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**Stop TB Symposium: XDR-TB and TB/HIV:
A Threat or Opportunity for TB Control
Part 3
November 8, 2007**

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ROSALIND VIANZON: -Afternoon Session. I am Dr.

Rosalind Vianzon from the Philippines who will be co-chairing this afternoon session with Dr. Jeremiah Chikia [misspelled?] from Kenya. And for the first speakers we would like to invite Betina Durovni, M.D. from Brazil who will be giving us some aspects on the implementation of Isoniazid preventive therapy for people living with HIV, overcoming the barriers respective of HIV program.

BETINA DUROVNI, M.D.: First I would like to thank the organization of this symposium to invite me to show our experience with IPT among HIV patients. So the experience I am going to share with you today is based on the Trio study, which is mainly the implementing of Isoniazid Preventive therapy for people living with HIV and I am going to be discussing some of the barriers and challenges from the HIV program perspective.

I work in Rio de Janeiro City at the Health Department and I am also from the Federal University of Rio de Janeiro. I would like to give you some background about the situation of TB and HIV in Brazil and actually Rio is a good example of what happens in that country.

Our TB incidence is for 100,000 people it is almost double of things [inaudible] of the country. Although this is the overall incidence for the city we have some places, some communities more where the incidence can be as high as 300 or

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400 for 200,000 people. Our HIV prevalence in the general population is likely below 1-percent and our main route of infection is sexual transmission. Rio is a big city. We have six million people living in the city and although our TB incidence is not as high as in other countries, TB is the leading cause of morbidity and mortality among HIV patients in Rio de Janeiro.

One important characteristic of our service is that anti-retrovirals are free and have been distributed in the public sectors since the mid-90s and our services are free for all patients regardless of their socio-economic status. HAART is currently recommended in Brazil for all patients with CD4 counts below 350 and in Rio de Janeiro we have around 24,000 being followed in the public annex.

Brazil has in its guidelines the IPT as a recommended policy for HIV patients, but although this policy is recommended since the '90s, '80s rarely use it. So the study in which I will be basing our discussion today is actually a wide leading factor of widespread use of TB preventive therapy with access to anti-retroviral therapy in Rio de Janeiro.

This is the Rio de Janeiro map. These blue dots represent all the clinics in which the study is being developed. The reason why you see more clinics in one side of the city is because this is where most of the people live in Rio de Janeiro and the west zone is less populated, so these

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represents 29 public health units that are directly managed by the health department and is the setting of our experience in implementing IPT for people living with HIV.

So this is the objective of the study. Our study is implemented in phases. We start two clinics every two months. We starting intervention and we started in 2005, so now at the end of 2007 we are actually including the last two clinics into the intervention. I want to give you some numbers of our baseline.

Our studies based on data collected from charts of patients that are seen in these clinics and we have almost 11,000 patients eligible for the intervention, intervention here being having a PPD, a TST, and those that are not eligible are those patients had prior INH, prior TB or both. So we have around 11,000 patients that are eligible. Since September 2005 when we collected first baseline data, we actually have more than 2000 patients entering the system from September 2005 and the present date and we have reviewed 36,000 charts so far.

In terms of some demographics, we are in our clinics almost 40-percent of the cases of HIV patients that are being followed are women, 35-percent do not use anti-retro viral. They are being followed, but they don't fill the criteria to start anti-retro viral yet and the cut off for the PPD is 5mm among HIV patients, and we have around 23-percent of positively retrospectively, but it is important to notice that here many

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patients here had PPD to diagnostic purposes. It was not only for the diagnostic of latent TB. So that's why you're going to see that the presentation of positivity is a little lower when we start to do it prospectively.

When we compare the positivity for the PPD and the CD4 count we see what we expect, a trend of positivity as high as the CD4 is we have more positivity among the patients. So when we collect our baseline data we already had the opportunity to analyze retrospectively what was impact of the anti-retro viral therapy in this population, because we had patients that were already taking anti-retro viral and some of them used Isoniazid and these results were recently published and we have shown that the strategies were differentiated by anti-retro viral only, IPT only, and both.

