

**37th Union World Conference on Lung Health:
From DOTS to the Stop TB Strategy - Building on
Achievements for Future Planning: Implementation and Scale-
Up of the Stop TB Strategy: Experiences from Countries:
Part 1
October 31, 2006**

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MALE SPEAKER: ...Introduce the program manager from Peru, a country that we learn so much from in the past and we'd like to continue to learn from and the floor is to Mr. Cesar Bonilla from Peru.

CESAR BONILLA, MD: Thank you, Chairman. Good morning. In 1990, only 25-percent of the services of the Ministry of Health of Peru conducted [inaudible] diagnostic and [inaudible] activities. Today, 107-percent of [inaudible] ensure access to free diagnosis and treatment and [inaudible]. The management model is based on the application of the public health paradigms honoring [misspelled?] the National Tuberculosis Control Program to be incorporated into the system thus, strengthening the response of the country to the disease and, at the same time, [inaudible] for new strategic partnerships within. The new paradigms proposed to combine knowledge and credibility [misspelled?] by strengthening a strategic partnership - this is a new challenge. In the 80s, serious organizational, structural, and logistic problems did not allow appropriate [inaudible] attention and access to free treatment for all of the diagnosed TB patients. Only 50-percent were receiving anti-TB treatment. The high proportion of treatment failures and [inaudible] made the situation worst. In the last 15 years, significant changes in the

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operational world for the effective [inaudible] of tuberculosis have taken place requiring the involvement of experienced professionals and technical experts in the field improved the knowledge and the skills of healthcare workers at health facilities generating communion to create a new culture in the quality of care. Many years have gone but since the one organization of the TB counter-program in Peru was introduced in the early 90s and successfully implemented the dose [inaudible]. The one [inaudible] organization considers dose implementation in Peru as well as the most successful in the world. [inaudible] enable morbidity rates to decrease in about 5-percent a year. The case detection of morbidity 70-percent of smear positive cases among the population and the cure rate of more than 90-percent of [inaudible] smear positive cases that receive treatment. Under the context of political changes in Peru and the implementation of the health sector reform, a gradual decrease in the identification of symptomatic respiratory patients was observed in the 2001 - [inaudible] making the decrease in the rates no longer valid. Frequent changes of heads of the program have impaired sustainable TB [inaudible]. [inaudible] and around 12,000 of smear positive pulmonary TB case failure to be diagnosed. [inaudible] have not yet reached an agreement regarding the magnitude of the MDR-TB epidemic in Peru. World DOTS strategy serves as a model

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to other countries in the world. Peru was one of the first countries to implement adult [inaudible] in 1997, which was approved by the Green Light Committee in the year 2000. The presence of MDR-TB within any community is a result of [inaudible] imperceptible [inaudible] system that are not fairly on time and results in these kinds of problems. Ineffective MDR-TB treatment regimes leads to increased resistance and therefore the need of multiple drug regimens, persistence of MDR-TB cases in the community without timely access to appropriate treatment results in the persistence of sources of transmission. In a [inaudible] or underestimation of the magnitude of MDR-TB does not allow implementing unequipped [misspelled?] intervention. The new trends require the managers in the field of the TB to have not only the operational/technical knowledge but also for understanding of innovative strategic thinking communication, research, and social marketing in a context of ethics and human rights. The [inaudible] has brought a change in public health paradigms in Peru in relation to TB management basic tools - innovation, monitoring and culture, and taking into consideration this 4-dimensions - epidemiology, operations, public health and management. Under the DOTS framework, this change enabled the management capabilities by encouraging intra- and inter-institutional coordination, optimizing control plans, and

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avoiding duplication, and overlapping of activities.

[inaudible] to achieve efficiency and continuous improvement in order to obtain quality results. In 2004, the National TB Control Program was [inaudible] by four functional pillars - coordination, management, communication, and cooperation, which all share the responsibilities of management [inaudible] achieve and accountability. Something very important is the [inaudible] composed of agencies of the Ministry of Health and Church of ensuring the functioning of the TB program. For example, financing, logistics, [inaudible] et cetera - also an advisory committee was created composed of [inaudible] organization technical and financial institutions, scientific associations, academic institutions, and TB patient organizations. However, I don't want to neglect, to mention the role of external financial sources. We believe that the [inaudible] in Peru will continue to [inaudible] in the National TB Program honoring the rapid adaptation to changes resulting from health sector reform. These will [inaudible] reform into an opportunity for further development of the National TB program.

In the policy guidelines, of the health sector for 2002-2012, the high prevalence of infectious diseases is identified as a critical issue and a decrease in the associated morbidity and mortality rates is considered a

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strategic goal. The National TB Control Program uses these guidelines to define these [misspelled?] kinds of patients. Due to the multiple [inaudible] to the disease, both the [inaudible] and Ministry of Health have joined first to work as a team by sharing leadership and responsibility and integrating activities under a new organizational culture that development of inter-sectorial and inter-institutional actions and the understanding of a strategic partnership have brought encouraging results through the articulation of social [inaudible] at various institutional, community, or individual levels. With the establishment of the ever changing coordination with all the state sectors such as [inaudible] Society Institutions and organizations of people living with TB. The intersectorial [inaudible] principle has been introduced into the TB control plans. However, the [inaudible] process is still needs to be sustained. Because of this approach, the National TB Control Program has a [inaudible] political commitment not only from the Ministry of Health but for all our ministries such as Justice, Internal Affairs, Education, among others. However, the competencies of the national level is still needing to be [inaudible] to the regular and local levels. The Greek philosopher said - Plato said "If a man knows not what harbor he seeks, any way is the right way."

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We prepared a strategic plan. It is important to help assure vision and mission, clear goals and objectives, clinical standards and clinical healthcare guidelines. The National STOP TB Committee is now up and running. At present, we also have three regional STOP Committees. Our friends [inaudible] from the World Health Organization and [inaudible] from the Pan American Health Organization among others, are presently following the progress mainly in Peru.

