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**38th Union World Conference on Lung Health
Making Integrated TB-HIV Care Work:
Operations Research Experiences in Delivering
Joint TB Services in Low-Income Settings
November 11, 2007**

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DR. PAULA FUJIWARA: -joint TB/HIV services in low income settings. I'm Paula Fujiwara from the International Union against Tuberculosis and Lung Disease, your host of this conference and also a medical officer with the U.S. Centers for Disease Control and Prevention.

I'm joined here by my colleague, Professor Martin Neaful [misspelled?] from Benin and he will join me in these presentations.

Everyone who's coming in and who's also sitting, please have your - what do you call these things here? These translation devices because there will be simultaneous translation in French and English. Two of our presentations will be in French and two in English.

Just as a way of introduction, the Union and our country partners have been developing models and best practices to help reduce the morbidity and mortality caused by the dual epidemic of TB and HIV, particularly in many of the low resource countries where human and financial resources are limited.

We're working now in Yanmar [misspelled?], Benin, Democratic Republic of Congo, Uganda and shortly in Zimbabwe.

In our model for collaborative TB and HIV services included capacity building and strengthening linkages between the National AIDS and Tuberculosis Control Programs,

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development of a logistical support and also the information systems and the provision of antiretroviral and care to those with, who are dually infected, and these the TB program is the entry point for HIV care.

So we have four presentations. We think the program said five, but we have four presentations from Uganda, Zimbabwe, Benin and The Democratic Republic of Congo.

So I'd like to just call to the podium now our first speaker, who's Dr. Rose Okot-Chono from Uganda, and she's the integrated HIV care coordinator for the Union in Kampala, and she's going to talk to us about addressing the barriers to the implementation of combined TB/HIV activities in Uganda. Dr. Okot-Chono, welcome.

DR. ROSE OKOT-CHONO: Good morning, Ladies and Gentlemen. I'll be sharing on operation research findings regarding the barriers to the implementation of TB/HIV collaborative activities in Uganda.

Just as a background, Uganda is among the 22 high volume countries with TB [inaudible] prevalence of about 7-percent and the estimated burden of HIV in TB patients is 50-percent.

TB is still a leading cause of morbidity among people living with HIV/AIDS in Uganda, and it's estimated that approximately 30-percent of HIV patients die due to TB.

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Because of the dual epidemic that we are experiencing in the country, the national TB program and the national AIDS control program embarked on setting up a national coordination community that was spearheading the activities of TB/HIV implementation.

And specifically their first task was to develop policies to implementation of TB and HIV in the country, and this policy was developed and disseminated early in 2006 and disseminated to the various implementers.

The Minister of Health also revised the recording and reporting tools for TB/HIV, specifically the tools in the TB regions as well as the tools that are used for recording TB data, and they incited columns that captured TB/HIV activities.

This currently ongoing training of health providers on the aspect of TB/HIV collaboration and continual support supervision to ensure that health workers are implementing TB/HIV activities as per the national guidelines.

Despite all of the efforts from the Ministry of Health and various partners, we still, however, are seeing that uptake of HIV testing among TB patients is still low and this can be a proxy for us to understand that TB/HIV collaborative activities are still low and not well implemented in Uganda.

So the national TB and AIDS control program together with the Union embarked on conducting an operational research that was multi-phased to help them to understand why the

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implementation of TB and HIV collaborative activities was still at a low scale.

The guiding question and objective for the operational research was to identify barriers to joint TB/HIV activities and through the barriers that we have indentified, provide recommendations to the policymakers as well as to the implementers on how best to implement TB/HIV activities.

I'll now go into the details of the operational research that we started in 2006. It started [inaudible]. We used both qualitative and quantitative methods and I'll explain that a little later, and we conducted this operational research in five districts.

I should mention that initially we had three districts; however, because of the restructuring that is currently taking place in the country two of our districts were split and we ended up with five districts instead of three.

We selected primary health care settings, both government and non-government institutions and there were hospitals and health centers fours and threes.

And we selected these sites specifically because they were providing collaborative services, at least the basic collaborative services that included diagnostic services, TB treatment and [inaudible], as well as provision of continual care, especially in the aspect of management of opportunistic infections and contrimoxazole; however, I should mention that

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three of the sites that we selected were not providing [inaudible].

Our study population included TB patients, HIV patients and those who were co-infected, as well as health care providers and community members.

So in Phase I we conducted a qualitative study and we assessed the knowledge, attitudes, practices and beliefs of our study population in regards to TB/HIV collaborative activities.

We used qualitative methods including focus group discussions as well as in-depth interviews, and we assessed barriers to the implementation of collaborative activities at the health system level, at the provider level, the patient as well as community levels.

Then from the barriers that we identified in the qualitative study we then implemented another cross section of quantitative study and used the barriers that were identified as a baseline to help us to develop our questionnaire for the quantitative study.

The guiding question for the second phase or cross section of study was to determine factors affecting uptake of HIV testing in TB patients. We used a standardized questionnaire.

We - our outcome measured for the second phase of our quantitative study was TB patients reporting an uptake of HIV testing or reporting that they had had an HIV test and we

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validated that report using the variance resistors, the TB resistor, the HIV cognitive testing resistor or any patient medical form that had information indicating that they had had an HIV test.

We conducted this study in the same setting. In the quantitative study we just increased the number of sites to have a proper and more generalized aspect of understanding our issues and barriers.

We also were able to interview 399 patients in the quantitative study and of those, among those, 252 were males. We used both systematic and convective sampling techniques in recruiting our patients, and this was based on the number of patients that we could identify from each of the various facilities.

I'd now like to present the results and I would like to up front say that Phase I study was completed and the results conclusive; however, for the Phase II, we have just completed the data collection and the results I shall be presenting will be preliminary.

So from the Phase I qualitative study, some of the factors that we identified as barriers were limited planning and coordination at the district level as well as at the health center level, specifically the issue of lack of leadership and who should take a role in overseeing and coordinating TB/HIV meetings was found to be a barrier.

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The HIV side or the TB side, nobody seemed to know who should take a lead in coordinating the meetings. Aspects of shortage in testing kits was noted in almost all the facilities that we worked at, as well as lack of contrimoxazole and ARVs, and the issue of high cost of the CD4, the x-rays and the drugs also was noted as a barrier to implementation.

The issue of lack of provider awareness and knowledge regarding TB/HIV was also identified, and specifically from the health workers.

The challenges were how do I, as a health worker, manage to manage a patient who is co-infected with TB and HIV? How do I address the issue of TB treatment together with Nevarapine containing regimens, and how do I initiate HIV counseling and testing if I am at the TB site? And for patients, for the health workers working the HIV clinic, diagnosis of TB was quite a challenge.

We also noted that TB and HIV clinics go in the same compound, within the same facility, while not operating in a similar manner, and while not working on the same day in most of the facilities, and as a result patients, for example, who had been identified to have TB and were referred to HIV counseling had to wait for another day that the HIV clinic was open to go and get tested.

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And in that process many patients get lost in the system, and those were referred sometimes to must go to the site that they had been referred to.

Also notably was the issue of poor recording and reporting. We do understand that it is possible that because the new tools were introduced in the district alley in 2006, some of the health workers didn't have the resistors that captured data on TB/HIV, but also that they were not recording and reporting information regarding TB/HIV.

The issue of also staff motivation and shortages of staff was noted, specifically in the private sector. We found that many of our health workers were leaving their private facilities to go to their government facilities because of discipline in government.

Then there is also the issue of HIV related stigma and the dual epidemic between TB and HIV causing a lot of stigma in the community.

Results from our quantitative study; we found that approximately 77-percent of our TB patients out of the 399 TB patients that we interviewed in the cross section of the study, approximately 77-percent had tested for HIV, and if we compare this with our findings from the qualitative study, only 40-percent had tested, so there seems to be an increase in HIV testing from 2006 and 2007.