As you can see in the incidence rate ratio they all give some protection but the higher protection was observed among those patients that had access to both anti-retro viral and IPT. This is just to give you an idea of the path that the patient has to go through since he is identified in the clinic and becomes eligible for the TST. Does the TST then start on INH?

And this is important because in each of the steps we identify challenges and barriers, so this is some of the experiences I want to share with you today. So what we call intervention is actually a package of training, development of

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educational material. We are providing the doctors with tools to summarize their patients experience through their HIV infection, because some of the patients have big, big, big charts like they have been following for 12 years, 10 years and sometimes it is difficult for the physician to actually summarize all the interventions that the patient had in the past.

We are investing a lot of our time and policy and advocacy. We do weekly supervision and reports and we are also keeping weekly month with the Trio staff, with the study team, and we do at least two meetings with the clinics that are already on the intervention to discuss with them the results that we have so far and to also to listen to their problems and what we can do to overcome this, this barriers.

So it's a pretty simple intervention, but it's very important to actually scale up the intake of IPT among the patients that as it was very low on the baseline when we analyze it the first time.

This is some of the materials we have developed. It's in Portuguese of course and I just want to try to translate it a little bit. The message we are trying to deliver here is that if you have HIV you should test for TB because TB can be prevented. And if you have TB you should test for HIV because AIDS has treatment and we try to do it less. A win-win situation here for the patients and this is a poster, a big

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poster, and we include it here like this health unit is prepared to answer your questions and to help you, so ask for information. Talk to your doctor.

This is a very popular publication among HIV patients in Brazil. It's a magazine especially driven for people living with HIV dealing with difference problems, nutritional problems, discussing cases and we worked with editorials, editors of this magazine to launch this issue that is entirely dedicated to the TB prevention. And what it says here is that prevention in the right time and it discuss all the things about prevention, interaction with the anti-retro viral drugs and this is dedicated for the patients. It's a tool that physicians, nurses, and other health professionals have to work with their patients.

So talking a little bit more about our intervention, these are the numbers of people trained so far. We have been training people together for TB and HIV this is one of ours to make the programs to work better together. PPD has been a challenge. We have PPD in our services for many years, but when we come back to train our, especially our auxiliary nurses, we find out that many of them didn't know how to do the PPD properly so it's a very demanding training.

We need a lot of volunteers. And we have been training so far 120 new people that were already working but new people also to improve the quality but also the accessibility to the

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PPD. We also include specific counseling training, because we are actually promoting a package that includes the HIV testing for our patients with TB and the TB test and the PPD for our patients with HIV.

So we are also investing in counseling. And we, as part of our advocacy and our policy activities, we have been also training HIV activists to help us in delivering the message of the importance of implementing IPT and the use of IPT among the community of people living with HIV in Rio.

So this is kind of our algorithm you can see how the funnel effect here would be, we were working with almost 8,000 patients and we were able to place so far half of the PPD's we expect to place but once we do the PPD we have almost 90-percent of the patients coming back to read it and once the PPD is positive fairly 80-percent of patients are started on IPT.

Here what you can see is a little bit of time effect on the intervention. We are actually doing some differences at the clinic level. This is the pre-post prevention comparison. In blue you can see the pre-intervention and we can see that the lines they are much separated after the intervention. But still we see that there is a delay in the realization of the PPD and this is one of our challenges.

It seems like it takes a long time for the patient to be counseled and to come to the clinic and to have PPD placed. We are on the impression that a long time maybe around two

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years we are going to be able to cover all the patients that have indication to have PPD. In terms of the IPT of course, here we are talking only about those patients that had positive PPD and again we see that there is a sharper effect in the beginning and then the follow up it still takes a long time to start IPT.

