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**38th Union World Conference on Lung Health  
MDR-TB and TB-HIV Control in Prisons:  
Achievements and Challenges  
November 10, 2007**

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**MARTIEN BORGENDORFF, M.D., PH.D.:** –for a number of reasons. First of all in many settings it's difficult to get political support for improving the prison health conditions. And this is closely linked with prison reform and civil rights of prisoners. In health there is a particular problem of the coordination of health services between the prison authorities and the civil health authorities.

And for conditions such as TB and HIV where treatment takes a long time, this coordination is quite important because people can be treated partly in prison and partly outside prison. There is a high prevalence of drug-resistant TB in central Asia, a global problem but also in this setting is the coordination of TB and HIV control activities, there is of course stigma, fear and issues to do with this particularities of the situation in prison, the jail hierarchy. And then finally there are issues to do with funding and new resource development.

How does it come that TB and HIV go together in prisons? Well first of all there is HIV-related TB. That is a global issue and that is well recognized, but there are some additional reasons for these two infections to go together. First of all there are common risk factors before imprisonment and they include homelessness, unemployment, migration, and drug use. And also prisons themselves are a risk factor for

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both HIV and TB, TB because of overcrowding, poor ventilation, poor nutrition, and stress, and HIV because of needle sharing and unprotected men having sex with men.

This graph shows the TB trends in Europe over the past two or almost three decades. What you see there is the bottom green line is the trend in the European Union before the accession of Romania and Bulgaria, and there you see a declining trend. TB rates are low and they continue to decline. For Europe overall this is not the case. That's the yellow line in the middle, and in particular in the 18 high priority countries in the WHO Europe region there's been a tremendous increase over the past two decades with more or less a doubling of the TB rate.

The numbers then are on this slide. In each year there's more than a quarter of a million people newly infected with HIV. The total number of infected people is estimated to be 1.7 million with 84,000 deaths in the year 2006. And then there are 445,000 new TB cases with 66,000 deaths. And the, as I said before, the collaboration between TB and HIV control programs is often insufficient. Now prisons are a problem because of their high rate of TB and HIV among prisoners, and this is- but an additional problem is that in central Asia the rate of incarceration is very high. A relatively large proportion of the population is in prison, and these are the numbers. In the former Soviet Union countries there were more

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than a million prisoners and among these there were 82,000 cases of TB. And as you see, the prevalence rate is horrendous. It's very, very high. In Western Europe the prevalence is a lot lower, but still it's a lot higher than that among the general population. This is the map of central Asia, so the area that we are talking about in this presentation with a total population of 56 million people, and a lot of different ethnic groups.

This slide shows the size of the prison population in three of the central Asian republics, and as I indicated before these are high numbers of incarcerations and therefore high number of prisoners.

This slide shows the TB case notification rate and mortality rate in Kazakhstan. And what you see there is a topping of the notification rate in the year 2002 and from then a gradual decline. And also the mortality rates are the graph there at the bottom. In the TB prison the rates are a lot higher. The good news is that the rates are declining, but the bad news is that they are still extremely high.

The project that is the subject of this presentation, and especially the next one by Joost is a partnership between the Ministry of Justice, which is very important for the political commitment for a prison project, the prison health authorities, Penal Reform International that is dealing with human rights and prison reform, AFEW and Joost Van der Meer,

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the next speaker is the Director of AFEW which is specialized in HIV and HIV-TB control, and the KNCV that I represent, that is specialized in TB and TB-HIV control. And thank you for your attention. The presentation will now be continued by Joost van der Meer.

**MALE SPEAKER:** Thank you very much Martien. For the sake of time actually and also since these two presentations are linked, please keep your questions until Joost's presentation is finished. Thank you.

**JOOST VAN DER MEER, MD, PHD:** Yes, now I will continue the presentation and good morning. I hope to be entertaining you as well as Martien did and keep you a bit awake and lively on this early Saturday morning.

Because I come from the HIV angle and many of you may not know our organization, I will take two slides to introduce Aids Foundation East West or AFEW as we call our abbreviation. We are a Dutch non-governmental, humanitarian public health organization and our main mission is to make an impact on the HIV and Aids epidemic in eastern Europe and central Asia or to put it differently, the countries of the former Soviet Union. That's where we work. Here is a map of the countries where we work, although this slide is slightly outdated because Mongolia is no longer in our list of countries. Martien has already highlighted some of the data about TB and I will focus a bit on HIV. There are 1.7 million people living with HIV in eastern

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Europe and central Asia, 260,000 new infections in 2006 alone. I am very curious what that latest or upcoming Aids epidemic update by UNH will show in this region. In contrast to Africa the HIV epidemics are driven by injecting drug use, not so much by sexual contact, which means that injecting drug users are the group that is most at risk, but also sex workers who are also often injecting drug users.

And because of their inherently mostly illegal activities they usually end up in prison. So that's where the epidemic concentrates. There are also emerging target groups: men having sex with men, but also street children. A recent survey that we conducted together with UNICEF in Ukraine reveals an HIV rate of 20-percent and more amongst street children living in Odessa. Although the prevalence rate of HIV in eastern Europe and central Asia are not so high in absolute numbers, the growth rate is very high. It's the fastest growing epidemic in the world. And here on the graph you see the four central Asian countries, Khuzestan is the highest, the dark blue line there, and then comes Uzbekistan, Kurdistan, and Tajikistan.

And so the growth rate is quite frightening, and even more frightening when you look at the graph here that also shows the growth rate in Russia, but then five years back. And then you compare the growth rate of Uzbekistan with it, which is almost exactly the same, even a little bit higher. And now

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Russia has a significant HIV problem, about 1-percent of the general population has HIV is the current estimate. And so it shows two things: there is a window of opportunity to do something now, but if we sit back and don't do anything we will end up with a major problem in central Asia as well.

Martien has also already told some of the challenges in the prison setting in terms of HIV. It is risk behavior, and a couple of the risk behaviors that accumulate in prison. It's not only injecting drug use and not only unprotected sex and rape, let's call it like that because that's what it also often is, but also other practices like tattooing and body piercing with unsafe equipment and sharing other appliances like toothbrushes and razor blades. And of course there are also the fights that contribute to it. There is exposure to tuberculosis and the whole concentration mechanism reveals that in some countries up to 40-percent of all people registered with HIV are actually in prison.

Other challenges are from the side of staff, the knowledge about HIV and also about HIV and TB co-infection is often insufficient. There are high levels of TB and co-infection, 7 to 8-percent. And there are very separated health care systems, both the TB and HIV systems that are very much separated in central Asia and as well as the non-existing link between society and prison inside and outside presents a challenge. Harm reduction, so needle exchange and substitution

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treatment with methadone or with mubenaphren [misspelled?] is not around in most countries. Turkistan is a good example. It's the best pupil one can say. And monitoring of actually what we do and what our impact is very difficult in prison because data are classified. Some denominators, if we want to know if we really have an impact, how many staff did we train. And how much of all prison staff does this represent? We can not know because the denominator is classified information.

So we recently asked, what is actually the role of NGOs in this prison setting? What is your added value? Well we, and that's not only for AFEW but also local NGOs, partners with which we work, we know our target groups very well. We know that injecting drug users are distressed in this system. But we know where to find them. We can gain their trust. So we have this link with society. We know the target groups and so this is our added value. And the government systems usually have very little attention and also very little experience with this. So this is where our added value comes in. We can provide continuity of care between prison system and outside of prison system, which we call transitional case management. Building a client's network around a client or a patient, where all the services disburse a needs this person can access.

Peer-to-peer approach is another sort of approach that is developed by NGOs and that is- that governments' has very little experience of, but that generally it works very well

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with this group and also to make sure that the target group trusts the services given.