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And HIV uptake was highest in patients from the district in Kunmi and lowest in our [inaudible] district.

We also found that among those who had tested for HIV, significantly approximately 50-percent had tested for HIV before they know their TB diagnosis, and this is a good thing, I think, for the HIV control program because it shows that many of our population in the districts are actually accessing HIV testing, and also it addresses the issue of TB suspects. People are being identified even prior to knowing their TB diagnosis, they're having an HIV test.

We also found of interest that 13-percent of our patients had had a repeat test before they knew their TB diagnosis and after their TB diagnosis, and we think this is important because if someone tested for HIV and they're found to be HIV negative, there is a possibility that they could become HIV positive at some point in time, and therefore it's encouraging that people tested not only before they knew their TB diagnosis but also after their TB diagnosis.

We also noted that of 166 patients we tested after TB was diagnosed, approximately 70-percent had been tested in the past two months; however, we noted also that the 30-percent who tested after two months are still a challenge for us, for people who are involved in TB and HIV programs.

We need to get as many of them back to test for HIV as soon as possible, because we know that for TB in the first two

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months if someone does not receive care then they are more likely - they have a 40 to 50-percent chance of death.

This is just a graph to show us HIV testing among TB patients by districts. As I had mentioned earlier, Kunmi district had the highest uptake of 95-percent. It's interesting to note that in Kunmi, of those who tested, the 95-percent who tested, of other 60-percent had tested before they came into the TB setting, in comparison to the other districts.

I'd like to also present results that we found and these results are really cross-tabulations and bi-variant analyses. We'll significantly look at the issues that we think, although may not be predictive, but are helpful for us to understand our setting and our populations and we feel that these associations can help us in our program interventions.

When we look at demographic factors, patient demographic factors, we found that education and marital status were associated with HIV testing.

Patients who were educated, more educated, had the higher uptake of HIV compared to patients who did not have any formal education, and among the married people, the married patients had less uptake of HIV testing compared to those who were not married, and in Uganda this is of interest to the HIV program because we found that the marriage seemed to be the drivers of an HIV epidemic, and so if we are still seeing few of them getting tested then that's also an issue of concern.

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I put here qualitative and quantitative. We also looked at some of the key factors that were identified as barriers from the qualitative study and compared to what extent they were actually significantly associated with HIV uptake.

So we found that in the qualitative study it was reported that males feared to test and they discouraged their female partners to test because also have then noted that male patients tended to use their female partners as a proxy to HIV testing, and this is an issue, especially in our setting where we have a high discordance.

Each individual actually should have an HIV test and not use their results of their partner, and this is further confirmed. We found that most females tested compared to males in the quantitative study.

It was also reported that elderly and young patients were not routinely offered an HIV test, and this was mainly because they thought they were not sexually active they were less at risk, and when we looked at our findings at some of the cross sections of the study, it does show that more of the young, 18 to 24 year olds tested compared to the males that this was not going to be statistically significant.

The issue of inadequate patient awareness and knowledge of TB/HIV issues was also reported in the qualitative study and from our quantitative study we find that only half of our TB patients were aware of the relationship between TB and HIV, and

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among those who were aware, you find a higher uptake of HIV testing compared to those who were not aware about the relationship between TB and HIV.

Issues of poor infrastructure and privacy, lack of privacy, we have found to be barriers in the qualitative study and when we assessed and evaluated this in the quantitative study we did find that actually about, again 50-percent of our TB patients expressing discomfort at the level of privacy in the health facility, and lack of privacy seemed to be associated with less uptake of HIV testing compared to those who did not feel that there was an issue of privacy.

We also noted that most of our patients paid for transports to travel to the health facility, and of interest, contrary to what is normally expected, we found that people who paid for transport had a higher uptake of HIV testing compared to individuals who didn't pay for their transport, and the issue here is one could only speculate, probably the issue of proximity and fearing to go for an HIV test because maybe you'd be identified, or either that you pay for services. I am more likely to maximally use the opportunities and utilize the services that are available.

We also found that patients have long waiting time in the health facility, and this was mainly associated with providers who are very few and cannot attend to all the patients.

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When we evaluated this particular factor, we found that indeed 50-percent of our patients reported that they spent less than 30 minutes receiving care at a health facility; however, spending a short time in the health facility was associated with a low uptake of HIV compared to individuals who spend at least between 30 to 60 minutes in the health facility.

And, again, here the issue might be that the interaction time between the provider and the patient, if it's small, if it's short, then it's possible that issues of TB/HIV are not addressed, patients are not offered counseling and are therefore less likely to have an HIV test.

In regard to some of the provider factors, we found that only 50-percent of our TB patients were informed about the relationship between HIV and TB after their TB diagnoses, and uptake of HIV was higher among patients who had been informed by a health provider about this relationship.

And this obviously is an issue of concern because we are moving toward patient information. We are moving toward provider initiated diagnostic counseling and testing and we find that only half of our TB patients were given the opportunity to have an HIV test and also half of them were given information regarding TB/HIV.

And I'd like to also emphasize that we found that it was statistically significant that over 97-percent of our TB patients who were offered a test by the health provider

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actually took up an HIV test, and only 61-percent of those who were not offered the test took it up, so it emphasized the importance that health providers need to be more proactive in initiating issues of TB/HIV/

Now what I have just presented were mainly associations, so from our logistics regression, we wanted to identify what factors among those that were statistically significant could predict an HIV test uptake among TB patients, and I'd like to mainly emphasize the bottom two.

Where a provider did not give information about TB/HIV and where a patient didn't know about the relationship between TB and HIV they were then less likely to have an HIV test.

In regard to the three districts, I believe there are other compounding factors. For example, how the health systems are run, issues of human resource, capacity, issues of logistics could have given us these particular results.

I'd like to also share some of the lessons that we have identified from Kunmi district as we realize the mission [inaudible]. Over 95-percent of our TB patients in Kunmi district had an HIV test, and these are some of the things that we identified that probably could have contributed to that high uptake.

We found that health providers were trained routinely to initiate [inaudible] and testing at any service point in the health facility. It wasn't restricted only to the TB and HIV

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clinic, but in all patient departments. In the wards patients were offered an HIV test, and I presume that this could have contributed to the high uptake of HIV testing prior to TB diagnosis.

And then TB patients are also informed that HIV testing is part of policy and were routinely offered an HIV test and given the option to opt out.

We also noted that in Kunmi, TB patients are referred directly to the lab, and not necessarily having to be referred to the HIV clinic for an HIV test, and this minimizes the waiting time. It also helps in minimizing aspects of continual referral from one site to the other, and we feel that this is a good thing that could be adopted.

We also noted that there was collaboration between the services providers in the health facility. The TB, the HIV clinic and the lab were working hand in hand.

And also in Kunmi specifically, we noted that there's involvement of non-professional staff, mainly noting assistance in provision and initiation of HIV counseling and testing.

It's not really restricted to a clinical officer or a nurse, but any health worker, irrespective of their qualification, was able to initiate HIV testing, and this is the aspect of human resource.

And also of significance I'd like to note that in Kunmi there's a strong partner of the CDC that is supporting in

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provision of logistics, specifically provision of HIV test kits, which is Uganda is really a very big problem and a very big barrier to TB/HIV, and CDC's also supporting the provision of Cotrim, and this in a way kind of makes patients go for testing because they know if I am found to be positive there is an aspect of being introduced into care.

I'd like to conclude with some recommendations based on our findings this far. I'd like to advocate that all TB patients should test early for HIV, within the first two months of TB treatment.