Here the most important thing is that we have to rule out TB. We have to do sputum smear, the x-ray to be sure that there is no active TB. This is also important activity because we are actually doing an active case finding of TB along our HIV patients and only after we exclude TB we start IPT. So we are, we are going to discuss a little bit later on how this is sometimes a challenge and a barrier in terms of timing to start IPT.

So now I am going to start to discuss some of these challenges and I am going to base the issues here on two studies we've done in the Trio. This is one of the posters that we are going to be presenting on Saturday, and we have compared the adherence of the doctors to the HIV guidelines.

How much do they adhere to the guidelines when it comes to PCP prophylaxes and to HIV monitoring like CD4 and viral and it turned out when we compared these to how much they adhered to the TB part of the guidelines, it's very different. They are much more compliant with HIV monitoring the PCP prophylaxes than with TB screening and prophylaxis guidelines.

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So this is a very important indicator for us on where we have to put energy and fort with the HIV doctors. We also did a qualitative enquire that included interviews with TB and HIV physicians, nurses and also local administrators. In Rio it's very important that the local administrator also understands and buys the idea of IPT because there are issues like the agenda for x-ray, for PPD, the way you allocate your human resources so the local administrators are a very important piece for us.

So what they said, what these people that we interviewed said, they said that they think that they are doing their best. But they acknowledge that they need more information about TB prevention and the nurses said they would like to have more autonomy. In Rio and Brazil as a whole much of the decision is in the doctor's hand and the nurses sometimes feel like they could do more if they could have more autonomy in some decisions.

They also asked us, asked us for more organization in terms of how to register TST and the IPT prescription and they think they said that TB and HIV teams should be working together and we like this statement very much, because we think this is true. So what have we learned from this experience so far? The physicians, nurses, and local managers they think that the patients are kind of afraid of the TST.

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The concept of doing a test to diagnose latent infection is a little bit difficult to understand. Sometimes they think the test will actually say that they have TB and so it's very important to explain and to do the right counseling, consultation with these patients to make clear, to make the concept of the latent infection clear and also the patients sometimes they think that TST takes two visits you have to place the TST, you have to come back to read it and some of them also say that this is a barrier.

It was clear also that the doctor's lack of knowledge about TB prevention is an important reason for different performances. When we did the qualitative enquiry we asked questions for nurses, doctors, and local administrators from different clinics, clinics that were doing better than others.

So we could notice that very clearly that those clinics where the IPT intake was scaling up better than the others were those clinics where the doctors new something about TB protocol the new barrier about prevention of TB among HIV patients. They also think that there is some kind of problems because of the complexity of the HIV treatment and the HIV patient's style of life. And although we had very few from more than 400 IPT's we had only 15 cases of adverse reactions and only one had toxicity that was mild, didn't have any major consequence.

It's still the doctors are afraid of the adverse events of IPT. So this was very important for us that we have to

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bring forth the message about safety of IPT. So after all, after almost two years implementing this strategy, we are actually revisiting our strategy and developing new communications strategists. The recent launch of stop TB statement is an important tool.

I am going to show it in a minute. Also we think that it is very important to bring prominent authorities to talk about TB as we have for HIV. We have very important researchers, doctors that are respected by the other health professionals. They talk about HIV very often and we want them to also talk about TB. We are also developing specific strategize the local health administrators involving them in more scientific and technical meetings to make them understand importance of this strategy.

New training models for health professional and also raising awareness about TB among HIV community. This has been a very good experience. We are actually training them but we also learning a lot from them on how to improve our strategies to implement IPT among HIV patients. And all these forts in Brazil they only make sense if they are really incorporated in our public health system. This is the only way that we can actually believe in some sustainability after this study or any other intervention.

