential people at communities and using media.

Plenary:

Question of interest was how to deal with the issue of duplicating activities. Forum members agreed that civil groups needed to find out what other TB/HIV groups (CSOs and government) were doing in the area before providing service to avoid duplicating interventions. They discussed the importance of sharing the same message during advocacy to avoid confusion or division.

3.7.3 SHARING BEST PRACTICES:

What countries have done to generate user demand for services

KENYA:

Lucy Ghati presented a summary on what Kenya has done so far to enhance community mobilization. The Kenyan team shared with participants an overview of a project by NEPHAK and KELIN on incorporating rights based approach in community engagement in the control, management & care of TB. The project sought to encourage collaborative approaches between rights holders and duty bearers within local communities on issues of TB and HIV bringing together the judiciary, local administration, health care service providers, PLHIV and TB patients and survivors. The project succeeded in discouraging TB treatment defaulting and helped in addressing various other needs. The presentation also covered KELIN's initiative to train community organizations on TB/HIV and health rights associated legal issues.

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UGANDA:

Summary presented by Ms. Namata Kevin. The group explained how communication activities were being used to help mobilize communities for services. The Ugandan team stated that signs were used to show people where to go for service, and that several government officials would show up in these gatherings including district and provincial commissioners.

TANZANIA:

Summary presented by Mr. Dickens Eliasath. The team stated that Tanzania already has a curriculum for TB education and IEC materials for health care and community members. They said that the country has radio and TV programs, mobile health education, and voluntary counseling and testing for communities as well. In addition, volunteers who are former TB patients and PLHIV give testimonies in communities. The team listed groups of those sensitized to issues of TB and HIV including government leaders and traditional healers.

BURUNDI:

To enhance mobilization in communities, the Burundi team said they hold regular meetings and workshops to provide education on how TB/HIV issues. They explained their feedback mechanism where health care workers compile reports to send to health centers. However, they said that health care workers did encounter some challenges including shortage of material and financial support.

RWANDA:

The Rwanda team described how their community health workers help enhance mobilization in communities. They said that Rwanda has about 60,000 community health workers country wide. They defined them as health care volunteers, elected by village members. The team said that the volunteers were motivated through performance based financing. They further explained how each volunteer had a list of indicators they had to keep up with. For example, number of cases identified in a certain period of time, hand in reports in a timely manner, etc.

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4.0 RECOMMENDATIONS AND STRATEGIES TO ACCELERATE IMPLEMENTATION OF 3IS

COMMUNITY LEVEL	Make an Inventory of what is existing in the communities in regards to TB/HIV collaborative activities and activities around implementation of the Three I's Advocate for implementing partners including CSOs and NGOs to integrate TB in ongoing HIV programs Create awareness on the 3Is in TBHIV management including scaling up treatment literacy. Seek authority to involve stakeholders at policy level (both government and civil servants) Information sharing among stakeholders involved with TB and/or HIV starting with the Report from the Workshop Documentation for an evidence base response
NATIONAL LEVEL	Inventory on existing policy guidelines Engaging policy makers e.g. national TB and HIV Coordinating mechanisms, sharing the workshop report, seek audience for further deliberations Get buy in from community stakeholders on the ARASA toolkit for its country adaptation and harmonization with other similar existing tools if any and incorporating the gender dimension Share information for opportunities particularly to mobilize resource Involve media in TB issues as much as they are in HIV
REGIONAL LEVEL	Identify entry points for engagement within the EAC (Moses from Uganda to advice) Joint regional forums for experience and sharing e.g. KELIN/NEPHAK's initiative on community engagement Social media for continued interaction e.g. Skype hosted by KELIN (Use doodle.com, to help people respond within a certain time)
MONITORING & EVALUATION	Develop a simple tool (Reuben to share a template to be customized in line with report). It helps to find out what activities/indicators countries have completed, whether timelines have been met and what remains incomplete

5.0 WAY FORWARD AND CLOSING REMARKS

As a way forward the participants expressed their commitment towards the developed plan of action that would facilitate achievement of their recommendations on adaptation of WHO policy recommendations and localizing the ARASA toolkit.

Reuben Granich thanked KELIN for hosting the meeting. He urged the participants to remain focused on the timelines for the activities. He encouraged the participants to share within their national networks the outcome of the workshop and interest them in the advocacy agenda to accelerate implementation of 3Is I TB/HIV collaborative activities. He called upon them to hold each other accountable for the achievement of their set objectives.

