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**2007 HIV/AIDS Implementers' Meeting:
Preventing Mother-to-Child Transmission
Mothers2Mothers and Public-Private Partnership
for Preventing Mother-to-Child Transmission in Africa
PEPFAR, The Global Fund to Fight AIDS, Tuberculosis
and Malaria, UNAIDS, UNICEF, The World Bank, WHO, GNP+
June 18, 2007**

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[START RECORDING]

SHANNON HADER: I'm Shannon Hader. I'm with the PEPFAR Program at the Office of the Global AIDS Coordinator in D.C., and it's my pleasure to welcome you here this morning.

I'd like to start with a few important housekeeping announcements. Just as a reminder that I'll tell you a couple times during the session, because of the limited time in the plenary, we have an extended period for questions and answers to the plenary speaker. That will be held in Jolly [misspelled?] Two, immediately following this session. Par usual now, we will have the lunch round tables available at all three lunch locations. Any presenters for today or tomorrow who have not yet loaded their presentations, please remember to proceed directly to the speaker ready rooms after the session to get your presentations loaded up and ready to go for your session.

And very importantly, as it quiets down, I want to emphasize the pink sheets that are sitting on all of your chairs. These are our surveys and evaluations of the meetings so far, and these are critical to our being able to take your input from this experience and apply it to the planning for next year's meeting. So, if you can, please carry with you today, please fill it out and at every site,

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there is a drop box for your pink evaluations. And if you have any left from previous days, please bring them along and go ahead and turn them in as well.

Now with that, I would like to go ahead and invite up to people to make a very special announcement. Dr. Thomas Kenyon of the Office of the Global AIDS Coordinator and Dr. David Akubi of the National AIDS Council of Uganda, if you'll please join me at the podium.

DR. THOMAS KENYON: Good morning. It's difficult to believe that tomorrow will be the last day of the 2007 Implementers' Meeting. Putting this meeting together is a true partnership and, on behalf of PEPFAR, I'm pleased to announce, along with my colleagues from the Global Fund, UNAIDS, UNICEF, The World Bank, WHO and the Global Network of People Living with HIV, that the 2008 Implementers' Meeting will be held in Kampala, Uganda.

[Applause]

I'm going to ask my colleague, Dr. David Akubi, the director general of the Uganda National AIDS Commission, to make a few remarks.

DR. DAVID AKUBI: Thank you, Tom. I just want to make you dream between now and when you come to Kampala. I just want to say one thing, those of you who have never been there, Sir Winston Churchill after the Second World War, came

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up from Umbasa on the train. And he had never been to Uganda, and you know, the train lumbers and lumbers and lumbers uphill, and uphill through the Rift Valley, the Eastern Rift Valley. And when it reached Kampala, he could not believe his eyes. He said, "I have found the power of Africa." So you're welcome to the power of Africa, and please dream about it and God bless you.

SHANNON HADER: All right, well, with a vision towards the future, it's my pleasure to start today's presentations.

Our first presentation will be Mr. Gene Falk, and the title of his talk is "Mothers2Mothers, 'Soul City' and Lifeline, a Public/Private Partnership to Increase Awareness about MTCT." Now, Mr. Gene Falk is the executive director and co-founder of Mothers2Mothers and he brings an unusual background to his role. After receiving his MBA from Wharton [misspelled?], Gene spent many years as a senior executive in the media industry, overseeing the start-up of new businesses for companies including HBO, MTV and Viacom. Three years ago, he decided this is where the action is and he moved to South Africa to apply his management background to the battle against HIV and AIDS.

[Applause]

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GENE FALK: Good morning, thank you very much and thank you to all the organizers for what has been an incredible event. I wanted to start with the background on PMTCT, but I think over the last few days we've heard so much, it doesn't require a lot of detail. A couple of highlights, just to remind us all: There are 700,000 children who become infected with HIV each year, 1,800 every day. That's 15-percent of all the new HIV cases that are kids. And nearly all of those kids are in the developing world. I could cite more stats, but over the last few days, you've heard not only all about PMTCT, but just about how frustrated everybody is because we know how preventable it is. Over the last few days the frustration has been tangible, particularly so because we know that the obstacles are things we can tackle. The medical obstacles and logistical obstacles have been discussed in some detail.

I'm here to talk today about the psychosocial hurdles, about the reasons that women who have the opportunity to receive PMTCT frequently don't take advantage of that.