So all the things that we discuss and implement, we try to do it as much as possible in the context of our public

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services. So this is the stop TB partnership statement. This is a very important tool for us at the local level because then we can show that what we are actually advocating is aligned with international guidelines and best practices. So it's very important that this kind of tool is available now because then we can actually show that TB is not only important for many different agencies but that there is scientific evidence not only what we are saying at the local level or even at the country level but internationally.

Just to finish some of our operational strategies has been promoting integration between HIV and TB programs as everybody in this room might know it is not exactly easy but we are progressing on this matter and as our nurses and doctors asked us to do we are improving the tools for registering PPD and IPT and we are starting a study to see what are the bottle necks for the ruling of TB. If we can improve the timing to the x-ray to the smear what we can do to shorten this time and have IPT initiation right after the PPD and thank you very much. [Applause]

ROSALIND VIANZON: Okay. Thank you. So please reserve your questions at a later time and I will be calling on the second speaker for the same topic of INH preventive therapy. May we call now Dr. Oaitse I Motsamai from Botswana, please?

OAITSE I MOTASAMI: Okay. Good afternoon I am going to be talking about the experience of Botswana in the use of IPT

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countrywide and this is the outline of my presentation. I will start with the background rush now for IPT in Botswana, inception implementation outcomes, administration TB/HIV integration achievement challenges and planned interventions.

Botswana it's located in southern part of Africa just north of South Africa within the [inaudible] area. It has a population of 1.7 million and has an area of about 581 sq km. It's a developing country. Right now there's high HIV prevalence in the country and this is the reason why we are implementing IPT in the country and the estimated TB/HIV co-infection rate is 80-percent and there has been an autopsy study that was conducted in 1999 in one of the federal hospitals in the northern part of the country where 36-percent of HIV adults were found to be treated TB and there were other studies that were carried in the area like an inpatient study that was carried in another federal hospital which showed the prevalence of about 84-percent and the other one on the outpatient we showed prevalence of 73-percent, and therefore our prevalence rate was much, much higher because it was 80-percent, I mean the co-infection rate. TB rates and HIV prevalence among pregnant women and this was between 1975 and 2001.

Our TB program was established in 1975 as you can see and from 1975 our rates were very high, over 500 cases per 100,000 and as time went on with the planned TB strategies we

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were able to control TB until we reached the lowest rate of 222 per 100,000 in about 1991 and from then this was when we started seeing high jumps in the rates of TB in the country and the highest rate that we have ever recorded was 623 per 100,000 population and that was in 2003.

And currently the rate is 603 per 100,000 and published our policy statement on IPT our implementation of IPT was also based on this statement in 1998, which recommended the use of IPT to people living with HIV in high prevalent countries, and this is what happened in Botswana. We started by forming a waiting group of IPT in 1999 and then followed by a pilot that was conducted in 3 districts in Botswana in 2001 and the purpose of this pilot was to find the feasibility of implementing IPT countrywide given the situation because in Botswana we don't have many doctors. Most of the health facilities are meant and headed by Nexus and therefore the purpose of this pilot was to find out if Nexus could successfully screen a patient or HIV positive persons for active TB and exclude it. So it was recommended that the findings the pilot recommended that it is feasible to implement IPT countrywide that Nexus were able to have successfully screen and implement IPT and therefore it was started late 2001.

The eligibility criteria included confirmed and documented HIV positive patients. They have to be 16 years and

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above and this was based on the HIV testing policy that was the there at that time and also because we did not want to involve children in IPT because we couldn't successfully exclude active TB in these children. And people be currently pregnant because we are saying IPT is not an agency so people should come back after six weeks post-partum to come and be screened for eligibility into the program.

They shouldn't have active TB and not tell [inaudible] because they won't benefit from the program and they should not have hepatitis as we know that is a very important organ in what metabolism of INH. They should not have a history of TB within the past three years unless they had, they might develop a resistance; a relapse and of course no history of INH tolerance.