We also advocate that we should design and disseminate key messages that are specific to HIV screening for TB patients and use the various media, either the mass media or use the health education system in the health facilities, and also the community based organizations.

And we should focus on issues of TB/HIV relationships and address misconceptions as found in our study. We found that many, about half of our patients assumed that if someone had TB they also obviously had HIV, and that may not -- is not really true.

Also the issue of male involvement is critical if we are to increase uptake of HIV testing in our communities. The curriculum for TB and HIV should be reviewed and incorporate motives for collaborative activities, specifically in the HIV manuals.

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And then aspects of infrastructure should be addressed so that privacy is no longer a problem, and then we should think of ways to use the existing human resource creatively to improve delivery of collaborative activities.

And finally for the health providers, all the health providers should be trained in collaborative strategies at all levels, and not necessarily restricted to hospitals but go down even to the health center force and include routine HIV counseling and testing.

It should not necessarily be only voluntary counseling and testing, because routine counseling and testing is very brief. It's very short. It can be initiated at any service point in the health facility.

We finally recommend that all TB patients should be routinely informed about TB/HIV and where a patient has had an HIV test prior to TB diagnosis or had a test before, we should encourage them to test if they initially tested HIV negative.

And if the patient tested HIV negative prior to the TB diagnosis this test should be repeated, at least after three months.

And HIV testing should be offered as a routine to all persons seeking care in health facilities, because we are now moving toward the issue of getting TB patients while they're still suspects, or even before they become suspects so that they get linked to HIV care as soon as possible, and TB and HIV

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services should be offered on the same day and facilitated with viral. Thank you very much. [Applause].

DR. PAULA FUJIWARA: Thank you, Dr. Okot-Chono for that very comprehensive presentation. I think the use of the qualitative research to inform the quantitative research was very nice, the comparison.

I think what we'll do is to take questions now, after each presentation. There are microphones available, and also for the people who entered late I want to make sure that you all have your headphones, because two of the presentations will be in French for those of you who know English and vice versa, so please make sure that you get them so that you'll be able to understand the presentations.

Are there any questions - do I see microphones there? Yes. Are there any questions for Dr. Okot-Chono? Dr. Harris?

DR. TONY HARRIS: Yes. Tony Harris, Malawi. Rose, thank you very much for a very nice presentation.

At the beginning of your talk you mentioned one of the barriers to implementation being high cost of drugs, so I just wanted to seek clarification on this.

Do patients have to pay for CPT and ART, and if so, why? Because Uganda's well supported with Global Fund/PEPFAR, so surely these drugs should be free for all patients, including TB patients.

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DR. ROSE OKOT-CHONO: Actually the high cost comes in when we have shortages of ARVs and contrimoxazole. Patients then have to buy it off the counter from clinics, so that's where the high cost comes in, and we know that government provides our ARVs for free, but we've had issues with Global Fund and sometimes supply of ARVs is quite irregular, and it's in such instances that patients have to buy.

And then also the other issue for cost is our facilities, specifically those at district level and health center level are mainly given the varapiam continuum [misspelled?] regimen, and when you're talking about a co-infected patient, the issue of coverage comes in, and because most of our facilities don't regularly have [inaudible], sometimes patients may need to buy.

We have JCRC that provides drugs at cost, at a low price. Patients sometimes have to incur costs for that.

DR. PAULA FUJIWARA: Yes, second question?

KEVIN BALES: Yes. Kevin Bales, South Africa. You've spoken about the management activities that underpin this excellent presentation.

I just wondered whether you'd looked at trying to make accountability for managers part of the policies that you're trying to implement in Uganda, so people with a leadership issue are actually brought to account.

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DR. ROSE OKOT-CHONO: I think in regards to leadership of TB/HIV it has been decentralized, or that's the idea. The concept is that it should be decentralized and for most of our managers at district level, it's a bit of a challenge on how to hold them accountable, but in regards to the implementers at the lower facility levels, we have low level managers. Those ones can be held accountable. They come up with district plans, and based on those plans that can be used as a tool of assessment on how well they perform.

But it's still something that is very, very weak; accountability of managers performance is sometimes a challenge in a setting like ours.

DR. PAULA FUJIWARA: We'll take the last - I think there are two people at the mic, and we'll take those two questions and then move on. Yes?

FEMALE SPEAKER: Thank you for a very informative presentation. I thought that your study was very interesting and rich and well-designed.

My question is about how you disseminated the results from the study, and how widely and to whom, and whether you feel that just disseminating the results and maybe going back to some of those facilities that you, that participated in the study, has caused them to make any changes and improve in some of those areas that you found are barriers or weaknesses.

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I find that a lot of times operational research stops there with the research, and I see here a lot of different international partners that are obviously funding and interested in overcoming those barriers, so if you could just address how well you've disseminated, how widely, and then if you've been able to evaluate any impact of that dissemination.

DR. ROSE OKOT-CHONO: Okay, as I said we've just finished Phase II actually. We finished the data collection for the quantitative study just in October.

For the qualitative study, we held a workshop. Incidentally, the [inaudible] is working with the National TB and the National AIDS Control Program, and so they have been quite involved in being updated on our initial findings of the qualitative study.

We have also been able to disseminate and give feedback to the districts in form of a report, and also we held some workshops in the districts where we conducted the study, and of the facilities, because we went back for the second phase, we also sat down and mentioned some of the issues.

And I believe that because of our - we could also say that our presence in the health facilities where we are conducting the study helped to raise the awareness about the importance of TB/HIV and some issues that we were able to address at that particular time that we found as challenges

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have now been turned into some good success stories in some of the districts that we are working in.

DR. PAULA FUJIWARA: I want to add something here. There's a Phase III that has been planned in order to see some of the barriers that have been found and then to actually do some testing to see what - to design interventions to see if they actually have an impact, so that's another aspect.

I think your point about the dissemination of information from these good results is absolutely key and is built into the activity.

I think there's one, was there one last question? Yes.

EVELYN: Thank you very much for the informative presentation. My name is Evelyn from Zimbabwe. You just mentioned that health workers working in the public sector, and this is a challenge in my country. Would you like to share with us how you have managed attract health workers in the public sector? Thank you.

DR. ROSE OKOT-CHONO: I think that's a question for my government, but I can just - I think one of the issues has been that the pay for the health workers in government is actually better than in most of our private health facilities, and we're talking about faith-based health institutions. They tend to pay less, and there is a tendency to believe that government always is a good safety net. There are quite a number of benefits, so I think those are some of the motivators or

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incentives that have attracted health workers to the public sector.

DR. PAULA FUJIWARA: Thank you, Dr. Okot-Chono. We need to move on to our next presentation. I'd like to call to the podium Dr. Charles Sandy, who's the National Tuberculosis Program Manager for Zimbabwe, and he's going to speak to us on the challenges faced by health care workers in providing care and support for joint HIV and TB activities, so welcome.

CHARLES SANDY: Good morning, Ladies and Gentlemen.

DR. PAULA FUJIWARA: It's the one before? Yes.

CHARLES SANDY: I'm going to discuss a little about the challenges faced by health care workers in the Zimbabwean context in providing joint TB/HIV care.

This [inaudible] Zimbabwe. We are somewhere here today, and Zimbabwe's up here. It's a small country with a population of over 12 million and most of our people live in the rural areas.

The country's a bit poor. The GDP's \$263 per capita. One of the biggest challenges is [inaudible] inflation, which the country's currently experiencing, and in terms of TB the services are integrated within the general health services, and everything is free.

The country's adopted the missionary health strategy, which is based on a [inaudible] health care approach. We belong to one of the [inaudible] African countries and our

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[inaudible] rates in 2005 were 388 to 300,000 for all forms of TB and for sputum positive it was 101.

Our [inaudible] rate is consistently low at 42-percent and the treatment success rate is also very low at 54-percent. This is coupled with a high case fatality rate.