And that's where Mothers2Mothers comes in. Mothers2Mothers is about making PMTCT programs more effective. We focus on testing to increase the number of women who are accepting testing, on increasing the number of

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mothers who receive PMTCT, helping women to choose and adhere to safer feeding choices, and providing a bridge to ARVs, and to other health programs for mothers and for infants.

Our program starts at the grassroots, where we draw on the most underutilized resource in the developing world - that is, women. The program model is built on our mentor mothers, HIV-positive mothers, who themselves have been through PMTCT. They're hired, they undergo extensive curriculum-based training and then they go back to the clinical facilities where they receive PMTCT treatment to serve as pure educators. They provide education, information and support to women just like themselves. And they help to empower these women in order to help them overcome the psychosocial obstacles to PMTCT, particularly issues around stigma and disclosure. We employ over 400 women who are currently living with HIV/AIDS, and I emphasize the word "employ." We philosophically believe people should be paid for the work that they do, and we also believe that paying them is not only good for them, it's good for the program.

The good news we're having is that we're making some headway. According to a recent quantitative analysis conducted by the Horizons Program of the Population Council, and funded by USAID, it found that M2M is having a significant impact on PMTCT services. The details are in a

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poster in the tent across the way. But to give you some top-line, 95-percent of the mother's studied received Nevirapine, 88-percent of their babies received Nevirapine. Seventy-nine-percent had their CD4s count taken during pregnancy, and 88-percent knew the results of those tests. Eighty-nine-percent chose exclusive infant feeding methods, and in disclosure, 97-percent had disclosed to their friends or their partners, which was 4.4 times more likely, than among the non-participants.

We've come a long way since we started in 2001, when my colleague, Dr. Mitch Fesser [misspelled?], who is out there somewhere, initiated a small counseling program in a couple of clinics in Cape Town. We are now in four provinces in Cape Town, with over 100 sites. And in our first venture outside of South Africa, we launched 10 sites last month in Lasutu.

Looking forward, in the next 18 months and primarily with the help of USAID and PEPFAR, we'll be nearly doubling our reach in South Africa, and launching 100 to 150 additional sites in Kenya, Zambia and Rwanda. And we're also in conversations to initiate service in other parts of sub-Saharan Africa.

In South Africa, we're about to extend our model and our activities in another direction using television and

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telephone, to encourage women to seek out PMTCT. The story starts with "Soul City." It's an incredibly popular television show in South Africa, the second most highly viewed show in the country. It works within the conventions and the format of a soap opera, and it combines them with a sophisticated approach to public education. At the end, it delivers an incredibly entertaining program, that's also very educational.

When the new season begins to air in August, M2M will be part of the story line. The season will have a number of educational focuses. One of the highlights will be PMTCT. And the vehicle for the PMTCT discussion is a very popular character, one of their most popular characters named Connie. She's an openly HIV-positive young woman. And interestingly, she's played by an openly HIV-positive actress. In this season's episodes, Connie comes to work for Mothers2Mothers and confronts many of the issues that you would expect someone to see when they're working with HIV-positive pregnant women, who newly found out their status.

They haven't finished filming the season yet, but I would like to try to show you, and try, I will emphasize, a very rough clip here. It's not edited, the sound stinks, but then again, the dialogue is in Sutu, so for most of us, it

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wouldn't matter very much. I will give it a try and it is subtitled if it works. There we go, sound, please.

[Video plays]

That's the first scene when Connie meets with the clinical staff and introduces the notion of Mothers2Mothers to them.

This is clearly an opportunity to reach a huge number of people with information that they might otherwise never have access to. But we also realize that this story line provides a springboard, it might be an opportunity to reach people on a more individual basis also. We began to consider the notion of a telephone line where women could call and talk about issues involving PMTCT, speaking with women just like themselves who had been through the process. In other words, just like what happens at a Mothers2Mothers site.

We decided to go and pursue the idea of an M2M phone line, and to do this, we started working with a couple of very, very important and wonderful partners, who helped us through this process. The first is The Dialogue Group. They come from the private sector. We have a long relationship with them, they've helped us out in many ways, and they're a leading international telemarketing firm that runs call centers throughout South Africa and the U.K.