So we have this screening algorithm that we are using and these are the main focus of our screening algorithm prove what HIV positive status we need to solicit that from our clients. We need to take data history and make, do a physical examination from head to toe, exclude persons with cough and fever so that we can better investigate and be sure that they don't have signs and symptoms of TB before they could be enrolled in the program and data counseling of clients is expected so that they understand why they have to be on IPT and why they should adhere and complete the treatment and then we have to start them if we find out they are eligible and then we

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expect them to come back on monthly basis for review, assessment and drug supply.

Our IPT runs for six months and they take treatment on monthly basis so far instead; this is a sample of the screening algorithm that we use and these are the outcomes of our implementation. [Inaudible] has been very difficult to implement this program in the country. We started by training [inaudible] in the whole country. We had another reach of five [inaudible] in each district and these [inaudible] are expected to go ahead and continue training the rest of the health workers in the, in the, in their own districts. These are the outcomes for [inaudible] since the inception of the program and we have screened over 71,000 clients, HIV positive people and have started 67,413 and among these only 27 were found to have completed treatment.

And 10-percent were still under treatment none, and none completes were, 63-percent and we think those who have not completed there is those whom we know where they ended, where we have reasons why they did not complete is 24-percent, those without reasons were 76-percent. And this means that we know the outcomes of about 51-percent of our clients who were enrolled in the program. So the question is where is the other 49-percent? So this is a bit of the same old summary of the same thing. Where we are looking at the progress of implementation since the inception of the program we started

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with the pilot in 2001 and then late 2001 this way we sent the administrator of health of Botswana and CDC signed an [inaudible] cooperative agreement on the implementation of IPT. Unfortunately the IPT office was not established by then until late 2003 where we had three officers coming into the office. And from there we can see a big rise in the uptake of the program showing that indeed the office is established and then it was rolled out to the rest of the districts by June 2004.

And currently the initiative is available in all health facilities including health posts in the country and it is implemented by Nexus and doctors who have to go undergo training before they could implement it and then in 2005 was when we managed to develop a data base, a national IPT data base and it was rolled out late in November 2005. And our routine HIV testing strategy was also accepted in 2002; a result which assisted in the favored uptake of the program.

These are some of the reasons, which were recorded. Why some of the people did not complete treatment. Most of them did not complete were found to have been lost to follow up and this was found when they actually visited in their homes, in their homes and found not to be available or moved/changed accommodation and then 90-percent of them had other reasons like pregnancy and others, and we see active TB among 2-percent of those who did not complete. Administration, the funding of the program comes manly from CDC and the government. Right

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now we are in the second cooperative agreement, the second was started in 2005 and runs up to 2010.

The Minister of Health provides infrastructure, directs IPT counseling support while CDC provides money for salaries, training, patients and equipment and so far CDC has used more than 3 million in the program, IPT study, we at the original office or original level where we the original coordinator, original coordinators one for the North the other for the South. Data officers and a data manger we still are waiting for and IC officer but implementation is taking place in all facilities like I said in hospitals, clinics, mobile stops, and the like.

Support and supervision district health facilities are doing supervised by TB coordinators from DHT's and question anything that we do have from the original TB coordinators now I think is about a year since we had some of them. District TB coordinators are supervised by us at a national level including the TB district team management.

The national level at the same time when we do supervise we do sample some facilities. DHT's have been given feedbacks on their performance, the level of performance. District TB coordinators normally are invited for workshops where they meet and discuss about the district performance and then they are trained on IPT, TB/HIV surveillance and TB case management. This way the tide is set for 2006. We had

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intended to train 96 [inaudible] but we ended up training 151 and this is because this tendency that this high mobility of health workers some of them when they are transferred to other districts they don't continue as TOT's some of them go out for greener purposes.