TB care is provided by various health care workers which include village health workers, nurses, environment health workers, pharmacy technicians and doctors.

Zimbabwe is in the HIV is facing a big HIV challenge and according to the DHS survey which was done in 2005-2006, we are going to a rate of about 29-percent HIV in women and 15-percent in men in the 15 to 49 age group.

The rate is actually declining, and last week our Minister elected that it was now around 15-percent but this counts for people from about 30-percent in 2000.

In terms of HIV services, we have got a well-running PMTCT program which started way back in 1999 and so most of our services are offered in public health facilities as various [inaudible] organizations where rapid HIV testing is being done.

The [inaudible] laboratory scientists and technicians; however, in terms of [inaudible] our TB patients actually undergoing HIV testing in our country, and we have discovered that 60 to 80-percent of the tested patients are also HIV infected.

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One of our biggest challenges is that early diagnosed people with HIV end up being routinely screened for TB. This is the case in most common institutions, but when it comes to NGOs, I think they've got the tools in hand to screen for TB.

In terms of antiretroviral therapy, we still have some discordance in who covers it that would like it. The ARVs have been available since 2003, but we are now reaching about almost 100,000 people on ARVs and those people who are also on TB treatment are eligible for ARVs, but we don't have figures as to how many people actually are benefitting.

So I will say that some of the top three challenges that we are facing in terms of HIV care are inconsistent availability of test kits, and then with the high attrition rate of health care workers, so continuously we need to be training people on all aspects of HIV care. Then the other limiting rate is the unavailability of adequate ARVs.

Just to highlight the HIV problem further, we have about 160,000 new HIV patients in 2005, which is quite a lot, and we estimated that almost 1.4 million people are living with HIV and AIDS.

So 80-percent of our inpatient admissions are also due to HIV problem and in 2005 we estimated that about 140,000 people died from AIDS.

This has led to a decline in the median life expectancy, that which is now just about 36 years. To fight

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the twin disease we need to activate human resources and this happens to be one of our biggest challenges unlike Uganda, where there's more people [inaudible] people trying to leave the service.

Data from the World Health Report of 2006 just illustrates the gross differences in terms of availability of human resources, and if you look at physicians we only have about 286, and I think this figure is the global figure for all the physicians who are registered, but not who are currently working in Zimbabwe, so the coverage is actually lower than this one.

The same applies to nurses where we have about [inaudible] of the population and I think, looking at it carefully, we are almost in the same league as Mozambique and Malawi who are experiencing critical shortages of health workers.

There are many reasons why we are losing our health workers, but the underlying causes seem to be the economic crisis which the country's currently facing and because of [inaudible] inflation, lack of resources for health care workers to be able to do their work, unattractive remuneration packages as well as lack of retention packages.

Despite all these challenges, the government has introduced, has come up with a number of responses to address the problem, and one of them was to introduce incentives for

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rural based health workers in the form of special allowances, [inaudible] accommodation, water and electricity.

The government has also increased production from the traditional schools of medicine and nursing and laboratories, and this has assisted to some extent, and we are now requiring that all people who are trained in Zimbabwe also offer the government some compulsory form of [inaudible] after training, and what they're trying to do to enforce this is to return the certificates of those people who have been trained, and then after their compulsory service they are given their certificates and can go elsewhere.

We have also introduced some middle grades, which we had done away with years back, and we have what are called [inaudible] and we are also introducing [inaudible] officers and laboratory technicians instead, who are scientists and we've also started a program of training microscopists [misspelled?].

With assistance from [inaudible] we are going to be introducing some better packages for people who are working in districts, but this is mainly going to target the senior management that is a [inaudible] or officer and the pharmacy technician as well as the medical laboratory scientist.

We are not sure whether this will be the right move whether to also note, created in harmony with the other health workers who will not be getting this package.

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The Ministry has also announced that they're developing a human resources strategic plan, and I think the aim is to address the problems more comprehensively.

So in analyzing the challenges which are being faced, I looked at the current interim policies of [inaudible] collaborative TB/HIV activities, I don't have to go through it because I'm sure I must have asked [inaudible].

So in terms of TB/HIV coordinating board is, we are still at an early stage in having this in place and including it at a national level. We have the people but it has been difficult to have meetings going.

There seems to be some lack of motivation to actually provide joint services amongst health workers, and one of our biggest challenges is that we haven't developed clear guidelines and tools which will guide the health workers.

In terms of HIV [inaudible] depressions, this is not being routinely done, though we actually encourage it to be done, and when it's done it's not being captured because the tools for capturing this have not been available.

TB/HIV joint planning is down to some [inaudible], because the people responsible for TB are not [inaudible] management structures, but at the district level and the provincial level.

In terms of TB/HIV monitoring, we have incomplete data, and we are also not utilizing this data for planning. I think

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we, as a culture, we need to address this of using the available data for our work.

When it comes to the intensified case finding, we have assayed the local standardized screening tools as a challenge, and there's a problem in having good access and availability of diagnostic services.

As [inaudible] preventative therapy, it's a very topical issue, and because our health providers are concerned about whether or not we will be able to generate [inaudible] resistance, given the fact that our diagnostic capability is not as it should be.

Our x-ray machines are very old and they are prone to breakdowns, and sputum microscopy, the services are not available every time. Sometimes there are some operational challenges on the ground.

In terms of TB infection control, we still have a problem, and that's our TB suspects and patients are just [inaudible] with other patients in the [inaudible] and the x-ray department, and which means that both patients and staff are at risk, so we've started to work on a review of the current policy and updating it.

Sort of this is, because a lot of the slides looking at HIV testing and counseling, we have an opportunity in that most of our patients are here to know about their HIV status because there are still the benefits for areas to other people, and so

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there is operating demand; however, our shortcoming is that we are not able to have the tests because [inaudible].

In terms of preventative methods, we're trying to give [inaudible] and condoms, but [inaudible] materials are inadequate.

Contrimoxazole has not been a big problem, and there's good coverage for those who have been identified to be HIV infected. Almost all the patients are actually on contrimoxazole; however, there's a problem in terms of [inaudible] because we don't have the tools to actually ensure that we are monitoring and following up all the defaulters.

When it comes to HIV/AIDS and support, we have various community networks available, that as health workers we haven't had the capacity to utilize those fully, and the collaboration is still poor.

Our HIV patients, a small portion are actually getting ART because there's no special prioritization given to the TB patients and I think this is mainly because we've got a very critical shortfall in terms of the amount of ARV drugs that we need.

Then there's a problem in that some of our doctors do not believe in coaching patients in ART use and [inaudible] criteria. They would rather wait for a patient to have a CD4 count, and that service is still limited in most provinces.

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For some reason they do not even commence on contrimoxazole because they still want to see a CD4 count, so this also indicates the need for strong and regular training.

So the biggest hindrance to all these activities is the irregular supply of ARVs, which is sort of a measure of frustration for both the health care workers and the patients.

So in summary I would say the [inaudible] challenges which we are facing as health workers is the human resource capacity in terms of lack of training, lack of training on the job on the TB/HIV, the inadequate numbers of personnel, and the unattractive [inaudible] packages which result in high attrition.

Then we have got limitations in diagnostic capacity in terms of the supply of HIV test kits and sometimes the test kits are available at a central level, but due to poor supply management they will not be available at the operational level.

Then we have got problems with smear microscopy where we are now trying to address this by training microscopists [misspelled?] and one of our challenges is that when it comes to HIV tests, the stance by a lot of professionals in terms of [inaudible] rapid tests is a big challenge in Zimbabwe.

A lot of professionals have been very firm on this issue that nobody but them should be doing a laboratory test, and when nurses are trained to do the HIV tests, the professional council of laboratory scientists insists that they

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should be certified and they should be paying annual fees to their body, so this is a very critical problem.