So with KNCV and AFEW we decided to have a strategic partnership, mainly because it actually mutually strengthens our knowledge and the quality of our work because we know a lot about HIV, KNCV knows a lot of TB, and you can not ignore this problem in prison settings. So it's very logical to combine our efforts at that level. And working in central Asia, of course, in prison systems we line up with the government so there's our private, private, public partnership. And the objectives of our program in central Asia with Dutch governmental funding from 2008 to 2010 is to improve TB case finding among those at risk with HIV and also improve HIV prevention among TB patients and improve TB prevention and care for people living with HIV not only in prison settings but also outside. But it makes sense to start things in prison setting because of the highly concentrated epidemic there.

The expected outcomes of our program, and I am talking then by 2010, we hope to have an HIV-TB conditional case management model in place, meaning that there's really a continuity of care in the prison system and when a prisoner gets released he or she will find that care also outside the prison in the civil or in the regular health care system. The other objective is to have in-house TB-HIV collaboration. I've already explained, and Martien as well, that there are this

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pillars or TB and HIV care and never the twain shall meet almost. That is of course not what we want and what is needed to get a good response. So we hope to have in-house TB collaboration by setting up interdisciplinary working groups, increase capacity of service providers in providing care for HIV-TB infection, co-infection, and that is will be achieved by training. And so we will see hopefully by the end of this program, enormous increase. I've seen myself that TB doctors in this region are very in familiar with the clinical picture of HIV-TB co-infections or TB and HIV and often looking for cavities or looking for the very specific tuberculosis picture in X-rays and of course you will not find that.

Labs is another underdeveloped part in the region that needs really a lot of support. So we envision to have enhanced laboratory capacity to provide adequate care for HIV and TB co-infection, and train lab staff and provide equipment. And finally, of course, the objective is to have universal access for prisoners and all patients with HIV and/or TB to adequate medical care. And so in setting up this whole transitional case management we will monitor with special database the successful referrals. So we will start with piloting the model of transitional case management and [inaudible 16:32] management with which we have already started in central Asia and then expand and support the national working groups and set them up on prison health. And train and capacity-build medical

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and support staff, but also set up peer networks in prisons of prisoners who do HIV prevention and TB prevention information. Material and technical support and like I said, inform people in civil society and patients because that's also very important to make sure that actually the services that we want to deliver are meaningful to the target groups. Thank you very much. [applause] These are the acknowledgements of all people involved in this project.

**MALE SPEAKER:** Thank you Joost. Any clarifications? The floor is now open for questions, discussion, clarifications. And there are microphones in each aisle. Thank you. Please state your name and where you're from please.

**THERMA GOLDMAN:** Okay. Good morning. Therma Goldman [misspelled?] the Centers for Disease Control and Prevention in South Africa, one of the inmates after they've been released from the prison.

**JOOST VAN DER MEER:** You mean treatment of TB and Aids?

**THERMA GOLDMAN:** Both TB and HIV.

**JOOST VAN DER MEER:** There is TB treatment in prisons where there are special what they call colonies for treating TB patients. In theory there is also ARV treatment and in some countries it is happening in prisons. It is starting slowly, but it's actually just starting. And that's what I was referring to as one of the challenges. Actually a lot of staff

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and medical staff in prisons is not well prepared to do the ARV treatment in prisons yet, let alone patients, so we have to also get this going in prisons. It's not a matter of only pushing the pills, and the pills are coming in with Global Fund money, but it's also a matter of setting up this whole treatment-preparedness efforts and peer adherence groups among prisoners, et cetera, that has to be-- still to be done. So there's a lot of work to be done still.

**USHWIN DEMATICARI:** Good morning. My name is Ushwin Dematicari [misspelled?]. I'm from the Brigham and Women's Hospital in Boston, Massachusetts, U.S.A. My question is along the same lines as the previous question. I was curious if you could describe what systems exist currently to handle openly infections patients with TB for example. Are there infection control measures that are being utilized?

**JOOST VAN DER MEER:** As far as I know, I can not speak for all prisons of course, but there is no or very little infection control. So there is-- that's one of the challenges that we will face, that we will have to install measures for. People are just grouped together so there's really not a policy there. I don't know whether Martien will want to say anything about that, but--

**MAIA EDIE:** I am Maia Edie [misspelled?] from Sao Paulo, Brazil. I'm interested in how do you link patient, the case of patient management when they release prison? What kind

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of information system? And also we have so much trouble from one prison to other prison. They are transferred. How do you act?

**JOOST VAN DER MEER:** The vision is to, and we've already started working on that, is to prepare prisoners when they know that they will be released in a couple of sessions on their new life in society, and also then list what sort of services and what sort of things they would need once they are released. Then once they are released, so they are prepared and also in coordination with health system in prisons, their medical needs are known. Then they will be referred once they are outside to what we call social bureau. That's where a social worker sits. And this social worker then coordinates the care, does an intake and will coordinate the care of this particular prison so not only medical needs will be part of this assessment or this intake, but also social needs.

Often prisoners are released without given any papers so they don't exist basically, have not access to the health care systems. Often the priority is to get papers. So this whole coordination will then be done, handled by social bureaus where often based in the same area as the prison and who are providing a service that is relevant for prisoners or by the target groups. So either it's a counseling and testing site or it's a harm reduction center or it's something else. That's

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how we envision it to work and we have started to set up these social bureaus already.

**MAIA EDIE:** Thank you.

**MALE SPEAKER:** Last question, please.

**ONTHEAL ZELLWEGER:** Okay. My name is Ontheal Zellweger [misspelled?] from the Swiss Lung Association. One of the well-known problems is usually the lack of coordination between Ministry of Health and Ministry of Justice in many countries, particularly in eastern Europe. My question, where do you start your intervention? At which level? Do you start with an intervention at ministerial level or do you start your intervention with the Director of the local prisons?

**JOOST VAN DER MEER:** We do both. So we work from all levels so we need political commitment from the highest level as well as from the prison authorities. So we will make sure that the Ministry of Health and Ministry of Justice know what we do and agree with it. And then work with prison authorities to also establish this model of care. So you need actually, certainly in these hierarchical systems of central Asia, you need to really get political support from a high level in order to make an impact, otherwise it is useless to work.

**ONTHEAL ZELLWEGER:** So my simple question is, is it successful when you intervene at the level of Ministry of Justice because in my experience, in some countries, it's just hopeless.

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**JOOST VAN DER MEER:** Well, we have actually quite good experiences with Ministries of Justice when it comes to prison health. I don't know why, but we have very good relationships with the Russian Gwinne [misspelled?] and so that's the prison health system on a federal level. And you need that support otherwise you can not work. And maybe it's out of enlightened self-interest that we have such a good working relationship, but they really do value the interventions and the sort of work that we do, both prisoners and their staff.

To give you an example there was a lot of talk in Russia about a year ago about registering NGOs and also international NGOs. We are a little bit under fire one can say so, however also, in the Russian press there was some articles about that. And one of the first phone calls we got was from the Gwinne [misspelled?], the prison system saying, "You can still work in Russia, can't you?" And I said, "Yes, we had no problem." We had no problem, but they were really-- they are really good partners.

**MASOUD DARA:** Thank you very much Joost, Martien. We'll go for the next presentation from Russian Federation Archangelsk region. Dr. Andrey Mariandyshev, would you please come to the floor? Basically all these questions raised are very, very important and pertinent and there are some good country examples. Hopefully we can get from this presentation some practical examples and at the end of the discussion we'll

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have some, after presentations we'll have some time for discussion. Thank you.

**ANDREY MARIANDYSHEV:** Thank you very much, Masoud.

Good morning ladies and gentlemen. I want to-- sorry. Just a moment, I forgot to click my presentation. Yes. Thank you. First of all I want to say thank you for the good opportunity to present data from Archangelsk region and I want to say thank you my colleagues from prison system who are doing very hard work in the medical system for the organization of the MDR-TB control in the prison system. And I want to say that big changes over HIV-TB control in my region enjoy very good political support from Central Medical Administration, our correction system of Minister of Justice of my country, and of course our local administration.