Health care workers train so far as about more than 60-percent and their involvement by then is less than what was expected but now is much, much higher. The [inaudible] that is trained for IPT. We do have doctors, nurses, pharmaceuticals technicians, health educators, and social workers. We also have family welfare educators and this kind of is expected to do follow ups of clients as well as to follow-up. Lay counselors and health auxiliary, this is the records that we use for IPT; we have the outpatient records; we have raised the compliance records; IPT dispensary tally sheet; this one is based at a dispensary; patient transfer format, [inaudible] format and electronic IPT register. We also have training guides where we have the facilitator guide and they have worker guide. The IC materials that are produced many some are brachiates [misspelled?], [inaudible], status-post and many others. And the database was developed and funded. Developed with assistance of CDC and it has been drawn out to all the districts. We do have computers at all districts and currently we are busy updating the client's records because what we have realized is that some of the clients there is a good number of

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clients who have been on IPT who have actually completed but have not recorded as completed.

Integration of TB and HIV care, implementation of routine HIV testing from Western, accepted from general 2004. HIV testing of TB patients is routine but so far it is at 68-percent. IPT is prescribed in all health facilities by doctors and nurses and IPT is usually given as a package of HIV care. And these are some of the sources of referral to IPT prevention of mother-to-child transmission of HIV, BCT's non-governmental organizations in IDCC or [inaudible] programs.

IPT provides a systematic people living with HIV for TB and for others; like maybe the hat and we do have TB/HIV adversarial ID, which has establish a year back. TB and HIV care issues are also included in the new TB treatment manual. Our shipment and challenges we've have been able to train an average of five TOT's per district and more than 65-percent of Africa's countrywide IPT program officers are at the national level, those that still feel that they are inadequate for the national level.

IPT is available in all health facilities and the public awareness of the activity of the program has increased. We have improved paper based reporting from the districts and computers have been purchased for all districts. Database is available in all districts and we do have dissipated TB coordinators in almost all districts. Initially we had people

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in our community have Nexus in other health carriers who would test with the responsibility of taking care of the TB program, but we have found that most times they put just maybe less than 10-percent of their effort on TB control activities and that is why we decided to come up with these designated TB coordinators and also this has helped us because we have actually improved on our records.

We have enabled linkage of IPT to TB and ARB databases through the use of national identity. We have also improved frequency and quality of separate visits, challenges that I will encounter over stretched national staff. At the national level, the IPT program belongs to the TB program and the TB program has been short staffed for many years now.

And when we came into the program we were looking at all the national TB [inaudible] and on that endeavor we ended up losing track of our core business which was IPT. And we have realized this inadequate counsel of some clients, because sometimes you cross at lines, who was put on treatment and we did not even know that he had to continue coming to the health facility and it was that lack of information given by health worker.

Rest of clients who are still on treatment the client's follow up is very limited and this is what we are trying to push that. All the lives that have been on IPT should be followed up and the TB coordinators they have been reporting

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transport problems which I think would be solved very soon because now we have been able to purchase some vehicles for TB coordinators by the Global Fund Grant, and there's high morbidity of clients who do not inform the health facilities where they are going and therefore we end up losing them, some of them even give health workers wrong addresses because there are situations where people have been followed up only to find out they are not even moved to addresses which they give to the health workers.

We also have challenges of recording [inaudible] problems incomplete [inaudible] records. Sometimes are registered and given the first or second doses or supplies then they just disappear, don't know what happened, nobody bothers to know where they are. We have lack of timely reporting and also like I said if you look into the registers, paper based registers as we do supervised services there are a good number of clients who have been registered in the program and have completed six months of treatment and is well documented but then people have failed to write to close them. To write their outcomes that they have completed so that it can be captured into the database.

Personal dishearten over district health workers including TB coordinators because the current TB coordinators that we have are directly from institution, training institutions, they are from schools and therefore they don't

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have some overtime allowance like their colleagues in hospitals and therefore they tend to rush back to the hospitals where they could get at least 30-percent overtime allowance and we have noted also that there are weeks supervision especially from the district level and this are the issues that need to be re-emphasized.