Now, let me show you some outcomes resulting from these interventions. Sixteen-percent increase in the identification of symptomatic respiratory cases in 2005. The result - 96-percent of TB detection in the community, as a result of improved World Practices since 2004 - we now have a more exact estimate of the total number of TB cases showing an increase in the rates of morbidity and incidence of [inaudible] positive in [inaudible]. We hope to continue these efforts in 2006 and by 2007, start observing an increase similar to that experience in the 90s of 5-percent generally [misspelled?], 90-percent efficiency in treatment, 98-percent of MDR-TB cases are found in Lima and [inaudible] located mostly around the coast, 84-percent of those cases are in Lima. [inaudible] the capital, MDR-TB is distributing mostly in 10 districts.

This information allows us to [inaudible] interventions and allocate resources in a more efficient manner. By

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improving our diagnostic capacity for MDR-TB, we can offer timely treatment, which will automatically [misspelled?] impact mortality rates. Our estimates indicate that in 2005, we achieved the highest peak of cases and by 2006, our predictions are showing an increased [inaudible].

The standardized treatment regimen was used during 1997 to 2001 before having access of this treatment, patients received, on average, [inaudible] treatments. This percentage of bacteriological conversion by the 6th month of treatment was 24 with a similar cure rate at the end of the treatment. In 2002-2004, the indication for standardized regimen were changed and this treatment was recommended only for failures of the primary regimen. However, the rate of bacteriological [inaudible] at the six months of the cure rate upon termination of treatment, remain almost the same. In 2005 to 2006, the MDR-TB treatment regimen was modified by adding to second-line drugs. After initiating a standardized regimen and then upon receiving the [inaudible] results, [inaudible] individualized treatment, the bacteriological conversion after six months, was 94-percent. These results are being analyzed to determine the exact implications.

In the last 50 years, the average [inaudible] allocated by the state to the National TB Control Program was \$3 million per year. In 2006, this was raised to our most - \$10 million,

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then we say this is a political commitment. This [inaudible] speaks for itself. The reform offers new concepts that will create new opportunities for National TB Control Programs. When the National TB Control Program has a strong [inaudible] strategy, it can quickly adapt to the [inaudible] reform changes. Many lessons have been learned in TB control. However, it is necessary to critically analyze this experience and as we look to the friendships [misspelled?], consider the response of the state of the civil society and of the people with TB.

The civil society has helped make TB control a priority in the public agenda of the state, the central government and the regional and local government as well. The priority is set in the context of consideration for the dignity of people with TB, of human rights, and of the quality, equity, and access to care at all health centers.

The question is how do we confirm TB control in the context of the epidemiological and operational ends within the Millennium Development goals that address poverty, exclusion, respect for the dignity of patients and of human rights. Our country is trying to find the answer to this question using these approaches. In cooperating, new indicators of TB control will allow us to integrate operational, epidemiological, and public health management. [inaudible] approach to the

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application of dose expansion contributes to TB control to considering high vulnerability areas with high risk of transmission - TB and HIV co-infection, MDR-TB and [inaudible] RTB. The [inaudible] is PPA [inaudible] social mobilization, and communication. Tuberculosis is an old disease but [inaudible]. It is a [inaudible] and can affect anyone in any place and in the modern age of mobilization, tuberculosis is a global concern [inaudible] confirm tuberculosis in the [inaudible] countries and the global community must have a Stop TB strategy that one - is [inaudible] foundation of public health; two - has a strong effective DOTS strategy and three - encourage strategic partnerships. Thank you.

[applause]

MALE SPEAKER: Thank you very much Dr. Bonilla for really this fresh approach and aspiring approach to TB control that - and that controlling the disease is one thing but then to sustain it or regroup the control effort is a totally different thing - very inspiring. I will allow for one question with an eye on time. If anybody would like. Well you have been very clear. Thank you very much.

We move on. The next presentation will be from Win Maung and I'd like to invite Dr. Win Maung to present his presentation.

DR. WIN MAUNG: Good morning and good afternoon for all

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our participants. Our colleagues, I am from Myanmar and I would like to present the planning in line with the Stop TB strategy and the global plan to stop TB 2006-2015. Now okay.

Myanmar is surrounded by China, India, Bangladesh, Laos and Thailand. Our population is about 51.4 million for 2005 and our country is in low-income levels and our national TB program [inaudible] more than 100,000 TB cases in 2005 and HIV situation, HIV prevalence in the general population is estimated at 1.3-percent and HIV prevalence among the TB patients is estimated as 7.1-percent and our nationwide drug resistance done in 2002 and 2003, which showed that our [inaudible] new cases MDR-TB is 4-percent and re-treatment is [inaudible] MDR-TBs is about 15.5-percent and our [inaudible] started the [inaudible] in 1994 with only 18,000 [misspelled?]. In our country there are about - there 325,000 and we started in 1997 with [misspelled?] dose strategy. In those days, our country implemented dose strategy in 152,000 - that is less than [inaudible] is 15-percent. In 2003, our gradually expand [misspelled?] our DOT expansion and improved on the treatment with [inaudible] we can cover the whole country, 325,000 and as you see in our outline [misspelled?] in 2005, our case deduction rate is 95-percent and the [inaudible] rate is 84-percent and our [inaudible] rate since 1997-1998 to 2004, our [inaudible] rate is [inaudible] in line

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with the 82-percent. In 2005, it rose up to the 84-percent and - yes - progress in the control TB in 2001 to 2004 is our decentralization of [inaudible] microscopy as [inaudible] and some in the rural areas and the establishment of the national TB laboratory in 2001 and public-private [inaudible] with the NGOs and [inaudible] drug facilities supported since 2002 and 2002 and 2004, we had the standard [inaudible] review [inaudible] is done and the standard quality [inaudible] laboratory and the first nationwide drug assistance [inaudible] in 2002 and 2003. I have already mentioned it and the progress in TB control in 2005 is that we have developed a 5-year mission strategy plan in 2005 and our Ministry of Health has proved it and we drove this 5-year mission strategy plan in line with [inaudible] TB strategy and global TB plan and with the [inaudible]. Our public-private [inaudible] operational guideline is published and TB/HIV treatment guideline published in 2005 and Global Fund [inaudible] fight TB and malaria grant is we implement [inaudible] generally fast to [inaudible]. Although the Global Fund is dominated, but we have [inaudible] to implement our activity in the face of [inaudible] up to the [inaudible] but although we can get opportunity, we can [inaudible] of like [inaudible] and we can continue [inaudible]. So that is the Global Fund, [inaudible] 82-percent who [inaudible] is one of the assistant - the one