6.0 METHODOLOGY

The workshop was conducted through power point presentations, dialogues, small group discussions, country discussions and skits. For discussion groups, participants were divided into

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three groups of approximately equal size. Tools used to guide group or country discussions included case studies accompanied by study questions to assist in focusing the discussion on specific issues. Every group discussion was followed by a plenary session, where groups reported on challenges and opportunities or strategies discussed.

7.0 CONCLUSION

The workshop was conducted successfully, with discussions and activities focusing on the objectives of the workshop. The participants' overall evaluation of the workshop conveyed that they were content with the discussants and the topics covered. The participants were confident that they would be able to carry out most of their recommendations within the minimal resources available to them. They felt more regional interaction was required to facilitate experience sharing and detailed interrogation of the best practices presented at the workshop. The major concern raised at the meetings was how to mobilize additional resources for the realization of the major recommendations targeting the broader regional advocacy.

All in all, the objectives of the workshop were met. The media coverage of the workshop helped to draw attention to the objectives of the workshop and the broader agenda of the need to accelerate implementation of the 3Is. The participants look forward to a follow-up workshop in Rwanda in 2012.

Faith Macharia (National AIDS Control Council) guides the participants in discussions on the way forward

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APPENDIX 1: WORKSHOP AGENDA

BACKGROUND

As resource-limited countries increase efforts expand their HIV treatment and care programmes, TB remains a major threat to the significant health benefits achieved with such scale-up. Among people living with HIV, TB is the most frequent life threatening opportunistic disease, even in those receiving antiretrovirals, and it has been shown to be a leading cause of death. Prevention and treatment of TB in people living with HIV is an urgent priority for both HIV & AIDS and TB programmes. The Three I's, Isoniazid preventive treatment (IPT), intensified case finding (ICF) for active TB, and TB Infection Control (IC), are key public health strategies to decrease the impact of TB on people living with HIV.

- TB preventive therapy with INH is safe and effective in people living with HIV, reducing the risk of TB by 33–62%
- Screening and diagnosing TB in people living with HIV can be challenging but TB is curable in people living with HIV
- TB infection control is essential to keep vulnerable patients, health care workers and their community safe from getting TB.

Despite the considerable benefits, The HIV and TB community, have not "owned" the Three I's agenda and have thus been slow to implement these TB-reducing services resulting in missed opportunities to prevent many unnecessary cases of TB related deaths.

WHO in collaboration with the Kenya Legal and Ethics Issues Network on HIV and AIDS (KELIN) and the AIDS Rights Alliance of Southern Africa (ARASA), will host a workshop to strengthen the capacity of civil society advocates, senior government officials and organizations of people living with HIV to engage effectively in advocacy for improved access to HIV and TB prevention, diagnosis and treatment services within the region of East Africa.

OBJECTIVES

The four day advocacy workshop will familiarize participants with the 2011 WHO Guidelines for intensified TB case finding and isoniazid preventive therapy for people living with HIV in resource constrained settings.

The meeting will have the following specific objectives:

- Overview of the WHO TB/HIV collaborative activities policy, global and local situation and current implementation and challenges
- Introduction to the WHO Guidelines for intensified TB case finding and isoniazid preventive therapy for people living with HIV in resource constrained settings (Three Is for

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HIV/TB - intensified TB case finding, isoniazid preventive therapy and infection control for TB)

- Introduction to the ARASA/WHO toolkit for HIV/TB
- Introduction to models of integration of HIV and TB services
- Develop better understanding of the concerns and needs of the community around HIV/TB and how best to respond to these needs.
- Network with each other and build momentum to catalyze implementation of a fully integrated approach based on the needs of people in their countries and regions.
- Discuss strategies to enhance community mobilization for implementation of HIV/TB services and demand generation for the services.