We are still continuing to train and retrain and our main focus now is on training institutions like the University and Health Training Institutions so that when they complete at least they already know what IPT is all about. Planned interventions; we have a lot of backlog of data in the district so we need to update this record to enter these records into the database and also update some un-updated records that new to be enclosed. Continue with intensive supervised visits because we have realized that with more frequent supervised visits now health workers are changing their attitude towards recording. Continuing training of untrained health care workers and we intend to reevaluate the program and I know that we have been waiting the results of the evaluation and it has taken a just too long but this is because of some of the problems like the records. I mean if you don't have records where do we get data to read the program and therefore right now we are very busy running around districts so that we can correct that anomaly and therefore we have plenty to evaluate

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the program possibly the second quarter of 2008. Thank you very much. [Applause]

ROSALIND VIANZON: And so I think this afternoon we have been provided with two good presentations of the topic of IPT in the light of TB/HIV. May I invite our two speakers please to join us here for some questions from the floor? So the floor is now open for clarifications or questions to our two speakers on this topic of IPT therapy.

Yes, please ma'am?

FEMALE SPEAKER: My name is [inaudible] from Compella [misspelled?] Uganda where TB is a common cause of morbidity and mortality among people with HIV. Now we have had a problem of implementing IPT among people living with HIV and the main reasons given by physicians are one the difficulty excluding active TB among people before they can be given IPT especially extra pulmonary IPT. The second main concern is issue of adherence and the risk of INH resistance in people who are incubating TB. In fact some physicians suggest that probably we should give IPT only to people with high CD4 count and those with low CD4 count give IPT when we give them ARV's that way if they are on ARV's and IPT they are closely followed up so if they get active TB it's more likely to be picked up as opposed to people who are fairly healthy and they are given treatment and don't complete it and they are more likely to miss having the diagnosis of active TB made because of poor follow up so

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those are some of the issues that we have had. The second point that has come up that probably we should consider more people who are on ARV's to give IPT so that we manage the TB virus that they might get and concentrate least on those who have not yet started ARV's they are less likely to comply.

Thank you.

ROSALIND VIANZON: Okay. So I think those were just points to consider as far as our speakers are concerned. Would you like to have any response?

BETINA DUROVNI, M.D.: I think it is quite clear but I mean the issue of resistance. You would expect resistance where there has been poor implementation like maybe poor screening with [inaudible] for IPT because we have workers we have our way of doing things. Some do what is called stagger to where they don't do a thorough examination like expected and in such cases of course they might better think if it is well implemented it's protocol is followed and if you suspect that this person is caught active TB they should be thoroughly [inaudible] for TB before being put on IPT. I don't think there can be any resistance.

ROSALIND VIANZON: Okay so very well said may we have the next question and I think due to limitations in time we can probably entertain one more question. Yes, sir?

DR. CALVER: I am Dr. Calver [misspelled?], mining Industry in South Africa. One of the things that worries me

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about the two presentations is that neither of the speakers actually alluded to how Tuberculosis was excluded. Certainly a thorough physical examination is part of it but it's not going to exclude active TB very well and then of course you've got the idiosyncratic situation in HIV where they have [inaudible] disease. So the value of doing a sputum is questioned in excluding active TB prior to the institution of IPT therapy. That's the one comment. Perhaps the speakers would like to elude how they did exclude active TB in their protocols. The other comment is that in analysis of an MDR cohort in our situation only six out of 140 patients had had previous IPT. All six of those patients developed MDR-TB within one year of incomplete treatment with IPT, two months or less those six patients had it. So I am concerned about Botswana's figures of high drop out rates from their IPT that that may well be feeling the MDR epidemic.

ROSALIND VIANZON: Address and response please.