And I want to say some institute who support implementation of DOTS PLUS and DOTS Program in my region, and especially I want to say Langhoff, organization from Norway for their big support in my region.

Archangelsk region is one of the 83 region of the Russian Federation, and is situated near the White Sea and Arctic Ocean. The total area of the region is the seventh amount of the biggest, oldest Republic and Republics of Russia. It covers 578 square kilometers. The population is 1,300,000. There are about 14,000 people in the penitentiary system, 20 [inaudible] and for [inaudible] for central allocated in the

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different places of the region, and are situated from 300 up to 500 from capital of my region Archangelsk. In the year 1998 those program has been accepted in Archangelsk area. In 2003 DOTS PLUS is approved by Green Light Committee. DOTS and DOTS PLUS Program have been implemented simultaneously in civil sector and in the prison system, measure of the organization of the DOTS treatment.

We are introducing it, examining of each patient by smear and culture method was established and supplying of external quality assurance of the drug [inaudible] to the second line drug. Those introduced in simultaneously in civil sector and in the penitentiary system.

Two reference laboratories were established in the original anti-tuberculosis dispensary and in the penitentiary system. In patient department for anti-TB treatment were made. The unified system of the TB registration of whole category of the cases of the disease and including MDR-TB is organized. The unified centralized doctor permission supervises chemo treatment and the treatment of the side effects of MDR-TB patient in the civil sector and in the penitentiary system. The amount of the new cases of the disease the Archangelsk area, as well as in Russia decreased since 2000.

In 2006 in my region it makes up 72 per 100,000 population, the same data in the Russian Federation. The death rate is higher and has started to decrease only since 2005 and

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make up 15 per 100,000 population. In the penitentiary system these figures have been decreased since 2000, but still exists the level of epidemic and make up 1,395 per 100,000 prison population. In my region like in other regions we have same data in the Russian Federation, in the middle level of the same data in the Russian Federation. The death rate is high too, and make up 115 per 100,000 prison population. The positive dynamics of the tubercular incident is noticed. There is reduction of the relapses in the absolute figures. Reduction, interrupt treatment and failure. You can find in 2001 we had 485 relapses, 88 defaults, and 59 failures. In last year we had 197 relapses, 22 default and only 4 failures. Failure rate is connected only with MDR-TB cases. TB rates in 2006 in Archangelsk region makes up 90 per 100,000 population, 45 by culture and by smear-positive and 33 by smear-positive per 100,000 population.

More than third of the cases, I am on new cases of the disease relapses and MDR patient are presented by the cases of disease in the penitentiary system. On this slide you can see that 2,065 new cases; they are reduced just last year in the prison system. The same data registers among the relapses and the MDR-TB cases. Unfortunately, in the Archangelsk region there is one of the highest index of the primary MDR in the world.

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In 2006 primary MDR has made up 23-percent. But it's not connected the same data in other regions. Some region in Russia we have 8, 10 some region have less percent of MDR, but unfortunately my region is highest rate of MDR-TB patient. But the highest index in the penitentiary system and every year is increased. As we cure it, there is a suspected tuberculosis very well and there was no financial opportunity to provide MDR treatment for all MDR-TB patient. The MDR TB budget of a patient is increased every year. In 2006, 47-percent of MDR-TB patient is diagnosed in the penitentiary system. The acquire rate MDR resistant to the drugs was always higher and made up about 80-percent. In 2007 it is also planned to see MDR-TB grow in the penitentiary system.

On this slide you can see that the reduce rate for the ninth month 2007, 33 new cases MDR; thirty-three new cases by culture positive, and among them we found 28 patients with MDR. It's a big percent of patient with MDR. The grow of the MDR-TB was the main cause of death of a TB patient, especially in the penitentiary system. In the civil sector more than half of the cases of death has been connected with MDR-TB. And in the penitentiary system all the patients died from MDR-TB. Last year it was 15 patient, and it was all the patient with MDR-TB. On this slide you can find that 54-percent of patient who died from tuberculosis, it was an MDR-TB patient.

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Last two years we annually have reduced up to 250 MDR-TB patient, and the MDR-TB prevalence made up 565 cases in my region in the penitentiary system. In 2004, 39 MDR were reduced. Twenty-eight started with treatment. In 2005, 34 were reduced, started with treatment 26. In 2006, 85 were reduced, and started with treatment 71. In 2007, 54 were reduced, and 52 have started with treatment. Result of treatment is early to discuss, but now 205 patient have started treatment in the penitentiary system, 129 continued with treatment in prison, 34 have been cured, 29 continue their treatment after the discharge from prison. In the civil sector, for failure rate, four died, five had interrupted their treatment, and three MDR TB is reduced.

All anti-tuberculosis measures in the penitentiary system are carried out simultaneously with implementation in the civil sector. And we hope for establishment of the control of MDR TB distribution, however, 300 patient with HIV are in the penitentiary system. It makes influence of the distribution of tuberculosis and MDR, too. We are very grateful for the help of the Green Light Committee, especially our drug deliverers in my region, but in the prison system we have organized the treatment with the support of a central administrative medical unit of the correction system Ministry of Justice. And there is slow receipt of the drugs through the international dispensaries association, doesn't allow us to use

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the opportunity of the drugs' application for the help of the MDR-TB patient in the penitentiary system. Now we do not organize treatment for the 49 TB patients in the penitentiary system. We need some additional drugs. And I want to say thank you for the attention. [Applause]

**MASOUD DARA:** Thank you very much Dr. Andrey Mariandyshev. Is there are any question or clarifications?

**CAROLYN MOHAN:** Carolyn Mohan, UFAID. I wanted to ask what you're doing for patients that have XDR-TB.

**ANDREY MARIANDYSHEV:** It's very hard question because I think it's a question for this conference, what we need to do with the XDR patient. Unfortunately now we only isolate one XDR patient from another patient, but how to organize their treatment, it's category patient, really. It's very difficult. It's a team of working group with MDR XDR and really it's very difficult. Right now we only separate with this particular category patient.

**ONTHEAL ZELLWEGER:** Ontheal Zellweger [misspelled?], Swiss Lung Association. Maybe I missed the point, but could you please clarify who will take charge of the prisoners with TB if they are released from prison before the end of TB treatment? Who will care for these patients?

**ANDREY MARIANDYSHEV:** In my presentation I tried to repeat many times that implementation of DOTS, DOTS PLUS Program in my region simultaneously with civil sector, and with

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the penitentiary system. We have a uniform recording. We have a uniform central medical committee. We have a uniform education. And if your patient with tuberculosis must release from prison, we know about this patient. And we continue to treat the patient at home and we have already good link between the medical service and the penitentiary system in the civil sector.

**ONTHEAL ZELLWEGER:** But more specifically, do you have TB nurses and outreach workers able to visit the patient after they have been released from the prison?

**ANDREY MARIANDYSHEV:** Yes, of course. Yes.

**ONTHEAL ZELLWEGER:** You say of course. I'm very happy to hear that because some years ago it was not of course in some regions. I don't know the region of Archangelsk, but in other regions in Russia, Russian Federation and in countries close to Russia Federation, it is not of course at all. There are no TB nurse and no community workers. So I am very happy to hear that you have these opportunities.

**ANDREY MARIANDYSHEV:** Thank you. I am very agreeful with you with follow presentation say thank you my country. Really it's hard work. I know that in other region not implementation the same program like in mine. Some region implement DOTS and DOTS PLUS, some region not implement it.

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**MASOUD DARA:** In fact there are changes when you go visit the countries and then see that lots of development. Michael, you have some other questions?

**MICHAEL:** Yes, the question, to please explain the laboratory system, and who does your external quality assurance on culture DST?