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Second is Lifeline, which is an NGO that operates the South African HIV/AIDS help line among other projects. Now, working with Lifeline, we realized that it was important to us, if we were going to do an M2M hotline, it had to stick with the M2M model. It had to retain the power that comes with the expert implementers on the phone, being mothers with HIV themselves. Now, as you can see from the picture here at Lifeline, the counselors are kind of unlikely, at least this group of counselors is highly unlikely, to ever become mothers.

So we started thinking about another way to do this. And when "Soul City" goes on air in August, not only will M2M be featured prominently within the story itself, but on air and through their off-air promotion they will also feature and promote the M2M hotline for pregnant women, new mothers and other women who have questions about HIV, their babies and their status.

There will be a phone bank overseen by one of our senior site coordinators and staffed by four of our former mentor mothers, acting in a new role as phone mothers. Just like at the site, they'll provide education, information and support. When a woman calls, she'll be able to talk to somebody who not only can give her the information she's

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asking for, but who can also share the very special perspective of her own experience.

All of this is with the intention of talking to women and getting them to go for testing and enrolling in PMTCT. We'd like to thank all the partners in the public and the private sector, who are making this possible. The Dialogue Group will also engage a number of their private sector partners, including Evastat, BusCall and Telecom, Lifeline and their HSA, South Africa AIDS Hotline, which is funded by the South African Department of Health and, finally, "Soul City." I shouldn't say finally, because last but not least, our favorite partners PEPFAR and USAID. Yes, this is a blatant whatever. But seriously, we want to thank PEPFAR and USAID, not just for underwriting our call center, but for the amazing support, that makes possible so much of the work that we've been able to do, and that we'll be doing in the future.

To close, it would be wrong to tell this story without hearing from some of the women themselves. The best way of telling our story is to listen to mothers, and we had hoped to bring a mother, one of our site coordinators, here to actually speak to you guys. However, the airplane arrangements, as some of you may have encountered, proved to be challenging. So instead we wound up with a clip, and I hope this gives you some sense of what happens in our sites.

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First you'll hear from one of our site coordinators, and then you'll see a new mentor mother who has just given birth and she'll tell her story too.

[Video plays]

Thank you all very much for your time.

[Applause]

SHANNON HADER: Wow, so I think we heard a lot about telephones on the first day of the conference. Now we've heard about telephones not just transmitting data, but with a human being on the other end, that can transmit not just information, but personal care. So I'm seeing a really bright future for expansion here.

It's my pleasure to introduce Dr. Teguest Guerma, who will chair the next speaker session. Dr. Guerma is currently the associate director of HIV/AIDS Department in WHO Geneva, and she has more than 20 years' experience in HIV/AIDS in Africa and Asia at country, regional and global level. She's also been incredibly instrumental and involved in the WHO 3X5 process, and therefore is a very appropriate person to introduce one of our next big challenges, TB/HIV.

[Applause]

DR. TEGUEST GUERMA: Thank you, Shannon, for the introduction. Good morning, everybody. As most of you know, TB and HIV are closely connected. About 200,000 living with

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HIV/AIDS die of TB every year, and most of them live in Africa. Globally, 40 million people are co-infected with TB and HIV. HIV is also one of the main reasons for failure of reaching the TB targets. Because of all these facts, TB and HIV problems should work together at all levels.

Countries have been implementing HIV/AIDS and TB collaborative activities, based on the WHO policy guidance. But this has been done only on adult [inaudible] on pilot basis. It is now time to scale up the TB/HIV collaborative activities nationwide. With us to present the experience, challenges and lessons learned of TB/HIV collaborative activities, that we have today with us, Dr. Chakaya Jeremiah Muhwah from Kenya. Dr. Muhwah is a medical doctor and an internal medicine and lung medicine specialist. He has more than 15 years' experience in TB care, control and research. He has occupied the position of National AAPB program manager from 2003 to 2006. He is also the chair of the Dote [misspelled?] Expansion Working Group, and he's the vice chair of the coordinating mode of the Stop TB Partnership. He's also a member of the TB Strategic and Technical Advisory Group. Please join me to welcome Dr. Chakaya Muhwah.

[Applause]

DR. JEREMIAH MUHWAH CHAKAYA: Thank you very much.