OAITSE I MOTASAMI: We do have a screening algorithm that I showed previously that we use to screen our clients for IPT. Actually our implementation was based on the results of the pilot that way. Was conducted in 2001 where among over 500 participants who had chest x-rays we found only one out of them was found to have heavy active TB and that is why we don't even do chest x-ray. We go for chest x-ray when we suspect TB and we do sputum micro-scoping then if it is negative we can go

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further and investigate use in the chest x-ray. So far we do find that we do physical examination and subjective information from patient so that is the policy as of now but we are conducting a clinic trial together with CDC. A three-year in [inaudible] where we are comparing the efficacy of IPT; six months IPT versus the 36 months IPT and then I think if there is need or need for a change of policy then it will be based on that trial, perhaps in Brazil.

BETINA DUROVNI, M.D.: Our rhythm to exclude TB is very similar. We of course use the clinical examination, the sputum is smeared and the x-ray and in our record in our patients the most important cause to have TB was actually having previous TB without finishing the treatment properly so I think that our focus has been on getting TB patients to finish their treatment properly excluding TB which in our reviews also gives the opportunity to deliver the HIV program to find cases of TB. Because if you are implementing IPT you are actually examining patients to do the TB diagnostics so I think this is also important and so far from literature has shown and in our experience we haven't observed any major adverse events or the surgement of any resistant cases of TB after the IPT. Of course we still don't have the larger follow up but we will follow these patients and hope we can report on that.

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ROSALIND VIANZON: Okay. I think maybe we call now for the very last question and may we call on the gentleman in this row in blue.

MALE SPEAKER 2: Okay. I thank you for two wonderful presentations. [Inaudible] from Nigeria. My two questions are one for the Botswana example is that the IPT program is it being run as a separate program because I was a bit concerned that IPT feeding into the TB program and HIV program and issues of collaborating sustainability. My second question is the algorithm for ruling out active TB. One I was happy to hear that its like doctors IV because the barriers to implement IPT seems almost barrier crossed and that in Nigeria the pilot would do it into widespread implementation of IPT includes a part from clinical screening, chest x-ray and for those who have symptoms of cough including culture. But despite all these things still there's a very big apathy from the doctor's end with regards to starting people that are within the national criteria on starting them on IPT. And I am really at least comforted to hear that it's applied elsewhere. Thank you.

OAITSE I MOTASAMI: That's funny.

BETINA DUROVNI, M.D.: Yes. Okay. That IPT program like I said in Botswana is based imbedded with 10 day that was on a national TB program. I think it can also be put under maybe the ARV program but in our situation it is within the TB

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program and we don't monitor our clients even though we are within the TB program we work as a team towards money carrying all these clients. It is only that we have so many in cities within the TB program and so far we have this collaboration between CDC and administrator of health which we know at some point will not be sustained but our government is very committed to take over when CDC ends and I think CDC is winning as scheduled towards that and the screening algorithm like I said our implementation is based on that but immediately you would suspect that this person might be having active TB they have to be thoroughly investigated and even they are fed to a medical officer for further assessment. We are not supposed to include or put in anybody who is a suspect of TB into the program. It's only that sometimes there are protocols and not everybody would abide by those protocols and as such you end up with problems here and there. But if it was implemented accordingly as stated or as expected I think there would be less problems.

ROSALIND VIANZON: I guess due to limitations in time we just perhaps request the other questions to have a personal discussion within the speakers.

OAITSE I MOTASAMI: Yes, and the other problem that we have had is that lack of designated TB coordinators. People are very carefree in the way that they implemented the program and we need to that [inaudible] but not that we have designated

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TB coordinators we do have control over them. We do monitor them. We do call them to table more frequently and we can see a big difference from the effect. We can see a big difference in the uptake the monetary and even the outcomes of the program.

ROSALIND VIANZON: Okay. So thank you very much to our two speakers. Perhaps you can give them a round of applause and [applause] just a reminder before we go to a round of coffee it is advised that you bring all of your things before going out and they suggested that no bags be left in the auditorium while we are on coffee break. So we will be assuming around session around 3:30 and Michael [inaudible].

[END RECORDING]