**ANDREY MARIANDYSHEV:** Yes. Thank you for the question, Michael. Really it's a key point of implementation. DOTS PLUS Program laboratory ensures quality, quality assurance of laboratory in this investigation. Now we have a centralized assurance quality laboratory investigation and during the four years we have a good result of investigation [inaudible 42:59] has talked about this. Each patient investigated by a culture method and each patient investigated to resistant first and second line drugs in the penitentiary system.

In the civil sector it's, never mind. If you're a TB patient you will investigation by culture method and drug susceptible results will be done. I know that's not over region strengthening laboratory capacity. Some region we have not good result of investigation of drug susceptible test and culture, not investigated in some region, but in my region really investigated for all the TB cases.

**MICHAEL:** Thank you.

**MASOUD DARA:** [Inaudible] Just a last question, please.

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**MICHAEL:** Last but not least, Svetlana?

**SVETLANA PARK:** Thank you very much. My name is Svetlana Park. [misspelled?] I am from KNCV Representative Office in Khuzestan, and my question is because in your presentation I saw that not all MDR-TB patients were put on treatment. So my question is do you have any criteria for patients who should be put on treatment?

**ANDREY MARIANDYSHEV:** It's a very, very difficult question, how to organize the treatment if you haven't enough drug supply. It's really, it's a very, very difficult question. I am happy that now we have a good opportunity to start treat all the MDR-TB cases and hope BY next month we will start treatment all the MDR-TB patient in the penitentiary system and in the civil sector because we received the drugs from Green Light Committee for 200 MDR-TB patient and we will start treatment all the TB cases.

But when we started DOTS PLUS implementation in Piovisia [misspelled?] we decided that we will start treatment first of all patient with MDR, new cases, because if you start treatment the patient who first time diagnosed MDR it's more easy to treat with the patient and we will have a good result of treatment of this category patient. But another I could not give the advice because really it's a very difficult recommendation how to organize treatment if you haven't enough drug supplies.

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**MICHAEL:** Okay. Thank you very much Andrey. [Applause]  
Our next speaker comes from the Republic of Moldova, Dr. Victor Burinschi. He is the former National TB Program Director and now is project coordinator for the World Bank and Global Fund Programs Projects ON TB and HIV in the Republic of Moldova.

**VICTOR BURINSCHI:** [Inaudible] friends and colleagues. It is pleasure for me to share with you the Moldovian experience in management of TB, MDR-TB and HIV in the country. I think you can not to divide the activities in prisons from the activity in civilian sector, because these activities provided in both the sectors are integrated, represent an integrated system for control of HIV and TB in Moldova. Moldova is a small east European country. It's former Soviet Union country. There is a lot of social and political problem. Out of them I can mention unemployment. We chiefly export now labor migration around 1 million people unofficial data, and frozen with eastern conflict. Some of the country development indicators are presented in the slide, including HIV-AIDS prevalence rate and the TB notification rate, new cases and relative, probably one of the highest rate in Europe. The number of registered TB cases in Moldova has been increasing during the last 10 years.

This situation is caused by the spread of TB infection due to the socio-economic problems, but also by improvement of case detection due to the DOTS implementation. DOTS

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implementation has started since December, 2000 in prison sector and since December 2001 in civilian sector. The result is the detection rate for new smear-positive cases have increased from 19 in '99 to 65.5 in 2006. The treatment success rate is less than WHO recommendation is only around 62-percent in 2005 and for three quarters for 2006. And probably the value of treatment success rates is less due to the [inaudible] of direct continuation phases only for 70-percent of patient, but also by the level of registered or diagnosed for MDR-TB.

My representative data for 2005 show what where MDR-TB was between new cases around 13-percent and between re-treated cases 49-percent. In 2006 a national survey was provided in Moldova. The final report is under preparation, but the previously representative data show that MDR-TB is 19-percent between new cases and 50.8 between re-treated case. The number of registered TB cases increase, has been increasing during last seven years, especially after DOTS implementation. In December 2000 which cover 30-percent of prisons since January 2004 when there is a penitentiary unit currently covered by DOTS.

Smear confirmation rate for new pulmonary TB cases has increased from 7-percent in 2000 to 33-percent in 2004. TB mortality rate is decreasing, but the number of co-infected TB-HIV cases among TB patient is increasing to 53-percent in 2006.

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Treatment success rate in prison sector is under the WHO recommendation, especially after extension of DOTS in all prison sector, with high number of transferred and failure patients. Regarding MDR-TB in prison the survey provided in prison in 2003 with support of Caritas Luxembourg show that MDR-TB between new cases was 26-percent and between re-treated cases 55-percent. New data for 2006 will be available at the end of this year.

Regarding HIV-Aids the number of notified and counted HIV cases has been increasing during the last 12 years, but the number is less than the number estimated by all the bank and inmates, 34,000 for 2006, due to the effective intervention provided in Moldova in HIV area, but also probably by the over estimation. The most important route of transmission of HIV-Aids between new cases has become since 2004 sexual transmission.

The actual number of drug users between new HIV cases is stable during 2005-2006 is around 200 people. At the same incidents of HIV-Aids among young adults have been increasing direct the last four years and probably this trend will remain the same for the next period, especially because of the spread of infection from specific groups, target groups to the general population. In prison the number of HIV-Aids cases under observation is stable during the last years, but the number of cases with co-infection HIV with TB is increasing.

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Moldova has two national programs, one for TB and another for HIV-Aids. Activities in prisons are accompanying part of these two national programs. For national programs, multiple associations of [inaudible] have been engaged. National budget cover only around 50-percent of necessity of TB programs and around 33-percent of necessity for HIV-Aids programs. But the rest are recorded by donor organization and international agencies. National TB and HIV-Aids program are coordinated by country coordination mechanism which has three levels. Decisional levels 22 members represented governmental sector including representative from Minister of Health and Minister of Justice, Minister of Internal Affairs, the civil society and agencies and donors.

Coordination level is CCM Secretariat and operational level technical working group: four for TB area, five for HIV area, and one common group is monitoring all organization. Each level has very clearly defined responsibilities. At the same time each player involved in the registration of TB and HIV-Aids program in Moldova has its specific contributions: managerial, financial, infrastructure, and structural. Achievements in prison in TB area, DOTS cover all prisons since [inaudible] prisons in 2004.

You use in Moldova specific case detection by using smear microscoping at the same time, active screening to expedite X-ray investigation for all prisoners. Prison sector

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use anti-tuberculosis drugs and fixed dose combination. Direct [inaudible] is assured in the intensity phase and in [inaudible] phase. Treatment in common for each TB case under treatment, and involvement of volunteers for early TB detection, is project funded by Karl Looks and Joss Karl Looks. It's activity has started, and KNCV, activity has started in 2005-2006. DOTS PLUS Project has asked it in quarter one 2006 if it is [inaudible] this presentation.

Now we have 34 patient on treatment out of 122 under observation in prison sectors. Conventional rate for culture after ninth month of treatment is around 63-percent. Also training of medical staff in DOTS, DOTS Plus and the management of second life has been provided equipment of medical equipment agents, continuous supply with first line drugs, second line drugs, but not all necessities are covered now in country for treatment of second of patient with MDR-TB.

Assurance adherence to DOTS PLUS treatment is project financed through the Minor the Global Fund Grant and assures the continuation of DOTS treatment for patient after release. Project is financed by KNCV and 72-percent of prisoners after release continue with treatment in civilian sector.

In HIV area you have in places needle exchange program which covers six prison with 35-percent of all the case from Moldova. The number of the case in Moldova is around 9,000. These all Transmisia [misspelled?] the region which has a

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separate penitentiary system. Substitution therapy of the project has started last year. It's covered now three prisons. We have only 51 patient on substitution therapy and there base identification on prevention HIV-Aids.