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of the [inaudible] of the Global Fund [inaudible] Global Fund. Integrated HIV care for TB patients with the [inaudible] order of union [misspelled?] and [inaudible] started in 2005 [inaudible] and two additional TB/HIV [inaudible] TB/HIV [inaudible]. HIV prevalence among TB patients in [inaudible]. HIV [inaudible] patient is 32. In the [inaudible] is 15-percent and [inaudible] is 25-percent and TB cases and the [inaudible] is [inaudible] is 62-percent, in the region it's 52-percent and in the county [misspelled?], it's 34-percent and global drug facility [inaudible] 2008. As progress in TB control in 2006 and we have the new three disease fund established to fight TB, HIV, and malaria totally for three disease, \$99.5 million for five years and human [inaudible] is [inaudible], TB/HIV initiated of HIV [inaudible] and [inaudible] TB [inaudible] can be established to develop national guidelines to treat the [inaudible] and TB. [inaudible] treated by our national TB control program. Our [inaudible] Association - [inaudible] establishment of a standard quality [inaudible] quality control of [inaudible] and [inaudible] project in the one division [inaudible] division to implement in hard to reach areas and the [inaudible] drug facility review in 2006 and that is with the Global Fund, we can train the [inaudible] in 2006 is in the [inaudible]. We can train the targeted of [inaudible] is 81-

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percent and [inaudible] is 7-percent and the lab technician is 46-percent. So that the rest, we train, we hope that with the assistance of the three disease fund or the [inaudible] and TB prevalence [inaudible] division is finalized in 2006 and we found that 15-percent of half of the TB patients are underdosed and ¼ is in the private sector or the GP and ¼ is [inaudible] they don't know where to go and they don't [inaudible] highlights to me or to us how this area is [inaudible] and give our effort. Planning for the [inaudible] 2006 and 2010 - in 2005, we had a 5-year mission strategy plan for TB control we have already mentioned and then we developed a regional plan for [inaudible] our national strategy plan, which includes the [inaudible]. The [inaudible] when the Global Fund is downgraded in the 21st of August, 2006 and the three disease fund will come but we don't know when we will start and so the [inaudible] that we need [inaudible] fund so that in the three disease fund, that we propose the [inaudible] fund and it included design to have mobilized funding from the new disease fund [inaudible] implemented by our national TB program and [inaudible] implemented by our Global Fund [inaudible], our global partner - INGO [misspelled?], and our NGO [inaudible] plan facilitated by the [inaudible], which is designed to help plan [inaudible] by getting in line with the global plan and Stop TB strategy at

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country level. The budget for operational plan - all activities and that is for the year one - that is available [inaudible] for the first line drug that is for the program management and supervision like that. That is for the 3-year our operational plan. There is a funding [inaudible]. For the year 1, our available money funding is \$7.5 million and our funding cap is 5.5. For year 2, our funding availability is \$3.9 and the cap is 10.2. That is why we cannot [inaudible] our international NGO - they don't know how many funds will come to then so that we cannot include their international NGO fund in this towards year two and year three so that funding cap is high. This figure includes all partners of national and international NGOs [inaudible] and global drug facility to [inaudible] HON [misspelled?], that is, we hope that three disease fund. We have plenty activities and challenges for the Stop TB strategies. Therefore, the Stop TB strategy - high quality, dose expansion, and enhancement so we decentralized [inaudible] through the health center and we revised national TB guidelines and we mobilized the team for the remote and hard to reach areas by our [inaudible] and we consider [inaudible] guideline [inaudible]. Our other challenge is you really assess a patient to dose strategies [misspelled?] and resource mobilization for first line drug for up to 2008 after global drug facilities [inaudible], that is maybe our

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challenge. The Stop TB strategy component to TB/HIV and MDR-TB and other challenges. We have the [inaudible] collaborated TB/HIV prevention and control activities and TB/HIV and MDR-TB guidelines, we will develop in the near future, integration of TB and HIV [inaudible] and our HIV prevalence among TB patients [inaudible] will be included in that national AIDS program [inaudible] and [inaudible] application for the MDR-TB treatment project - we will start and the one is [inaudible] but that will come in the near future and [inaudible] to establish the guidelines and for application [inaudible] and establishment of services [inaudible] at sub-national level. In our country, there is only two facilities - one in [inaudible] and one in [inaudible] facility and the only one drug facility or [inaudible] disease facility in the [inaudible]. So the [inaudible] the established sub-regional level - one sub-regional level in [inaudible] division and second regimen [inaudible] drug resistance [inaudible] in 2007. Our challenges may be the [inaudible] high drug resistance levels - I have already mentioned in the past and the immediate capacity to diagnose and management of the MDR-TBs. That is our challenges for TB/HIV, MDR-TB, and other challenges. The strategy component two - health systems [inaudible] health [inaudible] at all levels including [inaudible] training, logistic management, budgets, and

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planning. In 2006, a standard review mission [inaudible] come to our country and the challenges, the limited human resources with necessary competency at the [inaudible] level. The [inaudible] strategy - another one is engage all care providers. [inaudible] public, private [inaudible] and the public [inaudible] activities including integration of major public hospitals and the prison [misspelled?]. The challenge - maintain quality during scaling up of [inaudible] dose. Scaling up of [inaudible] activities including integration of major public hospitals and the prison. Our [inaudible], we plan to give training in the GB [misspelled?] [inaudible] training to the private laboratory and training to our public hospital and the township covers. We plan like this to engage all care providers.