And as I said, the limited availability of ARVs is contributing to the staff burnout, because the staff just see the patients and they feel that they are not able to do something about.

One of our other issues is infrastructural inadequacies, and here we are talking about availability of adequate numbers of consultation and consulting rooms.

This is an issue, but also from our visits we feel that we need to support our providers more often, which sometimes is just a matter of reorganizing what is available and starting the service.

The last challenge which I would like to highlight is that we will actually measure what you are doing to measure the impact, but at the same time it seems like we are overloading our health workers with too many data collecting tools.

We have got all the programs, want to know about malaria, about TB, about HIV, but at the end of the day this rests on the [inaudible] health worker.

So now we are looking at coming up with the integrated tool which would be able to gather the key information which would require at a problematic level.

Despite all those problems, I think we can still have some possible solutions and I tried to categorize the solutions

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by level. At the health facility level I think we need to work better with the communities so that we have a better continuum of care.

Then at the district level, we'd like our districts to set up a TB/HIV advisory board and to conduct regular supportive provisions to the health facilities as well as do a one time evaluation. This was supposed to be at the provincial level, and at the provincial level there's need to identify a focal point for TB/HIV and set up a provincial TB/HIV advisory committee, and also to support the provinces to conduct regular and supportive supervision to the districts as well as to conduct [inaudible].

But at a national level we have a big problem in that the national TB program is only composed of two people, so there's need [inaudible] to expand the national TB program and staff at a national level, otherwise we'll not be able to achieve much.

Then we are going to have to [inaudible] the development of guidelines and disseminate those guidelines and train our health workers in TB/HIV.

We also need to participate in all of the efforts at the national level which are meant to address the health system's improvement.

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Then we need to be more innovative in immobilizing the resources so as to facilitate provisional drugs, diagnostics, the coordination activities and the meetings of all of us.

I think this is one of our biggest challenges in that the national level has not been able to have adequate resources. We manage to get [inaudible] of the global front, but up to now we still haven't served the many who [inaudible] some of the activities which we should actually improve a lot on TB and HIV.

I think the main reason why we haven't been able to get the money is simply an issue of economics, whereby the exchange rate with the Global Fund was being given by government was not acceptable to Global Fund and a mechanism was designed to address that issue, but it still has to be implemented by the Global Fund.

So in conclusion I would like to say that TB/HIV collaboration is an important aspect of improving the quality of health services, given the magnitude of the HIV problem in Zimbabwe, and unfortunately we haven't realized the full spectrum of activities that we can do.

What is of critical importance is to improve the conditions of service for health workers so that we have workers available to provide the service and to provide the continual service and we need to quickly develop the TB/HIV

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guidelines and tools so that we expand the coverage and also improve on the quality of services that we are providing.

I think I'll end here. Thank you. [Applause].

DR. PAULA FUJIWARA: Thank you, Dr. Sandy. Are there any questions for Dr. Sandy, and if so please come to the microphone. While we're waiting, I do have one. I don't know if there's really an answer for this, but I'll ask it anyway.

Many of the possible solutions that you proposed need people, need people to do the supervision, the monitored evaluation, to develop the guidelines, et cetera, and yet you point out the very struggle that you have in the country right now to retain people.

People are leaving to get other jobs, et cetera, so I mean how will you do this? These are the possible solutions, but how can you really do this when the lack of the human resources is really the critical issue for the country?

CHARLES SANDY: Yes, I think it's a very big challenge, and one of the issues [inaudible] with partners is going to be supporting the districts' health executive members, so that at least if you have those key people at the district level, they might ensure that there's continuity of services.

On money from the Global Fund, once it starts rolling in, we will be able to recruit a few extra people for the national level that is a TB training officer, a data manager

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and two assistant program managers, so there are those opportunities, but we still need, I think, additional support.

DR. PAULA FUJIWARA: Are there any— yes, yes, with the mic there.

FEMALE SPEAKER: [Inaudible] from Tanzania; I salute you, Dr. Sandy, and all the health workers for remaining in Zimbabwe. [Applause] You seem to really love your country.

DR. PAULA FUJIWARA: Yes, sir?

KENNEDY MAPELI: Yes, I'm Kennedy Mapeli [misspelled?] from Botswana. I just want to find out from you, Doctor, you've outlined quite a number of challenges that the health care delivery system is facing in Zimbabwe.

You, if I quoted you very well, you said that [inaudible] 50-percent in 2000 and just last month the Ministry of Health announced that it has dropped to 15-percent.

What best practices can we copy from Zimbabwe that we can also implement in other countries, because this amount of achievement really is - we're admiring it and we want to applaud you for that.

So can you just outline to me briefly what specific activities you are conducting in the community to [inaudible] today the challenges that you are [inaudible] indicated here? How did you manage to achieve that? Thank you.

CHARLES SANDY: Thank you for the encouraging comments. The reason why we are experiencing this sharp decline in the

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HIV prevalence - I think there could be a number of factors in terms of number one, the methodologies which are used to measure the HIV prevalence rates. I think that there could be some slight changes which were done over the past two or three years compared to what was in turn in 2000.

Then number two is we have consistently been talking about HIV prevention methods on the radio, on the TV and everywhere, so there's a high level of awareness of HIV amongst the population and of how to prevent it, and we also make sure that the condoms are freely available and we actually encourage people to use condoms.

Then there's also the issue of some people saying the reason why it's coming down could be also an issue of we are not helping so many people leaving the country, or so many people also dying from the disease.

So there are a number of factors, but I'm sure it's a lot to do with increasing the awareness about HIV and the prevention methods.

DR. PAULA FUJIWARA: Thank you very much, Dr. Sandy. [Applause]. I now give the microphone to my colleague from Benin to make the next two introductions.

PROFESSOR MARTIN NEAFUL: [Speaking in a foreign language].

DR. DIANE CAPO-CHICHI: [Speaking in a foreign language].

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INTERPRETER: Benin is a small country in West Africa with a population of 7.6 million, and an HIV prevalence of 2-percent.

We have about 3,500 patients who are HIV positive and we have a co-infection of about 550 cases per year. In 2006 the HIV prevalence was 15-percent out of these.

I'm going to describe our health system. We have a Ministry of Health. Within the Health Ministry we have the Directorate of the Minister of Health who supervises the National Directorate of Health Protection, and another director as I did not mention here.

We have all the national programs, the TB program, HIV program, Malaria program will report to the National Directorate for Health Protection.

We have the National Directorate here that supervises, as I was saying, the National [inaudible] Program [inaudible] at the central level, the central level of the TNP [misspelled?] is based of the national hospital in Cotonou, while the [inaudible] is based within the Ministry.

As far as co-infection activities are concerned, and our collaborative efforts, we have developed collaboration with [inaudible] programs recently. So each national program has a representative at the district level. We have the health district directorate that supervises intermediary levels.

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At the district level the NTP [misspelled?] is represented within the service of protection and promotion of health, whereas the [inaudible] is represented by the [inaudible], which is an information and advisory service.

What do you call it? A CDT [misspelled?] is our diagnosis and treatment centers for HIV activities as well as [inaudible] location site of our health centers that care for our people living with HIV/AIDS.

What is the situation of co-infections before 2005? There was hardly any collaboration between the two programs who worked separately so there was no collaboration, and there wasn't much string activities across TB and HIV. Our staff were not trained in co-infection.

We had deaths in patients that were suspects of co-infections since the test was not systematically offered so very often. We were [inaudible 73:09 - 75:40]-

-Takes place on a daily basis and periodically we go in [inaudible] problems on the ground. Since this activity is new, we need to follow these activities closely.