After a while treatment is available in prison sector since October 2006. Now Aids is manageable chronic disease. You have also permanent supply of this medicine to assure prevention therapy for opportunistic infection. Sexual factor in Moldova probably, program intervention in HIV and TB area are comprehensive and cooperation and involvement by all quarters, the governmental sector of our society, donors and in agency, and long-term financial support. Thank you for your attention. [Applause]

**MICHAEL:** We'll now take questions from the audience.

**MALE SPEAKER:** Thank you for your presentation. As I understand correctly the data that you gave about the penitentiary system and MDR-TB rates for instance, they do not include Transmisia [misspelled?]

**VICTOR BURINSCHI:** No. It's only for Moldova, without Transmisia.

**MALE SPEAKER:** Can you say something about situation Transmisia? Do you know anything about that in terms of MDR rates in prisons?

**VICTOR BURINSCHI:** Okay. If you told about TB program you have good cooperation of people from penitentiary system

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from Transmisia. We have started implementation of DOTS in 2004. We covered all prison sector Transmisia They have medicines, they have consumables, they have the same standard of investigation. Regarding MDR-TB you have, we don't have enough medicine for Moldova. In Transmisia, MDR survey wasn't made at the moment. We don't have data about MDR in Transmisia.

**MALE SPEAKER:** Can I ask another question? You showed some data about heterosexual transmission. Now taking over from let's say a transmission through drug use, do you know in how far that is sexual transmission through let's say bridging populations like, is the sexual transmission from-- is it women who have a partner who uses drugs? Or is it pure sexual transmission? Is it related in any way to drug use?

**VICTOR BURINSCHI:** It is sexual transmission, is not sexual transmission between partners of drug users. You have very high level of pregnant women diagnosed with HIV infection with around 100 people per year. It's very high level for Moldova.

**MALE SPEAKER:** Thank you.

**MICHAEL:** Question, please.

**MIRANDA BRAUER:** I'm Miranda Brauer [misspelled?] working for Health Alliance International in Mozambique. You were talking about using volunteers for early detection. I

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would like to know a bit more. How you use those volunteers?  
What they do and how you recruit them?

**VICTOR BURINSCHI:** Okay. This is project financed by KNCV in Moldova. They responsible, 280 is represented of medical established in the prisons. They select the volunteers from the detention who have trainings in activities to diagnose the symptoms, the people who cough more than three weeks. And these volunteers work in unit, in the specific unit where they are. For these activities the volunteers are assimilated some food parcels each month.

**MIRANDA BRAUER:** Thank you.

**MICHAEL:** I have a question for you please. Do you have any problems with registration of any drugs in your country for treatment of second line? And do you have access to all the drugs or these drug categories?

**VICTOR BURINSCHI:** The second line drugs in Moldova are delivered through the GLC mechanism. You have approved now 700 people for treatment until 2009. We don't register the drugs in Moldova, second line drugs. You can use with special decision of Minister of Health to use these drugs because they are very important drugs for health system for Moldova.

**MICHAEL:** Okay. Question?

**MALE SPEAKER:** Thank you. Very good presentation, I am from Afghanistan. As I learned from your presentation, your service delivery is integrated in the district level and

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implementation level. So I am quite worried about the infection. Maybe HIV-Aids patient who is going to test for tuberculosis so in the same facility there is so much, I mean, the patient will get infection of tuberculosis external. So do you have any appropriate mechanism to control, to avoid dual infection?

**VICTOR BURINSCHI:** In prison sector or in civilian sector?

**MALE SPEAKER:** No, in prisons and also in general population.

**VICTOR BURINSCHI:** In general population you have vertical system of Physiopulmonological [misspelled?] TB services where people from HIV are under observation of another specialist infection is. In prison sector it is difficult because the infection control condition is not so well good. And is not excluded exist transmission infection in the facilities.

**MICHAEL:** We have a question on the far left please.

**MALE SPEAKER:** Is this on?

**MICHAEL:** Begin to speak and it should open up.

**ISAACS COSANA:** Thank you. My name is Isaacs Cosana [misspelled?] from CHMT South Africa. What I've been hearing mostly is like a great success regarding this screening. Is it happening internally or outside of the private sector? And

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two, we've also been hearing about the treatment, the medication.

What about the nutrition? Is it also sufficient, the nutrition inside the prison? And lastly the [inaudible] situation. Can you give us the light on that, maybe how many prisoners' percent that are sharing in a cell? Thank you.

**VICTOR BURINSCHI:** Probably, about nutrition, I think for prisons maybe it is problem. But some donors support the patient under the treatment especially under the DOTS PLUS treatment. Through the money of the Global Fund you have additional parcels of nutrition for these patients.

**MICHAEL:** The second question had to do with screening. Could you clarify? Did you mean screening inside the prison or outside the prison? I wasn't sure. It had to do with screening.

**ISAACS COSANA:** In terms of the screening I mean the diagnostics. Is it happening inside because that's served by what we know? We do have in prisons, I mean the hospital inside the prisons where there will be doctors available, or is it-- the question is when the prisoners are diagnosed for TB, is it happening internally or outside as in outside to internal?

**VICTOR BURINSCHI:** The prisoners are investigated and diagnosed for TB in the prison facilities. You have big hospital for 300 beds for TB in the prison sector.

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**MICHAEL:** Thank you. Last question on the left. Okay.

**MOSIDI NOHAMBER:** Yes. My name is Mosidi Nohamber.

[misspelled?] I am from South Africa. What I need to find out is on the DOTS, I'm not sure if I misunderstood, but you said that the DOTS is done by volunteers. I would like to find out who are volunteers? Is it prisoners themselves, is it the officials, or is it people from the outside that are brought in to do the DOTS?

**VICTOR BURINSCHI:** Volunteers are in with the prisoners.

**MICHAEL:** Who?

**VICTOR BURINSCHI:** Prisoners.

**MICHAEL:** Prisoners.

**VICTOR BURINSCHI:** Yes.

**MICHAEL:** Okay. Thank you very much. [Applause]  
Okay. We'll proceed with the next— [AUDIO GAP]

**MALE SPEAKER:** —short of this experiences are they really being reflected in the guidelines? And also with latest recommendations, namely for example for diagnoses. There is no need for three sputum examinations where two would be sufficient. So that sort of technical issue as I said should have some this synergy in the new guidelines.

The contributors? Editorial Committee is again KNCV order. KNCV Union. Michael is sitting here and Dr. Mongrosha [misspelled?] and myself doing the work of the committee,

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writing committee from CDCIRSC KNCB MSH union and WHO. On the review committee FU is foundation-based country representatives, so you're going to send these guidelines to countries and ask for their inputs to see how much it is understandable for them. And also MSF MSH, part of WHO. I would urge all of you who're interested at the end of the session please come to us if you're interested to be part of the review.

The new guidelines will have four kind of parts. Introduction, basically part one the background information, part two management of TB, all the technical issues; and also part three the programming aspect. The introduction part is going to talk about the audience, who is going to be using these guidelines. How is treatment used? Is there limitations or its best use? And also structure of the guidelines in the introduction part. The background information we will have three chapters, the global, [inaudible], and principle of TB control, TB rate in prisons, so we try to get as much evidence as we have and the latest information we have, and also the health system in prisons link that was raised during questions, we should be there.

The management of TB in prison is starting to be the case funding, the standard case definitions and treatment for non-resistant cases of TB-HIV, including the diagnosis HIV testing policies, and also going to drug resistant TB with the

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whole management part of it. And is good that the MDR-TB guidelines being updated so that we can use all the latest and correct recommendations and fit it into the guidelines, and also the monitoring the treatment outcome.

Under programming aspects you will have this chapters, which is we tried to follow those as mentioned in the Stop TB Strategy. Also look at the most of the more important to the prison guidelines. So political commitment, follow-up of released prisoners, the comprehensive discharge plan some people call it a continuum of care which is a major issue.