First, I would like to thank the organizers of this meeting,

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for giving me the honor to speak at this great meeting. I will then, over the next 20 minutes or so, share my personal experience and the experience of Kenya in trying to get TB/HIV collaborative activities moving. As part of this presentation, I will share with you our battle of TB and HIV in Kenya. I will then share with you some aspects of TB/HIV link. We will examine the achievements that we have gained in the last few years in Kenya in time for TB/HIV [inaudible] provision. We will try and examine the reasons for those achievements, and also discuss a little bit the reasons that - constraints and weaknesses, that we are facing currently. I do understand that the MDR-TB and XDR-TB and HIV are topical issues, so we will try and discuss those a little bit. And we will sum up with [inaudible] and make some conclusion. But first, the battle of TB and HIV.

Many countries in Africa, including ours, were in the '80s and in the '70s and '80s seeing a very stable TB disease incidence. Then in the 1990s, the amount of TB that countries started seeing escalated quite a bit. In Kenya, we started seeing a major rise in TB in round about 1991 and 1992. And we kept on seeing more and more TB until about two years ago, when we saw a little bit of a flattening of the curve up there, and we don't know exactly what is happening. This is not something that is only happening to Kenya alone.

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We have noticed it in other African countries. It may be something related to the HIV epidemic coming down a little bit, or maybe there are other factors related to this likely drop in the incidence of TB that has happened over the last few years.

In Kenya, like in many other African countries, the HIV prevalence also went up all the way from the 1990s and peaked about the mid-'90s and started coming down. Currently, it's estimated that about 6-percent of adult Kenyans are HIV-infected, giving an estimate of about 1.2 million Kenyans who are living with HIV. And about 260,000 of those are in need of antiretroviral treatment.

So what is the link between TB and HIV? This slide shows you what has happened with TB and HIV. As the HIV prevalence started going up in the adult population, TB also started going up so we had a twin epidemic, like in many other parts of sub-Saharan Africa. But you do notice that the HIV prevalence has been going down in the adult population in many parts of Africa, but the TB rates are still going up. And therefore, we really do not know how far up they will go and what other factors may be driving the TB epidemic to continue going up, despite a declining HIV prevalence.

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There is a lot here that we all are aware of that as you reduce your HIV rates, because the dynamics of TB transmission are different from those of HIV, you will probably continue seeing a bit burden of TB, which hopefully will come down as we apply the interventions, but it has been well described.

Because of the HIV/TB link, the World Health Organization put out this very important document in 2004, which we called "The Interim Policy for TB/HIV Collaborative Activities." And this is very critical for all of us to understand and for all of us to try and implement. The interim policy despite 12K [misspelled?] interventions, the first set of interventions were led to mechanisms for collaboration and coordination, including the formation of coordinating bodies at all levels, surveillance for TB prevalence among TB patients during planning and during monitoring and evaluation.

The second set of interventions relate to our decrease in the burden of TB in people living with HIV, and includes activities related to intensified TB case finding, the treatment of latent TB infection and infection from [inaudible] health care centers and congregate settings. By the last set of intervention relates to the decrease of burden of HIV in people with TB, so HIV testing and

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counseling provision are put in [inaudible] and preventive therapy and antiretroviral treatment.

Now, these interventions cannot be taken on by only one program. It must be both programs taking up these interventions. So TB control program must do their part and HIV control program must do their bids. In terms of who takes the lead for which intervention, this might vary a little bit from country to country. But for me, I think B. [misspelled?] decreasing the burden of TB in people living with HIV, should really lie and rest heavily on the HIV control program while the TB control program takes care of decreasing the burden of HIV in TB patients. I think that, to me, would make a lot of sense.

So what have we achieved in K [misspelled?] in terms of TB service and provision over the last few years? I think I could stop at this chapter, after this line, because this I think for me is the most important slide showing you what we have done over the last few years in Kenya. We started recording and reporting all our TB/HIV indicators in the 3rd quarter of 2005. And at that time, the HIV testing rates stood at about 30-percent and the HIV prevalence in our TB patients was something like 60-percent.

We have increased remarkably, I must say, the HIV testing in TB patients, so that by the end of the last

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quarter, by the end of 2006, more than 64-percent of our TB patients were getting the HIV tests. As we expanded our HIV testing, we have noticed that the HIV prevalence in our TB patients has been going down. So we started off with 60-percent of our TB patients being HIV-positive, and currently less than 50-percent of our TB patients are HIV infected. So by the last quarter of 2006, 49-percent of our TB patients were HIV-infected.