Since we are dealing with co-infection we have put into place a supply system for the centers, because [inaudible] has its own supply system [inaudible].

-Centers were already giving, offering care [interposing], that did not offer care were supplied by the

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FENT [misspelled?] as a national TB program, the NTP [misspelled?].

As part of this project we found that some CDTs recruit a large number of TB patients, so we asked the [interposing] to accredit them as care centers of people living with HIV/AIDS.

We have some of the outcomes of the first two quarters of 2007. These figures come from these pilot sites for the first trimester, or quarter, we have 653 cases of multiple TB and at least 88-percent accepted to be tested. Second quarter, 94-percent accepted to be tested for HIV.

We had 80-percent were given CTM and ARVs, 36-percent for the first quarter, 38-percent for the second quarter.

What are the, if I look at these figures, what I would like to comment is that we often [inaudible] package or two of the people living with HIV/AIDS. It includes CD4 free of charge.

Patients to whom we give ARV treatment are given ARVs if there is major deterioration of their clinical condition. We also look at the CD4 count naturally when making this decision.

What are the highlights? What did come out strongly of this, since we have started these activities?

We are fortunate, because the project is integrated within a program that was already functional and was reasonably

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functional. We also had the follow-up system that existed and that was well coordinated.

On a quarterly basis we visit all of the health centers and this is ongoing. If any problem was brought to our attention in one of these health centers, we find an intermediary to try and solve those problems, and if we can not solve this problem we decided to go directly on the ground to solve these problems.

We periodically organize steering committee meetings. We organize training sessions as well as refresher courses. We have acquired means to help us in activities, so recently we have adopted a guide for the care of TB/HIV patients.

We have harmonized the management support measures to better manage the data. What helped us greatly, also, in better management is that [inaudible] revised TB registers, and currently our registers we have columns that enable us to enter HIV data, so for all TB patients who are in the TB register we can also have the information on the HIV status.

We implement the guidelines of the [inaudible] when we prescribe ARVs within each facility we have a team that is responsible for activities when we have visits or when we arrive, very often the team is there to meet and greet us, and should these people not be there, documents are available to us, accessible.

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We've had a few cases where we could not find the documentation because the person in charge was not around, but it is rather rare, so this work methodology is working very well.

Counseling is offered to all TB patients with supervision on a regular basis, and once a year we have a feedback meeting to see what the results of the activities, the outcome, because the country is divided into six districts, and when we supervise a district at the end of this supervision we have a meeting with all the players on the ground, starting with the director of the health center, nursing staff, all those who could contribute to the improvement of what we are doing within the district.

We call them for this meeting and present the results, the data we have gathered and if the data is good we encourage them. If it is not the case, we try and find solutions to improve future results.

Currently we have undertaken a study on infected patients and we hope to give you the results of this study next year.

If we have the strength, it naturally means that we also have weaknesses. What are the weaknesses that came out? There is a lack of staff in some of the [inaudible] centers, remote centers, and very often the staff members are sent elsewhere and a few of them [inaudible] they do come back, they

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do come back to the major cities, so it is very difficult in remote areas to keep staff.

Staff retention is not easy, so we train the staff and you go back in the health center a few months later or a couple of years later and they've left.

We also have [inaudible] sometimes of the TDRs [misspelled?] and either weakness is of the case of not systematically offered to partners of co-infected patients.

When we discuss this issue with patients, and we know that they are not always prepared or ready to break out the news to their partner, to their family. Tuberculosis is better accepted because there is hope that a few months down the line a patient will be cured, whereas with HIV it is not yet the case.

The patient has to comply with the treatment, accept this HIV status; this is a progress and we hope that very soon these patients will be able to better disclose their status to their family and to their partners.

As far as the care [inaudible], we did not find a large number of TB patients of late, over 30-percent over the last two quarters of patients, co-infected patients, who also reported to be HIV positive, we have difficulties to change working habits of medical staff.

What are the impacts on our activities within these health centers? We were able to add new activities and the

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care of co-infected patients. In the beginning some of the personnel, some of the staff were not motivated enough, but we managed to improve the situation which is encouraging, then accept to carry out the work that we ask them to execute.

We also had an increase in the number of patients, thanks to sensitization awareness campaigns in the media, every fortnight patients who are hospitalized receive information, education and communication.

If the number of patients increases, it means that the work burden has also increased in some health centers. We have used, we are using a CD4 count and we have staff complain about the fact that this new method we have introduced is rather slow, but they do in effect this work.

There is a great improvement in the cooperation between the national TB program and the national HIV/AIDS program.

What are the challenges? We would like to make sure that all health workers are involved in co-infection work and we would like to be able to offer HIV testing to at least 95-percent of TB patients. We would like also to offer care to 100-percent of our patients and to sustain activities.

In conclusion, what did we gain since 2005 when we started this project? We were able to strengthen the cooperation between the national TB and national AIDS programs. We increased screening activities, HIV screening activities in

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TB patients. We acquired new competencies in our various structures.

Thank you very much for your kind attention.

[Applause.]

PROFESSOR MARTIN NEAFUL: [Speaking in a foreign language].

INTERPRETER: I cannot see the room so do use a microphone if you have any questions to ask, have any comments to make. Go ahead.

Thank you for this presentation. What I would like to share with you is as follows; you mentioned, you spoke about your approach to give access to ARVs to TB patients.

You also spoke about [inaudible] and that approach. Can you separately or what is the final choice? You also mentioned about the improvement of integrated supervision with the national AIDS program staff. Do you not think that we can also train people in their national AIDS program so that the only person who could manage and supervise both the TB and HIV aspects?

At that point, let's talk about the assessment meeting. [Inaudible] organize [inaudible] cooperation in 2005, in my view over the next three years I think that these meeting should take place every six months, so you do not wait for 12 months before you can look at the weaknesses of the people on the ground. Thank you.

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DR. DIANE CAPO-CHICHI: Thank you, Doctor. I'm going to start with the last question.

Supervision is done on a quarterly basis. The feedback meeting is organized on an annual basis because it was planned as such by the national program; however, since these activities are new, what we do is that we organize meetings with the health workers as well as people who are in charge of private centers with whom we have discussions, feedback on a regular basis, very often, so we do not wait a whole year to try and assess what is happening on the ground.

We actually have [inaudible], much more often than once a year only. You had another question about the CD4 count.

We do not prescribe only by looking at the clinical condition. We use a CD4 count, as I said before introducing ARVs into patients. If I did not show you the figures for this, we did not give ARVs to all patients with a CD4 count of less than 200. This is why, as I was saying, we also look at the clinical condition.

Some patients have CD4 counts above 200 to whom we have to administer ARVs also. Currently, although the national AIDS program is going to organize tracking, they also speak about tuberculosis, about TB, and in our training program we can also no longer afford not to speak about HIV.

Our training activities are done at the same time as currently. As far as supervision is concerned for the national

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TB program, recently we started integration supervision. I'm one of the supervisors. I'm part of the group, so we do the supervision together.

And on the aspect of this project which is [inaudible], the national AIDS program is its own support mechanism and there are not [inaudible] that, as I said earlier, we decided to harmonize some of these support measures and mechanisms.

We may be able, in the future, to evolve further and to use the same support, but we did not reach this stage yet.

PROFESSOR MARTIN NEAFUL: [Speaking in a foreign language].

INTERPRETER: Are there other questions, it seems? [Interposing].

FEMALE SPEAKER: [Speaking in a foreign language.]

INTERPRETER: I wish to thank and congratulate [inaudible] for the presentation. I'd like to know the [inaudible] as you highlighted it when a patient is co-infected over a certain period, this person has AIDS for life. [Inaudible] or do you refer this patient to HIV structure, and what about counseling?

DR. DIANE CAPO-CHICHI: [Speaking in a foreign language].