And we sort of in Moldova with that 72 person, I think that we should congratulate them. It is a good one. Is very difficult to follow patient after they are released, and there are some country examples that you could also bring it here, medical drugs, supplies, consumables, infection control and [inaudible] programming issues and the evolving patient committees. We heard from Moldovian experience that they have prisoners, ex-prisoners as volunteers to make create a link here. So that's also a helpful education, peer-to-peer education. And so then also last but not least, on my [inaudible] press for research, as we all know the screening and other issues there is a need for more further research. So hopefully it can provide some good examples and ideas for the countries so they can go toward professional research.

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What are the next steps on updating guidelines? A draft guidelines should be sent to a review committee by December 2007. Actually I should say here to tell that we have to wait quite a long time since last year. We did it on purpose because we wanted to make sure that the consensus are made in several issues. And the TB handbook has been published. That can also help us with the, to make sure that we have already the latest recommendation.

The draft will send also to the editing in January and also we decided to first post it in electronic version, because printing guidelines by definition can be a very conversion these days, and it may take time while the countries need these new guidelines. So as soon as possible then, once it's finalized, we try to put it online so that people can use it while the [inaudible] is going to proceed with the administrative issues to print them.

Last but not least, I should like to talk shortly about the Health In Prison Project. This is based in actually Copenhagen, and again it's a project established in 1995, hosted by Double Tree Euro, which is in the collaboration with the Department of Health of the UK a Dutch firm, and has also been funding some part of it. And the mission of this project is to bridge the gap between the prison health and public health is not only dealing with TB but also many other issues.

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And the idea is to promote evidence-based interventions and projects and to make sure there is exchange of experience between countries in the region. It is something that, as far as I know, we don't have it in other regions. There is much of interest rightly to TB increases in Europe, but we try to promote in other regions, but not often very easy to do that. So we hope that this could be our actually example for the countries. And this Health In Prison once per year they meet and each year there is one subject. So last year TB in prison was the subject and there's a next committee meeting that all the countries can get together and exchange experiences. Discuss one subject per year.

And so we came up with this status paper that I think some colleagues' white paper, is we have the guidelines, but is a very technical, but we need something for the policy makers and those who are not technical involving TB, but they are very, very important for TB control. So the target of this is just policy makers, those who are implementing, but this is not the guidelines.

It should be very concise and give some examples how you can organize the TB-related issues. It should also show the minimum standards that's needed and good thing with this white paper, this status paper vis a vis the guidelines is a national ownership. So the countries launch it. For example, Romania the last time around launched it, in The Netherlands

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we launched it, so the launch of it that is kind of endorsement by the national authorities, the health prison authorities. That's like if we endorse this fund into our setting and it is because it is general, but is just certain standards, is always useful to that. Thank you very much for your attention. I look forward to having your inputs for the guidelines. Thank you very much. [Applause]

**MICHAEL:** Any questions about what Dr. Masoud presented? There will be a TB in Prisons workgroup meeting on Saturday, I'm sorry, Sunday, tomorrow in Room 16-- [AUDIO GAP].

**MALE SPEAKER:** -and use in prisons. I'm sure that's probably included. But just for people's information WHO UN Aids [misspelled?] and UNODC are holding a working group meeting to finalize draft guidelines on managing TB and HIV together in injecting drug users next week, I think, in Copenhagen. And it would be useful to link that document in with the TB in Prisons Guidelines.

**MASOUD DARA:** Thank you. I think that Alasa. [misspelled?] I think this a very good suggestion taken definitely, and I would like very much definitely very much your inputs on the section for the ideas that are very important. Thank you.

**MICHAEL:** Joost?

**JOOST VAN DER MEER:** Thank you Masoud for your presentation. I have a just very practical question. When you

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publish the guidelines will they be available in Russian at the same time?

**MASOUD DARA:** They should be definitely translated to Russian. I mean hopefully we can also get funds to have it translated, but the first version would be English. But it would definitely be translated at least to Russian, and hopefully to other languages as well later on.

**JOOST VAN DEN MEER:** Thank you.

**MICHAEL:** Okay. Thank you. Okay. We will proceed with the next lecture will be from Indonesia, Dr.-- [AUDIO GAP]

**MALE SPEAKER:** Thank you very much. Carmelita's-- Good morning. It is real pleasure to present on the behalf the Inter [inaudible] of Indonesia and also Dr. Basri because she is going back to Indonesia to attend a meeting also in the other country to discuss about the Global Funds.

While I think that, I just wanted to tell a little bit experience about TB in prison in Indonesia because when we have been studying the program since 2003 and I think Dr. Michaels Impov [misspelled?] in the developing, in the basing this program, but I guess it's quite slow, the progress in this project in Indonesia. Right. So just to remind you, the second strategy plans TB control in Indonesia. We are quite equitable with all quality DOTS for all and try to expand TB control. And is one the program of intervention program is improving quality of that and as well as for a full and

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vulnerable population. It's the [inaudible] and facility related to TB control so lots country with high number of population.

This is data about the prisons and the prisoners until December 2006, so we have 500 prisons divided into prisons and detentions unit. Detentions unit has the inmate before being having judgment from the justice. And the solution of the entire prison ins Indonesia. Why do we expand those to the prison because as we know jail for those groups and also the high transmission, high rates of development of the disease and also how matters in prison is very, very neglected.

The organizational charts of the [inaudible 1:18:32] system here so the programs belong to the Director of Health Affair and collaborating also with Director of Narcotic Affair. A little bit [inaudible], but this in prison that we found that the number of cases HIV, TB and hepatitis here, but actually this on the route we have taken for several reasons. Here we have less than 10-percent prison [inaudible], and on percentage DOTS, it's-- we call DOTS in prison, but in reality it's not a perfect, it's just that we have been trying to train the prison staff that the information that DOTS is quite still full.

This is the process of developing, of establishing the program. As I said this is since 2003 however this progress is still slow. 2001 we have had the [inaudible] and between the CDC Minister of Health, and DG from the Department of Law. And

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then we try to conduct many workshop and unfortunately we have also had the consent when the global bank freeze, so some activities being delayed. And then finally, 2007 we have launched the strategy plan of TB in Prison and nowadays we are progressing the developing the training module and we plan to conduct the training in the following month.

So this is the programs of activity in prisons, basically at the Provincial level, we have the teams, DOTS Provincial team and the it's consists of the person from the Department of Law and then also the prison's director is part of the team, and we have also Provincial head officer in charge of TB control program. And we have district and Provincial TB supervisor we call WASA.

And go to the lower level, we have the DOTS implementing teams on prisons, it's consist of her staff and other staffs, and also what the prisons' unit purpose is doing screenings, smear collection and fixation and diagnosis and treatment and also conduct the reporting and recording contact investigation and also IAC.

This a little bit, well, we put the prison as the satellite health center, so other slide smear slide just send to the health center to be read by the lab technician and send back to the prison and the drug is available at the district level, district health office, and every quarter prison unit

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request the drugs to the districts and recording with reporting but also conducted by the prison.

We have had 7 target prisons for the following year, and results from 2003, we have again the comment from the DC of the prison and also the strategy plans from TB In Prison actually already launched and the tools for SS MAN we have ready in the country. And also we already build the linkage within the other six quarter, especially in the [inaudible] in the TB asylum. I think permanent [inaudible] ICOC and others we call. Nowadays we conduct separate [inaudible] on TB IP, and also we have the graph of TB IP guideline and also the graph for the implementation guideline. It is TB IP working group already in place. We have plan for the next quarter and several [inaudible] that we are like all the time because limited number of staff and also other kind of challenges is most in our administration and also communication among sick [inaudible] between the sick [inaudible] at the Ministry of Health and Ministry of Law. And prison system itself is a big challenge because prison, they have unique system. It really different from the Ministry of Health system. For instance, how they provide food, how provide health service for the inmates is become the challenge for us, and the power of our staff.