Another disease Stop strategy is involving people with TB in the community. Our major activity planned is [inaudible] strategy and implementation of the [inaudible] project for hard to reach populations in one division in Yema [misspelled?]. Our challenges [inaudible] scaling up of communication strategy, improving community awareness of TB program and another strategy is [inaudible] and the [inaudible]. National prevalence survey - now we have conducted the Yema [misspelled?] division TB prevalence survey [inaudible] and so that we went to [inaudible] TB [inaudible]

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where we are so that we went to two national prevalence surveys and the number two is maintaining the partnerships with the researcher and the academic institutions. That is regional planning and budgets too and this is very comprehensive and easy to use and requirement [inaudible] easily identified. The issue that is [inaudible] and graph it can get to [inaudible] in time and [inaudible] approved by all partners of the developmental joint operational plans and all major funding - the proposal - and that is like a [inaudible] budget sheet so that we can see it separately, clearly and easily but when we already developed the 5-year mission and strategy plan, we can get the regional planning and budget [inaudible]. In [inaudible] it is easy to update and revise [inaudible] automatically update [inaudible] when something is delayed and activities are postponed.

In our conclusion - number one is Stop TB Partnership in Yema is moving toward global TB control target despite the very limited resources and thanks to our high quality commitment, dedicated our staff and strong community support [inaudible] coordinating with our partners and continue to raise your technical assistance and number two is the [inaudible] additional resources mobilization is necessary to build on the three disease fund mechanism supported by the [inaudible] European community and also [inaudible] government

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to fully cover our [inaudible] needs.

Thank you. [applause]

MALE SPEAKER: Thank you very much Dr. Maung for the presentation of the solid work and planning in Myanmar. Is there any questions? I will allow for one. Yeah?

MALE SPEAKER: Thank you very much for your presentation. My name is [inaudible] and I am representing AIDS Foundation East-West. We work in Eastern Europe and Central Asia and there the epidemic is a bit similar in your country in that I believe your country has also a high number of HIV-infected people who are infected through injecting drug use, am I right?

DR. WIN MAUNG: Yes and now there is not so many.

MALE SPEAKER: But you have quite a number of injecting drug users who are infected with HIV, is that right or not? Because otherwise my question is irrelevant.

DR. WIN MAUNG: [inaudible] country, the HIV positive man is sexually transmitted...

MALE SPEAKER: Mostly sexually transmitted?

DR. WIN MAUNG: Yes.

MALE SPEAKER: Okay. Then I will leave my question because...

DR. WIN MAUNG: Because they use disposable needles.

MALE SPEAKER: Okay. Let me just [inaudible]. Do we have

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any TB services directed at injecting drug users especially as a vulnerable group?

DR. WIN MAUNG: Yes. I'm the TB program manager. This question should be asked to the Mission to AIDS program

MALE SPEAKER: See that's the problem. Yes.

MALE SPEAKER: Okay. Thank you very much again Dr. Maung. We have two exciting subjects ahead of us - one on MDR-TB control in the Philippines and one on TB/HIV activities in Kenya. I think that's the heart of the Stop TB strategy and it's a pleasure to call on Rosalind Vianzon again to present us the experience in the Philippines.

DR. ROSALIND VIANZON: Okay. Thank you again. I assure you that in spite of the long talks of MDR and [inaudible] this morning, what I have is just purely common colds. Okay.

So regarding the scale up of multidrug resistant TB management in the Philippines, allow me to give first - to give you first the magnitude of MDR-TB in the Philippines based on the [inaudible] importantly [inaudible].

In 1997, the Philippine National Survey conducted by [inaudible] showed that resistance among new cases was 1.4-percent, but it was quite alarmingly high among the previously treated at 40.5-percent and in the current national drug resistance survey of MTP [misspelled?] WHO [inaudible], which is still a preliminary report and still an unofficial report,

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you can see that the type of resistance among new cases is - has increased to 4.4-percent and also with the previously treated at 21-percent.

This is an analysis of the treatment failure rates among the smear positives based on the national TB program report since 1999 up to 2003. Among the new, it's fairly stable at 1.3-percent to 2-percent but at the treated cases, although we don't have previously done [inaudible], the 2003 revealed that there's this high failure rate among the smear positive cases registering at 6-percent. In [inaudible] Center in Manila, a privately [inaudible] public-private [inaudible] center, which is that of the center of McCarthy [misspelled?] Medical Center - the rates of treatment failure from 1999 up to 2003 showed that they were really quite high in terms of resistance [inaudible] - failure rates among the re-treatment cases ranging from as high as 32.2-percent to as low as 6.7-percent. Nonetheless, with this data, it turned out that all of these failure rates [inaudible] became multidrug resistant TB cases. So what does this say to us. It simply means that we need to go into analyzing the picture of MDR-TB in the country and when we did that, we simply went into a stage of going beyond what we call DOTS, labeling it as simply DOTS plus. So the first stage of the PMT [misspelled?] in the Philippines is aptly termed as the pilot stage in which the scope and context

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was basically on a project scale and it's aptly one of the GSE pilot projects, in which the Philippines has had with the McCarthy Medical Center then be in that starting point. So as I said, the MMC is a privately [inaudible] DOTS [inaudible] and it became the starting point for all the DOTS plus of [inaudible]. It was also found out that 75-percent of the failures actually came from the private practitioners, which means there's a need to harness private practitioners in the DOTS because they're the ones actually referring and creating or generating these MDRs. Laboratory capacity for culture and [inaudible] was then started also on a project basis and it was found out that second-line drugs need to be secured and assured once you go into DOTS plus so that the impending concern at that time was really sustainability. The second stage went into the stage of mainstream. Stage of mainstream simply means the integration DOTS plus into the public DOTS and in order for us to undertake such process, it has to be done in a strategic process or what we call as a stepwise implementation. I won't go through that process anymore but I'd like to mention that with that stage of mainstream, the Lung [misspelled?] Center of the Philippines DOTS plus project was born and this is more of a public counterpart from the BOH, which actually does not look into old TB cases but also looks into in-house services for MDR-TB cases. The photos