As far as provision of prophylaxis or preventive therapies are concerned, when we started recording and reporting what we were doing with our TB patients, about 60-percent of our TB patients were being, HIV-infected TB patients, who were being provided with Cotrimoxizole. And we rapidly moved on and managed to get more than 85-percent of our TB patients to receive Cotrimoxizole, and that has remained flat over the last few quarters, so that currently about 85-percent of our TB patients who are also HIV-infected are receiving Cotrimoxizole for the prevention of opportunistic infections.

What you notice, however, is that the antiretroviral, the proportion of TB patients who are HIV-infected were receiving antiretroviral treatment has not changed much. We started to offer it about 25-percent and it does remain at about 25- to 29-percent, and is not moving very much. So one

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would want then to examine the reasons why antiretroviral treatment is not being provided to a greater proportion of TB patients who are HIV-infected. And the reason that I put at this light here is to show you one little thing, that in terms of TB treatment centers, we had, by the end of 2006, 1,800 sites or more where people with TB could access their anti-TB treatment, as opposed to antiretroviral treatment sites, which were only standing at about 320 by the end of 2006.

So this means that TB control services or TB services have been decentralized to very, very pitiful health care units, but the antiretroviral treatment sites have not yet decentralized to the same extent. And we want to believe that that may be the major reason why a lot of TB patients are HIV infected and not yet receiving antiretroviral treatment. This just shows you the expansion of ART sites in our country. We started with only five pilot sites in 2002, and by March this year, we had more than 348 sites, providing antiretroviral treatment.

In terms of patients, we started with about 10,000 patients in 2004 and currently more than 124,000 patients are receiving antiretroviral treatment. Out of these, about five of them are TB patients, about 30-percent of these patients are TB patients.

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Now, coming back to look at the reasons that made us achieve, what I would consider, remarkable results in terms of HIV testing and provision of Cotrimoxazole. What are the kinds of things that we did to make these results possible? I think one of the key landmark things that happened in Kenya is policy setting, a political will and policy setting for HIV testing in clinical settings.

Before 2004, all our TB patients were being referred to the city sites for HIV testing, and there were a lot of drop-outs. But in 2004, the Minister of Health Care came out with a policy document on HIV testing in clinical settings, which emphasized one thing which I would also like to emphasize here. It said that if you don't offer HIV testing to persons presenting with an HIV-associated illness, then you are providing, as a clinician, sub-standard care. That statement was extremely prominent in that document and it made a lot of difference. No clinician, if there are any clinicians here, no clinician wants to offer sub-standard care. So when we started training people and saying, if you don't do an HIV test, that is sub-standard care, it became something that people did not want to do. And it really paved the way for rapid scale-up of what we call diagnostic counseling and testing, or what people initiated HIV testing with an opt-out option. I think that was a major, major

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event that really, really paved the way for a lot of testing of TB patients.

The revision of the TB recording and reporting system was another landmark event. We started doing this in 2004 and completed this exercise in 2005 and distributed new registers to all our TB treatment sites, by the third quarter of 2005. And the new registers had one or two, TB/HIV indicators were very important, TB/HIV indicators which included whether HIV tests had been performed or not, whether people had been given Cortimoxizole preventive therapy or not, whether they had received ART or not. And also included something that we have not used, which is with a [inaudible] had been carried out or not.

Now the beauty about this is that with time, it will be possible for us to try and analyze outcomes of our TB patients, based on whether they were HIV positive or negative, whether they were give Cortimoxizole or not, whether they were given antiretroviral treatment or not, and whether they [inaudible]. So these are the kind of data that we are collecting now that we should be able to use as time goes by.

What are some of the other factors that were important in getting us to move with our TB/HIV status provision? I think one of the critical things was political

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win and leadership, the NLTP, with support from our sister program, the HIV program, because it's the newer program, so we want to call it our sister program to this, to HOT and provided the requisite push for these activities to happen. But I think very critical is that we were provided with finances to be able to do all the things that we needed to do. Some of the things that we needed to do were to carry out those activities.

If any of you funded us and you are not in that list, please forgive us. Some of us tend to be a little tight when we are doing some of these presentation, so we recognize everybody who funded us during this activity. Particularly PEPFAR and Global Fund, because PEPFAR and Global Fund allowed us for the first time to get many other people to get involved in TB/HIV, so [inaudible] involvement became possible with this funding, which stimulated civil society involvement, private-sector involvement [inaudible], and that was extremely important.