The most important thing is to fund sustainability after a donor. We don't know after the Global Funds from the

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Indonesia, so it's a big challenge for us. It's why we have some recommendation. We try to reorganize the management and supporting system and also developing communication system with amongst six others and again to manage resources and follow-up TB-HIV infected activities and try to share the workload.

And we continue again the technical assistance from the international expert. We also due to the limit of staff, we try to recruit the technical officer and the TB care can to be and we intensified communication.

For the next work plan we looking at the citizen analysis on the 70 target prisons and after we have the document of citizen analysis we will develop a work plan next year. Developing a working group is maybe, hopefully this December we will be established and disseminate the strategy plans to the all Province and prisons and provide the training for the prison health staff. And then try to implement the program as far as we monitor and evaluate the programs together or in collaboration with the others. Thank you very much.

[Applause]

**MICHAEL:** Questions for our speaker from Indonesia? I have one comment. I think as he mentioned that even though there's been DOTS training, there is no really DOTS in prisons yet. In Indonesia and what he's referring to is the fact that sometimes you can start with training, but you don't have your strategic plan. And that's one of the important lessons that

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we've learned from the experiences in Indonesia, the importance of really having a strategic plan for implementation prior to generalized training of health staff. Maybe you could comment?

**MALE SPEAKER:** Yes, well as I mentioned before that there was a DOTS in prison based on the number of prison staff trained, but this a separate problem and that's set upon the provincial health office to involve the prison staff to be trained. It's not nation-wide and it's not a national policy because the policy and the strategy plan develop in following year.

**MICHAEL:** Thank you, Very important because Indonesia is a very, very large country in Asia. Please.

**UNGER ZOOMAGER:** Thank you very much for the presentation. I am Dr. Unger Zoomager [misspelled?] from Nigeria. I just wanted to clarify the picture you showed of four prisons send samples to hospitals to the lab and then it goes back to the district hospital before the result goes back to the prison. Is this hospital a hospital in the prison or is it an outside hospital, public hospital?

Because I think that we need to use the capacity of health workers in the hospitals within the prisons to be able to make diagnosis of tuberculosis. And secondly, considering the general population that exists in some prisons like in Nigeria, how do you address the issue of MDR, because it's a

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very serious problem if it gets into the prisons? Thank you very, very much.

**MALE SPEAKER:** Thank you very much from the Nigeria, great question. This network is to show that this prison is very limited, I mean in terms of diagnosis and also there exist limits on staff of the prison. I think that only less than 10-percent the prison has the health staff, for instance nurse, lab technicians, medical doctor. That's why we just train the staff, prison staff for the laboratory until making this fixation. So then after they make the preparation for the inmate specimen, then send to the other health facility, it can be health center with microscopic, and the hospital and the result from the smear send back to the prison then the prison will request the drugs to district health office. Does this make sense?

**MICHAEL:** And then about treatment of MDR...

**MALE SPEAKER:** Can you give more explanation?

**MICHAEL:** No, there is no treatment of MDR now in the prisons. There is in the private sector, but not yet in the public sector in Indonesia. And they're undertaking a large national survey the first one now of DST in Indonesia so there's as of yet no national data.

**MALE SPEAKER:** Yes, [inaudible] in that we don't have that because apparently they will send out surveys being finalized.

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**MICHAEL:** The issue he raises about where the slides go and where the hospital is, it raises the issue of the lack of resources in many countries for prisons. And so it's just a question then of does the Ministry of Health provide those resources or is it the prison sector itself? And so that's a good example in Indonesia where there is a basic issue about resources, access to resources, whereas in other large countries like in the former Soviet Union, Russia, there are very large well-developed medical systems that operate as a structure within the prison sector. That's not true in a lot of areas, and that's certainly not true in Indonesia. Thank you.

**MALE SPEAKER:** Thank you very much.

**MASOUD DARA:** So our next presentation is from ICRC Georgia, Shalala? Shalala Akhmedova is from in Georgia working from ICRC, Azerbaijan from ICRC International Committee for Red Cross. ICRC has been very much involved in TB control across the region and they have a holistic approach. They also try to look to renovation if needed and creating good laboratories especially in two or three countries have very good laboratory that also have good link with the external quality control.

**SHALALA AKHMEDOVA:** [Inaudible] Ah, sorry. Good morning. In there are to be treatment in prisons of Azerbaijan. Just for information that one of the authors of the presentation, Dr. Rafael Meteer [misspelled?] Head of main

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medical of the Minister of Justice of Azerbaijan is also present in this hall. Therefore at the end of the presentation if you will have any questions you can address them to him and to me also.

I will start my presentation with the short information about my country. Azerbaijan is created in the south Caucasus on the borders of the Caspian Sea. Population is just under 8.5 million. And Azerbaijan begins its independence in 1991 after the collapse of the Soviet Union. Approximately 5,000 TB cases are reported to the WHO each year and about 700 TB cases start treatment in prisons each year. There are 22 penitentiary institutions nation-wide, with a prison population of approximately 6,000.

Then I will give the short information about the International Committee, about the cooperation of the International Committee of the Red Cross and the Minister of Justice of Azerbaijan. In 1995 International Committee of the Red Cross and the Minister of Justice of Azerbaijan decided to cooperate in setting up a pilot DOTS project in prisons of Azerbaijan. The objectives were to provide a full, supervised, complete, and correct treatment to 300 detainees, and to demonstrate that the DOTS is applicable in prisons. Then in 1998 Minister of Justice is approve DOTS practical, and then after that it create pact and agreement was signed between the Minister of Justice, Minister of Health, and ICRC. In this

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chart you see that [inaudible] goals among new and previous treated cases always fluctuated, and most new cases fluctuated between 50 and 65-percent and among the previously treated cases between 30 and 50-percent. A lot of factors come together to affect treatment success rates in prisons, including in some years high before treated because of amnesty, release and some administrative reasons, but the main contributor is the high level of the drug we've used on TB.

In the same [inaudible] rate among new cases in prisons in 2005, 2006 and 2007. In 2006 it was 10.2-percent. In 2006, 15.6-percent and for 2007, perhaps the interim results is 11.3-percent. This is the amount previously treated cases, 40-percent in 2005, 44.9-percent it has increased in 2006, and interim results for 2007 it show for 2007, so it is 3.8-percent. Resistance to the second line drugs in prisons. In 2005, 6-percent of new bacterial-positive patients were resistant to the second line of TB drugs. And 17.3-percent of previously treated cases were resistant to the second line drugs. Just remember these figures because then I will give the comparison with the civilian sector. For 2006, resistance to the second line amongst the new bacterial-positive patients has decreased. It became 4.9-percent, but the resistance to the second line anti-TB drugs among previously treated cases has increased and became 26.6-percent. This is the interim results of the drug resistance survey in Azerbaijan, which was

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conducted in civilian sector. This survey started in August 2006 and it shows the high prevalence of the TB activity rate among new cases and previously treated cases. And these figures are higher than the prison sector. There is some explanation for that because the prison sector started the DOTS implementation 1995, but the civilian sector accepted the DOTS national invite in 2000. And at the same time the civilian sector so far does not have the national reference laboratory.

And according to this drug resistance survey approximately 14-percent of TB patients are [inaudible 1:37:34] patients. And again in the civilian sector if you compare with the prison sector we can see that the resistance to the second line anti-TB drugs among the new bacterial positive patients is higher. In prison sector it was approximately 4.9-percent, but in civilian sector 14.3-percent. And to the previously treated cases also high, 43.8-percent.