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[misspelled?] at that time came from both public and private doctors and what we have seen in terms of [inaudible] is the need to approach it at a community base simply stating that there's a need to decentralize to public health centers the management of MDR-TB with participation from total [misspelled?] community volunteers. Even in the mainstream, there is a prevailing concern, of course, of absorbing [misspelled?] capacity. So this is a picture of how we decentralized MDR-TB services in metro Manila. This is the first day of the pilot, which is the McCarthy Medical Center. It went on to engage other public facilities, one in [inaudible] of the Philippines and the other one in [inaudible]. So in this regard, we have seen that as far as treatment centers concerned, we have started up building another treatment center in [inaudible] areas but when it comes to involvement or engagement of public health centers, it was rather low - only 11-percent of them being engaged into the system. This is also another slide - this map showing that different cases in metro Manila, where they are coming from within the region of NCR and you can see the high percentages scattered all over metro Manila, of course, metro Manila is the biggest region in the country and what is also significant at the time is the fact that outside metro Manila, we are also seeing MDR-TB cases. So in spite of the fact that metro Manila

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houses most of our TB cases, we're seeing also cases of MDRs outside that of this populous region. This is a graph showing the accruals of TB patients from 1999 up to August 2006 and these green bars or green boxes show to us the different fund sources that we have gotten from - to support MDR-TB management. Initially, [inaudible] on a pilot basis, it's largely a private initiated support but, of course, with the most [inaudible] involvement of government support through the Department of Health but in here, largely the mainstay has been contributed by external support largely coming from global fund. Just a picture of the demographics of those cases [inaudible] of the males was more prevalent than the females and the majority of the cases occurred really in the economically productive age group. So the treatment outcomes of those cases revealed that in terms of cure rate, there was really an increase in cure rates from 59 to 73 to 74-percent among these MDR-TB cases but what is also - what's to be seen is how we can address these problems of high [inaudible] of 25-percent, [inaudible] and even at 15-percent. So just a table of that previous slide seeing already here that there is high cure rates from 73-percent up to 74-percent. So we go into the third stage and we accurately label it as the stage of scale up. Simply stated, it simply means the expansion of project in the program. In fact we have even [inaudible] of

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DOTS plus project into [inaudible] multidrug [inaudible] management because it's not expanded or [inaudible] program aspect [misspelled?]. Geographically there's also expansion in which we [inaudible] Manila and expanding throughout the entire region of metro Manila but, of course in the future, looking into another possible region because as I said, we are seeing cases outside of this big region. What is also important in the scale up is that we need to engage more community-based facilities and with the advent of PPMD units, these units may be considered as potentials for engagement. We're also looking into DOTS hospitals or hospitals that [inaudible] doing DOTS such as the district hospitals in the country and, of course more importantly, our best public health centers having good performances on the ODS [misspelled?]. A more decentralized approach, we believe it's realistic and more viable because it's actually anchored on the country situation. However, the issue here perhaps would be the added complexity in terms of engaging communities in terms of expanding geographically plus, of course, the need for more financial demands. So there's the picture of metro Manila in 2006, we only have this one culture center, one [inaudible], site and we have only about three treatment centers. Hopefully by 2008, when we go into scale up, you can see that we're going to build up more additional treatment

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centers, more culture centers and of course, the [inaudible] increasing the [inaudible] centers. By the way, these DSD [misspelled?] center here [inaudible] is actually the National TB Reference Lab of the Philippines, which has been built through the auspices of [inaudible].

So again, the picture of accruals of these patients that since it's great to be largely supported by [inaudible] and particularly in terms of provision of second line drugs, you can see that we're able to treat at least 3,000 cases with that global fund support and as I said earlier, the round two global fund support actually used in the mainstream and the round five will be used for scale up. So you can already see a comparison in terms of difference - in terms of the cost or in terms of the budget - that's [inaudible] under round five and versus that of round two.

So again the picture of how we are going to geographically expand the treatment centers, culture centers, and the DSD sites and hopefully, at this last phase, that's where we're going to go outside of metro Manila. What is important here is that this incremental increase of these centers that's strategic enough that we would be able to monitor their performances. So just an evolutionary picture of how we really started with [inaudible]. These are the people in the unit at McCarthy Medical. As I've said, it's privately

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initiated people in the unit with large assistance from the public facility particularly that of the NPP in terms of provision of [inaudible] first-line. Of course, as a DOTS center, its main laboratory service was dealing with microscopy work. When it evolved to become a DOTS plus unit, the complexity started because aside from microscopy, it has to undertake culture and DSD and aside from doing more DOTS, it has to perform DOTS plus services but of course, [inaudible] involvement of the public facility through the NPP and provision of first-line drugs has been there and you can see here that the number of cases have already increased compared to the previous slide because they're already doing two types of services - DOTS and DOTS plus. And when we go into mainstream, this is that starting point at McCarthy Medical. We engage other treatment centers. This one is the public center, which is the [inaudible] Center of the Philippines and another privately owned DOTS plus treatment center - the [inaudible] but we have also engaged treatment sites, the purpose of which is really to decentralize management of MDR-TB cases so that they won't be too concentrated or too centralized in this particular facility because we have seen that really the problem of sustainability and absorbed [misspelled?] capacity was still an issue. So we tried to look into these different sectors - all of which or a

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majority of which are publicly owned centers or facilities and then when we go into scale up, it's just really replicating the practices of those that we have seen in the mainstream looking into other possible sites but have been strategically analyzed as to where they can be feasible without, of course, compromising quality of our DOTS services and hopefully in the future, we'll be able to install eight treatment centers, four culture centers, and three DSD sites, and of course, more treatment sites, which are community-based facilities. It is important that we increase in the DSD sites. There's still a network of laboratory and there's still that supervision from a supernational reference laboratory. This is the future of another region but we're looking into in terms of going outside of metro Manila or going - expanding outside of metro Manila. So just some words regarding this type of [inaudible] facilities that we have been using under the policies. We have [inaudible] treatment centers, which are actually treating more than 10 patients being treated at the time. It's more comprehensive and specialized management being delivered here at this level. Examples are the [inaudible] Center and the [inaudible] that we have at QI. A treatment site is a facility that handles less or fewer patients - less [inaudible] being treated at the time and it's largely presented by the public sector as public health centers, the PPN [misspelled?] units