APPENDIX 2: LIST OF PARTICIPANTS

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APPENDIX 3: TIMETABLE

MONDAY, NOVEMBER 28, 2011

OPENING AND GENERAL OVERVIEW		
TIME	**SESSION**	**PRESENTER**
08:30-09:00	Registration, informal introductions & tea / coffee	
09:00-09:15	Opening of workshop and Welcome remarks: Government: Ministry of Public Health and Sanitation Civil Society: TB Action Group	Dr. Joseph Sitenei, DLTLD Lucy Chesire
09.15-09.30	Participants introductions and Climate setting, expectations of participants	Mr. Allan Maleche, KELIN
OBJECTIVE 1: OVERVIEW HIV & TB - HISTORY, CURRENT GLOBAL AND LOCAL CONTEXT SESSION CHAIR: LUCY GHATI (KENYA)		
09.30-09.45	HIV & TB: History and current global context	Reuben Granich, WHO
09.45-10.00	HIV & TB: specific challenges in prevention, diagnosis and treatment for people living with HIV – Patients perspective	Lucy Ghati NEPHAK
10.00-10.15	HIVTB: specific challenges in prevention, diagnosis, treatment for people living with HIV – Clinical perspective	MSF – France
10.15-10.50	TB & HIV situation in East Africa, implementation of HIV&TB services and operational challenges (7 mins per presenter) Sighting an in-country model of Best Practice in TB and HIV services integrated delivery	BURUNDI KENYA RWANDA TANZANIA UGANDA
10:50-11.00	Plenary (Q & A)	ALL
11.00-11.30	**Coffee break**	
11.30-12.45	General contribution and discussions: Challenges in prevention, diagnosis and treatment for people living with HIV	ALL
12:45-14.00	**Lunch**	
OBJECTIVE 2: INTRODUCTION TO THE 2011 WHO GUIDELINES FOR INTENSIFIED TB CASE FINDING AND ISONIAZID PREVENTIVE THERAPY FOR PEOPLE LIVING WITH HIV IN RESOURCE CONSTRAINED SETTINGS. SESSION CHAIR: (UGANDA)		
14.00-14.30	Intensified Case Finding: recommendations, overcoming challenges	George Apina, NETMA
14.30-15.00	Plenary (Q & A)	ALL
15.00-16.00	Case Study: Implementation of Intensified Case Finding	Group work

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16.00-16.30	Presentations by groups	ALL
16.30-17.00	General contribution and discussions	ALL
17.00-17.20	**Wrap up Day 1 and Coffee break**	

TUESDAY, NOVEMBER 29, 2011

OBJECTIVE 2 (CONTINUED): KEY ISSUES: INFECTION CONTROL, IPT
SESSION CHAIR: BURUNDI

TIME	SESSION	PRESENTER
08:30-09.00	Interactive review of day one	Tanzania
09.00-09.30	Infection Control for TB: recommendations, overcoming challenges	Evelyn Kibuchi, KANCO
09.30-10.00	Plenary (Q & A)	ALL
10.00-11.00	Group work: How would you implement infection control measures in care and other congregate settings	ALL
11.00-11.30	**Tea/Coffee Break**	
11.30-12.00	Presentations by groups	ALL
12.00-12.30	Isoniazid preventive therapy: recommendations, challenges	Nelson Otwoma NEPHAK
12.30-13.00	Plenary (Q & A)	ALL
13.00-14.00	**Lunch**	
14.00-14.30	Rights Based Approach to TB and HIV: Principles and Challenges	Allan Maleche; KELIN
14.30-15.30	Case Study: RBA in HIV and TB	ALL
15.30-16.00	Presentations by groups	ALL
16.00-17.00	General contribution and Discussions: Summarizing Identified gaps in the HIV & TB response	ALL
17.00-17.20	**Wrap up Day 2 and Coffee break**	

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WEDNESDAY, NOVEMBER 30, 2011

OBJECTIVE 3: ADAPTING WHO POLICY AND GUIDELINES TO LOCAL ENVIRONMENTS SESSION CHAIR: (TANZANIA)		
08.30-09.00	Interactive review of day two	Uganda
09.00-09.30	ARASA Example: Introduce HIV/TB toolkit for Three Is How Zambia has adapted the toolkit	Paul Kasonkomona, ZAMBIA
09.30-10.00	Plenary (Q & A)	ALL
10.00-11.00	Group work: Adapting policy recommendations and Localizing the toolkit to Country context	(Country delegations)
11.00-11.20	**Coffee Break**	
11.20-12.00	Presentations by groups (7 mins per presenter)	BURUNDI KENYA RWANDA TANZANIA UGANDA
12.00-13.00	General contribution and Discussions	ALL
13.00-14.00	**Lunch**	
OBJECTIVE 4: MODELS OF SERVICE INTEGRATION SESSION CHAIR: (RWANDA)		
14.00-14.30	ART for Prevention: why is it important for HIV/TB?	Reuben Granich, WHO
14.30-15.00	Plenary (Q & A)	ALL
15.00-16.00	Group Work: Overcoming integrated service delivery challenges	(Country delegations)
16.00-16.30	Presentations by groups	ALL
16.30-17.00	General contribution and Discussions	ALL
17.00-17.20	**Wrap up Day 3 and Coffee break**	