And [inaudible] as you see as the percent of [inaudible] among new cases 5.9-percent in new cases and 14.3-percent among previously treated cases. Just also for information, DOTS PLUS Project started in the prison sector. Civilian sector does not have any DOTS PLUS Projects so far. In 2004, Minister of Justice aligned with the Green Light Committee to start a pilot DOTS PLUS Project. In 2005 the application was approved. In 2005, Minister of Health requested the WHO provide the technical support to prepare the

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TB proposal for around five, and 2006 the Global Fund grant was signed.

Finally, on the 25th of April, 2007 in fact treatment in prisons of Azerbaijan started. Actually it really started in Azerbaijan. And up to 16 October, 52 detainees have been enrolled to treatment.

This is just pictures from the laboratory that International Committee of the Red Cross has with the Minister of Justice had to create the laboratory and this laboratory, actually right now acts as a national reference laboratory. Has the capacity to do the full range of TB processes. This laboratory is performing for the sputum smear microscopic, send cultures on solid and liquid media and deals with the first line and the second line drugs. And this laboratory has been participating in external quality assurance with the Georgia national reference laboratory on the sputum smear microscopic since 2001. And with them on the [inaudible 1:40:07], both on the national and laboratory since 2003. Just a few reporting forms. Each patient has separated patient file and treatment facility. And just to mention that the political commitment from the Minister of Justice side is very high, and from the Cabinet of Ministers allocated them, \$115,000 in order to have the data, they have the [inaudible]. And with the financial support of the Global Fund a code ventilation system was installed. And just patient up here. A lot of [inaudible

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1:40:51] education on drug resistant TB treatment was allowed to join by the ICRC and Minister of Justice. And on resources. For the time being three Minister of Justice doctors and three nurses are involved, and each week different specialists are invited in order to solve some effects and some problems related with the site and place of the second line drugs.

Just information column is 52 patients who have been enrolled in the treatment, as if they were always in TB patients in prisons, they were kept in a separate structure at the [inaudible] border before, before the start of the anti-TB drug treatment. Some of them have waited for the treatment more than five years. There were only two ways go out of this ward, either death or release them. Therefore we have started, Minister of Justice started to treat the patients who have been waiting for a long period of time there, and 27 of them have already in the past received first and second line anti-TB drugs.

And they have received many times category two treatments and you can see from the percentage and the number of treatment interruptions including category two treatments, 73-percent have needed interrupt the treatment in the past. [inaudible] and statistical patients at the enrollment to the treatment.

As the treatment started in prisons and then most of you know that the prisoners, they don't only have the TB

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disease, they have a bunch of diseases. And one patient is HIV positive and actually he's responding to the treatment. And 48-percent used the drugs in the past. The major problem is the high prevalence of hepatitis C. We have never thought of before that when we face that problem, never starting them to last project.

Approximately 54-percent are infected with hepatitis C, and also hepatitis B not, in comparison to hepatitis C, not widely spread, and we also record the level of in 15-percent they have the high level of [inaudible]. You have been interested why the high level of hepatitis C in prisons and when will make some interviews with the patients, found out that 75-percent was injecting drug users in the past. Just, this is difference. We have one HIV-TB case and so far he's responding to the treatment. Up to now this is just interim results because the Minister of Justice started treatment only in April 2007. And among 42 checked patients 73.8-percent became smear negative, but different in different months. And 31 smear-negative patients are culture negative, approximately 42-percent. Most common side effects as usual, nausea, hypochloremia, lethargy and hepatitis. The major problem is the hepatitis.

Challenges? Non-existence of the DOTS PLUS Project in the civilian sector, therefore critical issues arises that as they are not full up of the treatment in the civilian sector,

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on the simultaneous enrolled to the treatment who have more than two year sentence. Again it's medical issues that it is incentives for the crime or incentives for the grave crime, and high level of hepatitis C and consist of difficulties in management of toxic hepatitis. That's all. Thanks a lot.

[Applause]

**MASOUD DARA:** Thank you very much Dr. Akhmedova. Again, I apologize for not mentioning you from Azerbaijan. For the sake of time would it be possible invite all the presenters of the day to come to podium, you can also take a seat here. And then the floor is open for discussion. All the presenters of the day, would you please come to the podium? [AUDIO GAP]

**MALE SPEAKER:** -and the number of incarcerated people in your prisons?

**SHALALA AKHMEDOVA:** [inaudible] In Azerbaijan the TB notification rate, case identification rate, case notification rate is going down in prisons. And the number of them of the prison population is going down.

**MICHAEL:** So is the decrease in TB notifications in prisons due to control or is it due to mass release of prisoners, for example?

**SHALALA AKHMEDOVA:** For me?

**MICHAEL:** For you and then also I'd like to hear about Russia.

**MALE SPEAKER:** And Kazakhstan.

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**SHALALA AKHMEDOVA:** I'll start. Yes, it's because of the big time organization of the TB services in prisons. Actually DOTS implementation in prisons of Azerbaijan, they make a strong and active case the active to introduce that, and also helps education active. It's just one week was both, there was not enough, it was the treatment of the anti-TB patients. Actually what we can say is that the TB services is strong in prison sector.

**MICHAEL:** Andrey? In Russia, do you have any comments?

**ANDREY MARIANDYSHEV:** I can confirm the main ideas, but really if the number of prisoners decrease, the number of TB cases decrease simultaneously of course, because it's drawing number inmates and number of TB cases. But I can confirm that DOTS program in the prison system in my country was implemented very fast and I know that you have information of the central medical units of Ministry of Justice implemented the DOTS and DOTS PLUS program in the prison system in my country. And it's linked to, if you recognize where DOTS program in the penitentiary system, decrease the number of TB cases. I think that they're both reasons to— [AUDIO GAP]

**SHALALA AKHMEDOVA:** —equitable services between the civilian sector and the prison sector. Maybe you are understood from my presentation and the politics that the TB services in prison sector is much better than the civilian sector. Therefore even for the ICRC we're also made the

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general objective to make the equitable services reach correspond to the civilian sector, but later we saw that the huge gap is developing between these services. Of course on the other hand it is not good, because the prison services should be part of the national tuberculosis control program and actually, but maybe we should think out of the box. It doesn't matter where is the model exists. Now in country a model exists in the penitentiary system and this model can be transferred to the civilian sector.

And for the time being the Minister of Justice is providing the technical support to the Minister of Health so that they can upgrade their services. Actually [inaudible] recently has refused the Minister of Health to start the DOTS PLUS Project, pilot project just for 50 patients, even saves the high level of the MDR-TB. But Minister of Justice taking into consideration the national interest, they also let us to the jails there and they took the responsibility that they would provide the lab services to the civilian sector so that the civilian sector can start the pilot project, treating 20 patients then. Therefore within Azerbaijan, we see the quite different approach to the problem. That's all.

**MICHAEL:** Thank you. So Azerbaijan is an example of the prison sector driving improved— [AUDIO GAP]

**MICHAEL:** So I'll ask Andrey to address any of the issues that were raised by the questions. [AUDIO GAP]

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**MASOUD DARA:** Yes, I'd like to respond together with KNCV promote prison's rights and the right to decent treatment. But on the other hand we know that in some of the countries in central Asia that is a very far reality and will be not so easy to achieve. In terms of stigma, I think you've answered that question, but in terms of incentive for prisoners to get TB or even HIV, I know that in some prisons in Siberia and probably also in central Asia there is a trade in sputa from TB patients so that this is really a problem that has to be controlled and tackled as well. So that is a reality that we have to face.

**MICHAEL:** Other panelists to respond to any of those questions? I've also seen incentives to get disease in the civilian sector side as well in some countries, especially where food or cash was given to individuals to comply with treatment or to get treatment. Then that also led in the civilian sector, especially in the very impoverished areas for people to continue to show a positive smear status for example.

**MALE SPEAKER:** We are seeing this is an issue to discuss further, and also I was looking at the poster presentation. There is some— [AUDIO GAP].

**MICHAEL:** Thank you very much. [Applause]

[END RECORDING]

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