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that we have installed, other public facilities and we can see that we have also engaged [inaudible] based DOTS units because we have seen that they are also doing or performing quality DOTS. As for the laboratory side, culture centers are those centers that perform culture services and that the [inaudible] being a culture center by itself still needs to supervise the external quality assurance of microscopy of our laboratory and microscopy centers. It will be having a broader [inaudible] of areas because it has to service outside of its own locality. So it has to service or accept culture services that is outside its current locale. Excuse me - and this identified under the drug resistance survey, we have these facilities that we have identified to be potentials for culture centers such as the [inaudible] Lab will be definitely used for this scaling up. As for the DSD site, of course, the main goal of our DSD site is to perform the DSD and again [inaudible] being our [inaudible] site, you still need to continue to oversee quality of microscopy, quality of culture, quality of culture. So it does not supersede the current function of [inaudible] in the National TB Reference Lab of the country. Once it has become a DSD site, it's still going to oversee those key important laboratories of culture and microscopy. They may be fewer. See the DSD sites are of course, fewer but as I've said, they have to be strategically located so that they can

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cater to better access and to what they call range within the entire map of the Philippines and of course, DSD sites will always have to be supervised or needs to be supervised by a Super National Laboratory, which in that case for [inaudible], it's supervised by [inaudible]. So the lesson here is that DOTS is still the overarching framework. Even if you go into DOTS plus, you still have to consider that DOTS will be the overarching framework. Nonetheless, we can translate these different elements of DOTS into corresponding statements such as [inaudible] that [inaudible] looks into how we can deliver DOTS plus but in the framework of DOTS. [inaudible] but frankly I'd like to mention that we have [inaudible] these elements of DOTS into elements of DOTS plus or PMTN so that in the context of implementation, it's still DOTS that's the overarching framework.

So what will [inaudible] the steps and requirements for the scale up? There's a need first to environmentally scan your area - the area because there's a need to determine or to define where existing resources are and capacities are and as I said earlier, since we had the conduct of the drug resistance survey, we have already existing resources and capacities that we have built in some areas. It is also necessary because we need to strategically select our expansion sites and like DOTS, we gradually expand the DOTS

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but for DOTS plus, there's a set of criteria that we need to undertake so that we will be able to see where this critical expansion sites will be.

Second is the advocacy to ensure political commitment. In here although the memoranda for understanding MOU has been signed a few weeks ago with the metro Manila local chief executives, we'd also like to mention that advocacy needs to be elevated to the higher level specifically to the ministerial level and we're finalizing the policies of this but we're going to have it endorsed by the Secretary himself so that there's going to be an assurance of political commitment.

Third, you have to create essential organizational structures. In the Philippines, we've seen the importance of having taskforces for the management of PMTN, the need for [inaudible] looks into the clinical aspect of making diagnosis and of course, the laboratory sub-committee that looks into the articulation of microscopy, culture, and DSD all at the same time and looking, of course, into its quality.

Fourth, we need to have some policies, guidelines and standards development - that should be anchored to country situation. There are a lot of materials internationally, but we need to look into what will be adaptable to the country situation, especially that we have already made some pilot

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tests and guided them [inaudible] are the best practices from this pilot test to come back to their policies, guidelines, and standards. Human resource development is an impending issue for scale up, so with that being said, we have to make some task analysis of the key people who will be involved in this undertaking and we have to develop standardized treatment materials so that in the rollout of implementation and training, we already have made these training materials standardized and easier for replication later on.

Laboratory - the network of lab services and other diagnostics should be made in [inaudible], microscopies still a part of the overall laboratory armamentarium. [inaudible] should be in place because this safeguards the quality of all of the microscopy services, culture, and DSD. Of course, the role of x-ray cannot be undermined especially in the country in the Philippines, we have already started out with the supportive diagnostic committee, which is actually a pool of experts that validates or looks into how this [inaudible] of cases can be given quality diagnosis and at the same time, be given judicial chemotherapy, so we would still like to capitalize on this positive aspect that we have inputted in our TB program.

So just a picture of how we're going to decentralize capacity building. If this is the pilot or the starting point

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of McCarthy Medical at the time in which it does all the training - now it can have to decentralize the capacity to engage the regional level for the [inaudible], to engage the province or city levels for training and [inaudible] supervision and of course, to engage the most [inaudible] units as the treatment centers [inaudible] treatment centers and treatment sites. This is where the actual implementation will take place. In the same token, once you scale up laboratory capacity, it looks into how you can decentralize culture, [inaudible] other key laboratories but particularly reference laboratories to do EQA, which is done also at the validation centers at the provision at city level and of course, microscopy will have to be maintained in the DOTS plus centers. Nonetheless on top of which is the DSD, which is going to be done by [inaudible] other DSD sites supervised by a supernational laboratory. So logistics - this is again one important aspect for the scale of PMPN because we all know the logistics management of second-line drugs is really a hurdle. It's complex because we are not looking into fixed dose combinations. We're not looking into TB [inaudible] but they're actually counting in the [inaudible]. So nonetheless, for the management of second line drugs, we still adopt these four important components of the drug cycle except that for selection, it will now have to be participated in by the MTP

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[misspelled?], the TDF so that the procurement, you have to look into other agencies such as the GSE and the WHO assistance for better procurement of all second-line drugs. Distribution will now involve the regional help offices and the [inaudible] but looks at the distribution of second line drugs and of course, [inaudible] have to be done by treatment centers and treatment sites. Also for second line drugs, the first-line drugs will have to be put into place even if you are doing PMTN and if there's the drugs for adverse reactions are also a requirement. Community involvement - community participation to facilitate a decentralized approach is very important and that's the reason why we came up with these separate terms of treatment centers and sites, which are actually public health centers, PMTN centers that will [inaudible] services for PMTN. Partnerships - based on previous results, we have seen that private [inaudible] to the proliferation of MDR-TB. So we need to harness them to the DOTS strategy [inaudible] to prevent proliferating this [inaudible] cases of MDR and engaging them through the public-private mix DOTS units is a very good endeavor - it seems to be a professional endeavor. Recording the [inaudible] just like either aspects of scaling up [inaudible]. It's quite complex but we need to standardize our information and data system looking into the different recommendations and reports

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that are not really or made available or made available to the different centers or to the different facilities that we have identified and monitoring, supervision, and [inaudible] has also to be put into place developing a monetary [inaudible] but also conducting internal MSE as well as external MSE and here we still like to see the presence of GSE [inaudible] external NSE. So for the access for potential agencies for support, as I've said, the financial demand for PMTN is really good and therefore at this point, in the meantime, if we have opportunities, we have to access these opportunities for support. Government would be a good support because the national and the local government need to be put into the system for sustainability. Non-government agencies are also necessary especially if they have the capacity as well as the private sector in terms of them delivering services also. External assistance for technical and financial support through [inaudible] also are very important support in terms of technical and financial assistance particularly in the field of laboratory. So we're seeing here that if we have potential agencies, we need to access them to support our [inaudible] financial demand and finally we have to address the five dimensions of sustainability - political, technological, social cultural, economic, and financial. Addressing of the sustainability should come in right from the

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very start because, of course, the inherent problem of complexity in PMTN and hopefully once we address this [inaudible], we're actually now being able to address institutional sustainability.