You cannot provide any service to any great extent or to any quality if your health care system is weak. And we know that most African health care systems are weak, so of course the question needs to be asked whether in fact we did strengthen our health care system during this particular exercise. And for me as a program manager, there were a few

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a simple things that I was concerned with, and one of them was human resources for health, looking at staff numbers, training and technical support and motivation. Looking at health physical infrastructure like buildings and equipment and consumables and health care management.

And I can tell you there are four simple things made my gray hair triple within a year, because they're actually very tough things to get done. So what did we do? If you look at the human resource issues in Kenya, there's been two exercises that were carried out between 2004 and 2006. The first was a human resource verification exercise, which was carried out by the Minister of Health in 2004. And what this exercise revealed is that number one, there were people who were receiving salaries who were not there, what the Kenya government calls "ghost walkers." So, by getting rid of those ghost walkers, we had more money to potentially employ additional people. But, it's also told us that there were deficiencies, in terms of numbers or the people we needed, to carry out health care service provisions. So additional doctors and nurses that we require to be able to make staff needs.

The second exercise that we need was the Partners for Health [inaudible] of 2006, which looked critically at the amount of people who were there, who will be able to offer

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services that would reach the PEPFAR and DG [misspelled?] targets. And I'm not going to go through this to tell you how many nurses were required and what have you. The key thing that I want to tell you is this, that there were disparities in human resource distribution. The dispensary is the most critical or rather close to the patient health care facility, but it the one that is most under-resourced in terms of people.

People tend to like to walk in the cities rather than in the rural areas and, of course, if you come from a highly agricultural potential area, you are more likely to have a lot more people walking in those areas than in semi-arid areas.

So what did we do as a program to try to get our human resource issues sorted out? This was difficult. By the time I took over as the program manager in 2003, there were actually, there was no possibility of recruiting people into the government to help the system, because I think the word would be a moratorium on employment. We couldn't get people in, so we had to use some crazy mechanisms to get people in, and we were lucky that we were among the countries that were selected to be the first entire conference for the intensive support and action countries or ISAC which was an initiative of the structure and partnership. And, of course, we had

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PEPFAR, which allowed us to get additional coordinators to stimulate action for TB/HIV in a few TB/HIV burdened countries.

We were able to train people in all our districts, we provided technical support through development of guidelines and checklists, we provided targets – and this is the key thing. Every service delivery point was provided targets for TB/HIV and all other targets of telephone [inaudible], this was extremely important. Of course, we provided finances for regular technical support and from the teams that were able to move around in the country to stimulate action, and we did receive technical support from external agencies like WHO, KCV and CBC.

In order to try and get the most out of our existing stuff, we knew we had one problem, which was a motivation problem. We had done studies that showed that health care staff in Kenya were highly demotivated, and therefore we wanted to get the best out of our health care staff. And there were two things that we thought would be important, and that was recognition and setting up competitions among our healthcare staff. This was not anything new. The Malawians have done it before and published their data in the *International Journal of TB and Land Diseases*. So we wanted

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to imitate what they had done, but be it a little bit differently.

So we started off with what we called our fast performance. It was in March, 2004. And here were the individuals, so the person that you're seeing in this photograph is the provision team, the leprosy coordinator, who we thought had done the best job in 2004.

The following year in 2006 we switched into teams because we thought that teamwork was much more important than individual work, so here we had the winning programs, for example, being awarded by the assistant minister. Here we have the winning facility being awarded something by a prominent physician in our country.

Did we plan and coordinate well? Yes, we set up our coordinating committee upper levels, and we believe at this moment in time that the National Steering Committee, which is a marker stick for that unit, is working very well, but we don't know how well the provision and district committees are working. We have been trying and are still trying to get a lot more joint planning between TB and HIV, and we are trying as much as we can to joint money [inaudible] to go on. We have one referral system, but we haven't evaluated how well that is working.

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The elements of the interim policy that we may not have done very well, and I think there is one that we did not do very well, which is decreasing the burden of people of TB and people living with HIV. Intensified case finding, TB prevented therapy and infection from [inaudible], these are elements that are difficult to carry out at the program level and we haven't done much with them. But we did not sit back, we decided this year in May to sit down as a country and look at ways and means in which you can stimulate action in this particular area.