INTERPRETER: Yes, it is true that TB treatment covers six or eight months. Once these patients have been [inaudible] to the national AIDS program's centers, but there is the short

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stigma which comes into force, and when patients are used to a caregiver they do not want to go elsewhere.

We have some patients who've stayed with us in our structure, but a bunch of them are accepted to continue their treatment in the various centers of the national AIDS program.

Some of our participants were accredited by the national HIV program, so in the centers you have the same personal caregivers who take care of TB patients or HIV patients. Very few centers that we will have to refer the patient to a different health center.

PROFESSOR MARTIN NEAFUL: [Speaking in a foreign language.]

INTERPRETER: Another one or two questions?

DR. CANN: [Speaking in a foreign language].

INTERPRETER: Yes, good day to you. I am Dr. Cann [misspelled?] of the national TB program of Senegal. I wish to thank the [interposing].

I've got a couple of questions to ask about health information management since you have integrated care between the two programs.

DR. DIANE CAPO-CHICHI: [Speaking in a foreign language].

INTERPRETER: I do not hear you very well.

DR. CANN: [Speaking in a foreign language].

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INTERPRETER: I would like to speak about health information management issues. Earlier you said that with the union you reprised the registers at the intermediary level for TB, as far as either the twos, or quarterly reports, assessment [interposing], between TB and HIV national programs. How did you do that, concretely?

Secondly our friends have spoken about the [inaudible] on an annual basis, we would suggest meeting that take place [inaudible] think about that, and as far as [interposing] collaboration, what will happen as of this project, and both teams speak about or think about the sustainability of this integrated chair?

Last question; at which stage is the Benin TB national program offers HIV testing?

DR. DIANE CAPO-CHICHI: [Speaking in a foreign language].

INTERPRETER: Thank you, Doctor. We'll start with the last point. As soon as we find that a patient is a TB patient, we suggest that an HIV test is carried out and if the patient accepts it this testing will happen on the very first day, on the same day, and within 48 hours we can give the patient the result of the test.

As far as sustainability of these activities is concerned [inaudible] ongoing since we will always have co-infected patients. AS far as the intervals at which these

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meetings are organized, the steering committee meets on a regular basis. We do not even wait for three months. In 2005 we met on a monthly basis, after which we decided to meet on a quarterly basis.

Whenever there is a major problem or issue we call all the committee members. We organize meetings to discuss these issues, so we do not unnecessarily wait three months for these meetings.

On the issue of information management, we harmonized our support mechanisms recently as we were saying earlier, and we have harmonized the register of patients on ARVs as well as the card for requests of tests.

The national AIDS program uses several support mechanisms. They have a great deal of them and they use a large number of them, which is not the case for our program, the TB national program and we cannot impose to the national HIV program to use our support mechanisms.

We can try and see what could be useful to them and suggest that they use these supports. I hope I have answered your questions.

Time is limited so we have to move on. We are going to give the floor to the next speaker because we have to leave this room at a quarter past 11. I'm going to give the floor to the next speaker. [Applause]

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PROFESSOR MARTIN NEAFUL: [Speaking in a foreign language].

INTERPRETER: Thank you. We are going to have now Dr. Jean-Pierre who's going to tell us about the challenges in providing joint TB/HIV care in rural health settings in the lower Congo and north [interposing].

JEAN-PIERRE KABUAYI: [Speaking in a foreign language].

INTERPRETER: Thank you very much, Professor for the opportunity that has been given to us to share with you the experiences in DRC in matter of the integration of the TB/HIV care, and more particularly in matters of logistics.

What I'm going to present to you today follows other presentations from DRC with posters which you'll find on CD4 counts, for example, and [inaudible] of patients and health [interposing].

[Inaudible] national tuberculosis program in Congo and we were technically supported by the union.

It is a project, so of course it necessitates funding and the funding came from the European Union and from USAID [inaudible].

This is a summary of my presentation that will give you an idea of the background, of the context in which this project took place, why we decided to integrate TB/HIV care, and to give you an idea of the supply chain in the DRC in terms of TB drugs and ARVs and HIV test kits, what kind of tools were used,

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what kind of instruments we have used to ensure good management of these new antiretrovirals that can treat, and what kind of results we got from this, what the challenges were, what the lessons were learned and I will give you a few conclusions and recommendations at the end.

Now for those of you who are not familiar with the DRC, you know that it's in Central Africa, a very vast country. You can see the map on the screen [interposing] war. We are now in a post conflict situation, and you can see the impact of war and conflict in the country with the destruction of infrastructure, in particular in the health system, for example.

Where the health facilities are concerned, we have a pyramidal structure of three levels [interposing] zone or health zone bureaus, as we call them in our country, and we have more or less 10,000 health areas as we all them in the country. As far as TB care management is concerned we have 1,069 health centers where you can have diagnosis and treatment.

At the provincial level we have 23 provincial coordination units of leprosy and tuberculosis to which we also have 12 provincial coordination units with HIV/AIDS, so we have at least one coordination unit in every province; we have 11 provinces in the country.

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And finally the third level is the central level and the level of the state where we've developed strategies and policies and we have the central unit of the national tuberculosis program and the national HIV/AIDS program.

Our experience of our professor mentioned it earlier; this project took place in two provinces of Congo, the one in north [interposing] Congo. We had TB screening in both provinces.

You see it goes from 4,000 to 5,000 cases of TB detected every year in the province that takes place in more than 150 centers if you put the two provinces together.

Our treatment rate is 80-percent for tuberculosis and 89-percent in the lower Congo, so 85-percent more is on average and HIV prevalence of 5.4 [inaudible] and 6.1-percent in [inaudible] Congo.

So we didn't choose these [inaudible] at random. There was a reason for it. There was a certain level of performance in tuberculosis treatment which was necessary before we could integrate HIV care within those [inaudible].

So, integrated HIV care [inaudible] it's the research and intervention. The idea is to integrate the - to use the national tuberculosis program as an entry point for TB patients for diagnosis and treatment of HIV, so 23 pilot sites, 13 in [inaudible], ten in [inaudible] Congo.

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Why or what was the rationale that the integration of this logistic dimension. First we [inaudible] more than 25 years of experience in the care and management of chronic TB patients, and this is the program that's been part of the national and primary health systems in Congo for 25 years, so this structure or these facilities are public, they can be private entities. They can be faith based, but all these health facilities that will be ensuring the care and management.

Let's not forget our country is now rebuilding, but we're not [inaudible] national tuberculosis program has its very specific supply system which covers the whole of the country.

You can go to your hospitals. You can go to your health centers. You are sure you will find TB drugs. You are absolutely certain you will find this because we have a very good and permanent supply chain, which is not the case with all other medicine.

But of course since this country's extremely vast, you might have an interruption in the supply, but the interruption would never be longer than a week at most.

[Inaudible] integration, again. We have a national tuberculosis program as I've told you, in which the supply and distribution of services are very good, and like the rest of the country, and we thought that the national HIV/AIDS program

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could be part of the supply chain and distribution system put into place by the NTP, since the national HIV/AIDS program is not as experienced as the NTP.

This is a very recent program. It's just starting to be integrated in the overall health structure of the country, and a few years ago that program was focusing more on awareness raising in communities in order to increase prevention and avoid transmission to the population.

This is a logistical circuit, the supply chain of the NTP in the country, and the way we integrate HIV/AIDS in this at the central level, we have what we call a management committee which you see on the left here, but you may see that comprises all the partners, all the stakeholders having played a role in TB management in the country, whether they're NGOs, international partners or others, and that management committee will mandate the validation and estimation of invasion of needs that grassroots label.