So this is going to be my last slide. I just want to share with you that in terms of approach and impact relationship, which my colleague Dr. Bonilla and I have discussed, we're seeing that [inaudible] all of these MDR cases [inaudible] and you still have that small peak there that represents this very fatal or lethal [inaudible]. [inaudible] also that [inaudible] that remains to be undetected if you don't try to catch them up and therefore in order to deliver [inaudible] slides, you have to really look for MDRs and record them or provide them with appropriate management. That's the impact that we'd like to see.

Now the approach perhaps is the question - how do we do it? In the Philippines, as I have said when we started the pilot, it only covers this much, so it will not make any impact if there's only this much of activity. We need the mainstream because we need to engage the public sector for, of course, sustainability and to also address the problems of complexity, but what is more important is once you mainstream, you need to replicate expansion to a wider scale so that we'd be able to address this number of cases that we'd like to

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provide with appropriate management and hopefully if we tried to get that, the Philippines would be able to contribute at least in terms of reducing MDR-TB cases locally and still internationally - globally.

So that's how we approach it - the [inaudible] DOTS plus project with a pilot, [inaudible] the mainstream, and now we're going to PMTN, which is actually the scale up process. So with that, I'd like to thank my Filipino colleagues here who I also [inaudible]. [applause]

MALE SPEAKER: Thank you very much for a wonderful presentation and you were so comprehensive that we have no more time for questions because we have one very interesting presentation to follow from Kenya, the experience of scaling of TB/HIV activities. The floor is to Joseph Sitienei.

DR. JOSEPH SITIENEI: Thank you very much. I'm now bringing you to the experience that we have in Kenya and scaling up of collaborative TB/HIV activities.

First, let me take you through the demographics of Kenya. The population is 33.4 million with our case detection rate that is estimated by WHO in 2004 - we are about 46-percent. The incidence of TB in 2005 - 108/401 TB cases notified. We've got case notification rate of 305. The HIV prevalence - the KDHS of 2003 puts it at 6.7-percent although this has been revised [misspelled?] downwards and the TB

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patients with HIV in 2005 was 57-percent. I'll take you through the TB/HIV milestones and where we came from. In 1994, we had a [inaudible] program in [inaudible], which was conducted amongst the smear positive TB patients in 17 districts of the country and then we found that between 40 and 60-percent of the TB patients were dually infected and therefore, subsequently, they were two attempts to [inaudible] tackle the TB/HIV issues. In 1997 and 1998 although there's really nothing that came out of those two meetings, where all the [inaudible] and the TB and the HIV fraternity were invited but in October 2004, the policy on HIV testing in clinical settings was released by the Ministry of Health setting the pace and in November of the same year, the National TB/HIV Steering Committee was put in place where we have also [inaudible] and the Chairman comes [inaudible] from [inaudible]. In January and June 2005, then we started actually local activities to be able to move this agenda forward. The first one was the remission of TB data capture tools, printing, and dissemination. When we devised these tools were also incorporated TB and HIV data that I will be able to present to you a little bit later. We also started the development of the TB/HIV training curriculum because we realize there is need for this and there is a big vacuum and we adopted the TB/HIV guidelines [inaudible] by the WHO and we

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began the training of healthcare workers to be able to effectively and to [inaudible] to this initiative and with that of course, we also moved to the next phase of setting up the provincial and district TB/HIV Steering Committee Meeting - Committees and by the end of 2005, [inaudible] comfort me to say that all of the [inaudible] had active TB/HIV Steering Committees and the provincial TB/HIV Steering Committees were active and the district TB/HIV Steering Committees were in the formation stages. In 2005-2006, we moved to the next phase of training the regional [inaudible] and the first training occurred in 2005 and the second round occurred a few months ago in 2006 and in October 2006, the [inaudible] starting printing all of the TB/HIV training curriculum for the widespread submission and use. Of course, for our success[inaudible] had to realize, there was a big need for training of the healthcare workers because this was a new initiative that needed the healthcare workers to be focused and to [inaudible] what was expected of them and the TB/HIV Steering Committee - the TB/HIV curriculum that we developed with [inaudible] actually is in the middle of [inaudible] and includes and captures practically everything from TB to HIV including laboratory testing, contacting the people who are going to [inaudible] come to the training, to [inaudible] lab people and eventually also the final one also captures

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recording and reporting tools so that they can effectively understand and also [inaudible] those records properly. Of course, this became none of [inaudible] because without the trained and well motivated staff in terms also of numbers, it was not feasible to allow this and of course one of the challenges that came with this is the infrastructure and the availability of the funding for upwards scaling up. Initially, we had thought willing to do this [inaudible] but then it turned out that the demand was so huge that we had to [inaudible] in the whole country and these are the findings.

This slide actually shows you that we started some time in quarter three of 2005. This was after the distribution of the data capture tools and the initiation of training and you can see from here that - this is the percentage of the people who are reported or the patients who are reported with the new recording tools and these are the districts that kept being scaled up that were now being able to offer TB/HIV collaborative activities and the first quarter of this year, we were at 100-percent in both the use and the districts that were using these tools and this is how the scale up went through especially for the testing of TB patients for HIV. We started in third quarter and we are testing about 32-percent of the TB patients and this came out to about 59-percent by then or the second quarter of this year, and our target, of

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course, is about 80-percent. This slide just shows you the trend of the HIV testing among the patients in terms of those who were [inaudible] testing and those who are actually tested. We started, again in third quarter, [inaudible] only 62-percent of the patients and this has since gone up to be about 100-percent by the beginning of this year and as expected, the HIV [inaudible] prevalence has been declining all through because as you increase the numbers, you also expect the number of those who test HIV positive to be good down. Initially, it stood at 60-percent and of course, this could be because of several reasons including of course, the fact that those who have been tested were those that the healthcare workers felt strongly that may have been HIV positive and you can see by the second quarter of this year, we are now at 53-percent of those TB patients tested found to be HIV positive.