And looking at [inaudible] for example, this was the most difficult thing, and the country has decided that this will not be implemented nationwide, that it will only be implemented in selected cities, which we can discuss a little later. As far as intensive case finding and infection control is concerned, we want to go, we are ready to go, but we do need to develop a few things like, for example, refinement of intensive case finding tool and adoption or adaptation of International guidelines and things like that, for infection control.

So, in summary, we have made some good progress with HIV testing of TB patients, and we have noticed that as we expand testing, HIV prevalence tends to decline. We're still unhappy that up to 15-percent of our TB patients are HIV

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infected and may not be getting a simple intervention called Cortimoxizole. And we are not doing as much as we should do with ART, and maybe because of lack of decentralization.

Now, to finish off, I'll talk a little bit about MDR- and XBR-TB. This was highlighted, as many of you know, by this report that came out on the World's XBR-TB day last year.

And the South African experience with MDR-TB and XBR-TB has been extensively reported. We know that it's young patients were involved, that about 50-percent of them had not previously been treated for TB, which means that there were probably new infections, and that many of them had had contact with the healthcare system. Many of them are HIV-positive, and the death rates were very high.

But the lessons that the TB community has learned out of this experience in South Africa is that MDR-TB and XDR-TB is basically a consequence of sub-optimal TB control. And that if HIV-infected persons, because of the fact that they tend to use health care services more, are at risk of acquiring TB, including MDR-TB and XDR-TB. And that when they do get XDR-TB, the outcomes tend to be very poor, and inadequate infection control practices may actually be encouraging TB transmission in healthcare settings.

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Of course, if you are in a country where there is a lot of second-line drugs available in the private market, that can also stimulate a lot of misuse of those drugs, leading to development of drug-resistant TB. Therefore, the involvement of all care providers is important, this is Kenya International Hospital and what you see in Kenya International Hospital is that they have clinic congestion, ward congestion. These wards are meant to carry only one person per bed, and you see two or three people in one bed, and therefore under such circumstances, transmission of TB can be a big issue.

We did examine this, the issue of TB transmission to healthcare workers in a little bit of detail in 2005, with support from CBC. And I'm not going to spend a lot of time here, but we did a test control study, and the key thing that we found here, is that if you had greater than five hours contact in a place where you potentially could have TB, if you are HIV-infected or if you are poor, your risk for getting TB as a health care worker was much, much higher. So there is probably quite a bit of TB transmission taking place in our health care settings.

So, in conclusion, we needed to integrate services. I think that's important for effective delivery of TB/HIV services. HIV testing and counseling for TB patients are

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under provision, especially if sympathy has progressed well in my country and is progressing well in some other countries. But the provision of ART to TB patients remains inadequate, we are not doing much, we have not been doing much, not just in Kenya, but I think in the rest of sub-Saharan Africa, with intensive case finding and TB preventive therapy. And MDR-TB and XDR-TB are opposing serious threats to TB control efforts in this country.

What do we need to do, then? We do need to strengthen TB control program, including our own program in Kenya needs to be strengthened a little more. We need better collaboration with TB/HIV, with the HIV control program. We need to identify measures that can be carried out for infection and for also resource-limited settings. And we should intensify surveillance for drug-resistant TB, and it's very treatable is everybody is involved or engaged in TB care. We must always remember to keep our eyes on the big prize.

These are old men who are participating in a race in Kenya recently. And the person who won the race is the man, if I can show you. That gentleman there is 77 years old and he done wonders, and ours is we want to keep our eyes on the big prize. And we said this last year in Abuja, that once universal access to TB/HIV services by 2010, and we need to

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move in that direction, making sure that every TB patient is accorded all the services that they need to get. And every HIV patient is accorded all the services that they need to get. And thank you very much for listening.

[Applause]

DR. TEGUEST GUERMA: Thank you very much, Dr. Chakaya, for this compensive presentation.

You have heard from Kenya, you have heard how important of setting national targets, and have heard how important it is to expand HIV testing in TB settings. You have also heard how they solved the human resource problems and at the time where XDR TB is in front of us, it is really important to scale up HIV/TB collaborative [gap in audio] nationwide, in all the high prevalence, HIV high-prevalence setting. Thank you.

[END RECORDING]