THURSDAY, DECEMBER 1, 2011

OBJECTIVE 5: DISCUSS STRATEGIES TO ENHANCE COMMUNITY MOBILIZATION FOR IMPLEMENTATION OF COLLABORATIVE HIV/TB SERVICES AND DEMAND GENERATION FOR THE SERVICES SESSION CHAIR: KENYA		
08.30-09:00	Interactive review of day three	Burundi
09.00-09.30	Developing strategies for PLHIV to call for services and get more involved in implementation	Paul Kasonkomona, ZAMBIA

09.30-10.30	Group discussion: General discussion on Advocacy strategies at National and Community level	ALL
10.30-11.00	Presentations by groups	ALL
11.00-11.20	**Tea/Coffee Break**	
11.20-11.45	Best practices for generating user demand for services Five participants should be selected (in advance) to give 5 minute oral presentations on what they have done to enhance community mobilization	BURUNDI KENYA RWANDA TANZANIA UGANDA
11.45-12.00	Plenary	ALL
12.00-13.00	Group work - develop a strategy for how you can generate demand for services through your networks? How will you mobilize your community? What are the key messages you will use? Next steps or actions by country delegation	(Country delegations)
13.00-14.00	**Lunch**	
	WAY FORWARD SESSION CHAIR: KENYA	
14.00-14.35	Report back from group work (7 mins per group)	ALL
14.35-15.00	Reflections of participants in relation to expectations Reflections from WHO Summary and next steps	ALL Reuben Granich Melba Katindi
15.00-15.20	Close of Workshop: National AIDS Control Council, Ministry of Special Programmes	Faith Macharia NACC
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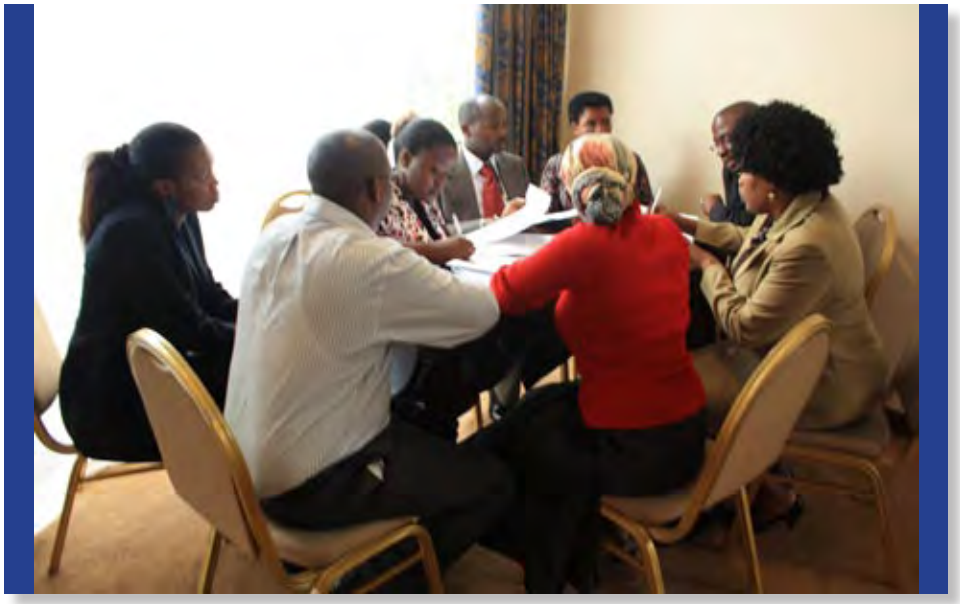

Participants finalize the plan of action that would facilitate achievement of their recommendations

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