This graph here shows you the scale up within the - in Kenya and the provinces - the percentage of TB cases who are tested for HIV, from that quarter through the second quarter of this year and this is Kenya. You can see from that quarter, we are [inaudible] and we've been increasing steadily the numbers of those who are being offered testing, higher target stands there and it's only one problem somehow within the whole country that has somehow tried to reach the target, the

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rest are closely following suit.

This again is showing the percentage of those who tested HIV positive in the whole country and in the provinces. As expected again, you can see in the country that this figure has moved down from 60-percent to about 53-percent where we're at right now and one of the provinces is actually leading where we have more than, in some cases, even up to 70-percent of the TB patients are actually are dually infected with one province having very, very, very minimal HIV but this is just a distribution of HIV among the TB patients in different provinces within the country and this again, shows you this whole [inaudible] HIV positive by type - those who are tested for HIV and those who tested HIV positive. The red bar shows those who tested HIV positive, and as expected of course, the relapse cases have no HIV cases including those who are in total, the ones who are on treatment, and I think in children below 15 years who are PTB positive. These are the results we are finding and amongst the total cases - 53-percent of the patients have dually infected.

This is again, showing you the male-female ratios over the years and over the quarters [inaudible] and the first time when we started the testing in third quarter 2005, there was a very minimal uptake among the men, but this has since increased and you can see now more and more men are getting

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tested. Perhaps the ladies accept new initiatives faster than men. I don't know, but the HIV program is among the TB patients in terms of age and sex using the figures that we have for 2005 and you can see in all age groups as expected, the females are more burdened by HIV and TB and the males of course are less, but again, the highest concentration are within the sexually and economically active age groups.

Overall we have here - where we have the males just about 50-percent and females about 62-percent and of course with the testing of the patients for HIV, we are to create linkages especially with HIV program, and we have our own targets as an LTP. The first one is to make sure and ensure that at least 80-percent of the TB patients are tested for HIV and to link 80-percent of those who turn out to be positive to coaching and to ensure of course, that 80-percent of these patients are on ARBs - these are our targets and ensure at least 20-percent of the [inaudible] are screened for TB. Well somebody will ask why we have a low level for the [inaudible] to be screened for TB, this is because this activity is undertaken in the ARB clinics and we are still at the discussion level with analysis of what programs to ensure that practically all people living with HIV/AIDS were started on ARBs are actually screened for TB and you can see here from the third quarter to the second quarter of this year, how this

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has changed through. In the last quarter, we had about 19-percent of those who turned out to be positive being put on CPT and this has been changing as the numbers increase, but of course, the most striking linkages towards HIV and especially ARB program that we are still at an extremely low level - one expects to have quite a big number of these patients to be put on ARBs. We have still not developed the necessary linkages, and right now, this is where we are.

We are testing about 60-percent of our patients. We are moving on. We hope to get 80-percent by the end of the year. We are now linked more than 80-percent of the TB/HIV patients to [inaudible]. This is because this [inaudible] is offered in the chest clinic, but we are still low as far as HIV is concerned. I [inaudible] the Minister of Health and [inaudible] staff at all levels and of course, the TB patients.

Thank you very much. [applause]

MALE SPEAKER: Thank you Joseph for this important report from Kenya. There's time for one more - two questions.

MALE SPEAKER: [inaudible] from [inaudible]. Thank you very much for an excellent presentation. The data you presented, does it include the prison system and if not, how is the collaboration between two sectors? Thank you.

DR. JOSEPH SITIENEI: Thank you very much for that. The

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data I presented is actually aggregation of all the data of TB patients reported on the quarter within the country so it includes prisons, [inaudible], all [inaudible] for this practically including also the ones who are on PPN dose.

MALE SPEAKER: So TB/HIV activities also in the presence in...

DR. JOSEPH SITIENEI: Yes. Yes.

MALE SPEAKER: In the back? This is the last question.

MALE SPEAKER: Right. Right. Thank you very much. I'm from [inaudible] Zambia. We talked of [inaudible] for HIV testing, but what I was also expecting to hear something that precede the testing because in my own country, it's [inaudible] we call it voluntary counseling and it's a very big issue and the HIV testing is key. I don't know in your own country, because I believe you have very good success story compared to my own country in terms of testing. In my own country because it is [inaudible] by voluntary counseling, the decline rate is very high [inaudible] for the use of - the rate of HIV incidence. It's very [inaudible]. I don't know what happens on the other end. Do you counsel them first on a volunteer basis or do you just test them?

DR. JOSEPH SITIENEI: Thank you very much. I have omitted that. What we do in Kenya is that the guidelines, which were released in October 2004 for HIV testing in

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clinical settings have an implied meaning that all patients who go to the health facilities have, in a way, consented to be tested for everything including HIV, but that does not mean that these patients are not counseled. What we use is an [inaudible] approach. All patients are tested unless they decline to be tested, but in the context of the three "Cs" - that is confidentiality, counseling and consent. They have to consent for that to be done. So we do it and this is one of the things that has created some bit of stress for us because to offer confidential testing under the three "Cs," it means you need an extra room and therefore maybe infrastructure needs to be revisited for purposes of offering this effectively. At the moment, our test clinics are tiny, small, and in some cases, inappropriate for offering the counseling and therefore these are things we are growing up with but we are [inaudible] as we learn. So we do that in the context of the three "Cs."

MALE SPEAKER: Thank you very much Joseph.

[applause]

This ends a very interesting series of presentations this morning. This afternoon we continue at 2:15 and your Chair will be Dr. John [inaudible] the NTP program manager from India is already waiting ready to take you through the afternoon.

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Thank you all very much.

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