So we analyze this, we validate that. We order TB drugs for the whole of the country from one company. The drugs are received at central unit level and taking into account the vastness of the country, we have two entry points in the country; one in Kinshasa and one in Goma for the east of the country.

We have storage facilities in both entry points, and then you go to the provincial coordination. They all have

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their respective storage facilities which are then used to distribute drugs towards the health areas and the diagnosis and treatment centers.

Once all this has been done, information flows back towards the central level with a varied performance and health system with which we collect data. We understand how they are being used and we can refine our orders.

As far as ARVs and test kits' orders are concerned, instead of this management committee, where you can see here on the health technical team of the Union that does help in estimating the needs for the order and how to order the drugs.

These were done on the basis of HIV prevalence based on the TB data that we received, and these are followed exactly the same circuit, the same supply chain as the TB drugs.

Next to that we also have some other partners that support our national tuberculosis program and national HIV/AIDS program, and these partners also order ARVs and HIV test kits and have distributed these ARVs and tests in the central bureaus in [inaudible] and in the diagnosis and treatment centers without the central units necessarily being aware of the quantities ordered and being distributed at grassroots level.

What kind of instrument, what kind of tool did we use for this management of ARVs? Here you have the form on the

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screen; our quarterly order form, which was based on the TB form. It's comprised of three parts.

The first part contains information orders on the patients that we have to treat. That's in the first box. In the second bigger box we estimate the needs based on cases which have been treated, and we use that to know what kind of stock we need, what kind of reserves we need, and based on all this data we can make a very precise order.

On the back of this form we have all the inputs or entrants from the laboratories and that's followed exactly in the same method used for the estimation of ARV needs.

Why did we do all this? It was to enable TB patients to have access to these tests, and these are the results here during the first year that started in July, 2006, ending in July, 2007 in these two provinces.

We did enroll -- 3,401 TB patients are registered. Three thousand fourteen of them, more or less 86-percent have been tested for HIV thanks to [inaudible] all the tests we ordered.

Fourteen-percent were co-infected, TB and HIV positive and 86-percent HIV negative. Among the co-infected patients, 58-percent had CD4 counts and 88-percent of these patients started contrimoxazole and 42-percent started ARV treatment.

And we kept following the evolution of the treatments, the TB treatments of these patients, as well of course.

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At the operational level what are the results? I would say that all of these drugs are managed in our diagnosis and treatment center by the same staff. The same people looking at the TB patient look at the co-infected patients.

You can see here all these drugs on the same table, TB medicine and ARVs and when our providers make orders they make orders for both at the same time, and this is done simultaneously using the same logistical system.

We did experience some difficulties in the management of these two drugs whether it was TB drugs or ARVs as far as TB drugs are concerned. On the left here you know that we have fewer drugs to actually manager, whereas on the other side there are more and more ARVs.

The regimen has been standardized. It's been stable for the last 20 years on the TB side, whereas on the consistence is quite recent on the standardization and it needs to be constantly adjusted because some people have maybe a certain intolerance to ARVs so then you have to replace them, substitute another product, and then we have some crossovers in the interim for people who have problems with the TB medicine which they are taking at the same time.

The shelf life for entrance of inputs for TB is generally longer than three years, which is quite low, but it's not the case on the ARV side which is often lower than two years.

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What are more important constraints or obstacles that we have in our way? I would say that the first constraint was the low enrollment of patients. This was based on a TB/HIV prevalence of conviction which was much lower than what we expected, only 15-percent actually here, so we actually have double our people that, twice fewer people that we expected, so there's a risk of expiry of many of these medicines with twice too much, because as I said their shelf life is only two years.

But since we had other people in need of ART, we have been able to reassign the surplus towards the national HIV/AIDS program and this medicine has been used for other people living with HIV and AIDS.

Another constraint or another difficulty, let's say it's to keep a reserve stock at a central level for products with a shelf life on only two years. It is very difficult to do that. The consequences before you even receive the drug is important that it's three, five months from the time they actually leave the factory, so sometimes they are only going to be usable for 12 months if you need a reserve medicine for another few months, sometimes you might have an expiry even at central level before it even reaches the district, so that's one of the big difficulties.

And the other issue was the multiplicity of supply sources because there very various projects. The Union did help us but all the other partners in the national HIV/AIDS

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programs have been able to order these drugs sometimes on the basis of an affinity or a relationship with certain firms, so sometimes we have different shapes, different dosages, different appearances so it was difficult to manage these medicines for our staff, because the people, generally they give these pills to people in an almost automatic way, so all of a sudden you have something with a different appearance, a different dosage, giving the administration of this medicine you may find yourself being overdosed or underdosed, so that was a big problem.

And the last issue was the high turnover of staff, which make the situation quite unstable, and the people were trained and worked in the health centers. The government doesn't have sufficient resources to keep these people, so there's a high rate of attrition of the staff and they do not stay in the same place for long enough to be able to prescribe ARVs in a very stable form with patients for the duration of a treatment, and the standards in DRC is that they always cover one doctors, and unfortunately these doctors are not there for long enough, and then you have to hire others when you need to put somebody else in place.

What are the lessons learned of this project which may be helping us in the future? We do think that the integration of those supply chain of ARVs within the TB medicine supply chain is absolutely feasible.

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We have seen it, but it can only be done with some prerequisite, meaning if we train these health providers in the use of these supply chains or these logical circuits and if we manage to have a unique source, the same way we do for TB medicine, we think ARVs should come from a single source and that would be a great help at the level of health structures at the grassroots level.

And we should have, really, a mechanism system in place between ARV manufacturers and our country and the partners in our country, because the time we order in, the time they are manufactured and they come to us, it takes almost six months, so already we have lost six months on the shelf life of this product.

And the last point, we can never insist enough on the harmonization, the synergy of activities within both programs, the NTP and the national HIV/AIDS program, but we don't want this harmonization to be just wishful thinking, so we have decided to take measures towards a more efficient, more effective harmonization of the NTP and the national HIV/AIDS program in DRC until these supply circuits become more performing and cover the whole of the country.

We think with a national HIV/AIDS program can be directed itself on the supply circuit of the national tuberculosis program so that ARVs and HIV test kits reach the HIV positive patients who are present in the health

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infrastructure system and, as I say, the NTP covers the whole [inaudible], so that's one thing.

The second aspect is the important to standardize guidelines for the management of HIV positive patients by health providers in our system and the third point, maybe it relates more to the partners in our country, our partners should endeavor to harmonize their activities, align themselves with the needs of the country so that we don't have sometimes an oversupply of some provinces to the detriment of other provinces, so we think that our partners should harmonize their programs and intervention and I think that would be very helpful to the health system in the DRC.

Thank you for your attention, Mr. [Inaudible], your colleagues for having listened to the experience in the integration of TB/HIV care in DRC. Thank you very much.
[Applause]

PROFESSOR MARTIN NEAFUL: [Speaking in a foreign language.]

INTERPRETER: Thank you, Jean-Pierre for this excellent presentation. I'm sure that the [interposing] session, but we still have maybe a few minutes, and I'm going to ask [inaudible] maybe to manage the rest of our time that we have at our disposal. Any questions for Dr. Kabuayi?

DR. PAULA FUJIWARA: [Interposing] -a very important topic, this issue. We've talked a lot in other sessions of

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this whole issue of harmonization of drugs, so I really congratulate him and the Democratic Republic of Congo for putting together this kind of effort in a very difficult post war situation.

I don't see any questions for him, so with that [speaking in a foreign language], and I would like to end by saying you've now heard the experience of basically what the Union is doing and will do regarding the integration of collaborative TB/HIV activities from the point of view of the TB patient, which we know in areas such as this part of the world there's so much co-infection of the TB patients with HIV, so I thank you for your attention and we hope that this has been enlightening to you. Thank you very much. [Applause]

[END RECORDING]