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| **Vol. 38 No. 313**  |

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| Archives  |
| [Today](http://www.starofmysore.com/index.asp?type=today)[7 Jan, Thursday](http://www.starofmysore.com/index.asp?type=archives1)[6 Jan, Wednesday](http://www.starofmysore.com/index.asp?type=archives2)[5 Jan, Tuesday](http://www.starofmysore.com/index.asp?type=archives3)[4 Jan, Monday](http://www.starofmysore.com/index.asp?type=archives4)[3 Jan, Sunday](http://www.starofmysore.com/index.asp?type=archives5)[2 Jan, Saturday](http://www.starofmysore.com/index.asp?type=archives6)  |

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| FEATURE ARTICLES  |

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|  | **AN INTERVIEW WITH DR. KOGIELEUM NAIDOO, PRINCIPAL INVESTIGATOR OF THE STUDY ON TB RECURRENCE IN TB-HIV CO-INFECTED PATIENTS** Description: http://www.starofmysore.com/image.asp?slno=9436&type=specialnews**HIV-TB: How to tackle the deadly combo?** *Dr. Kogieleum Naidoo, Head of the Treatment Research Programme at the Centre of AIDS Programme of Research in South Africa (CAPRISA), is the lead investigator in CAPRISA studies aimed at optimising treatment strategies for TB-HIV co-infected patients. She leads all Adult AIDS Clinical Trial Group (ACTG) network trials undertaken by CAPRISA and is the Co-Principal Investigator on the PEPfAR-funded Durban and Vulindlela CAPRISA AIDS Treatment Programme.* *Dr. Naidoo is currently the Principal Investigator of the CAPRISA study on TB recurrence in TB-HIV co-infected patients, who were previously successfully treated for TB. Her most significant scientific contribution is the CAPRISA SAPiT trial, which served as the basis for the 2009 WHO Rapid Advice on TB-HIV treatment integration. These findings were subsequently incorporated into the WHO international guidelines, the US government DHHS guidelines and the South African guidelines for treatment of TB-HIV co-infected individuals.* *Dr. Naidoo, a recipient of Union Scientific Prize awarded by the International Union Against Tuberculosis and Lung Disease in 2013, was in Mysuru recently to attend the HIVe Mysuru ART Update - 2015, an annual conference on HIV conducted by Asha Kirana Hospital at SDM-IMD. City-based writer Sujata Rajpal spoke to her on behalf of Star of Mysore (SOM). Excerpts.* **By Sujata Rajpal** **Star of Mysore (SOM): What are the current challenges in the treatment of HIV-TB patients?** Dr. Naidoo: Reporting of TB cases is the most important challenge. Patients don’t come forward to report the cases. TB is a highly contagious disease, it can spread without patients being aware of it. The second challenge is to capture the cases and put them on treatment. The treatment for TB lasts for six to eight months whereas treatment for HIV is life-long. TB is treatable and curable whereas HIV is treatable but not curable. Training and counselling frontline health workers is another big challenge. The patients should come back to the health centres for continuous monitoring as the relapse of the disease is very common. The cost of the treatment is borne by the government. Though the services such as blood tests, screening etc., are free, nothing is completely free as patients have to spend their time and money to reach the health centre and then stand in long queues for consultation and treatment. **SOM: What is the impact of drug-resistant TB in the TB control programme?** Dr. Naidoo: Drug resistant TB is a man-made phenomenon. It has been created mainly by the medical community as medical professionals focus their attention only on treating patients whereas it is very important to ensure that the TB bacteria are totally evicted from the body. Drug-resistant TB occurs due to relapse of TB. The patients need to completely adhere to the treatment as incomplete adherence to the treatment makes the TB drug-resistant. It is also equally important that the patients are counselled and monitored for a certain time period after the treatment is over as getting frequently infected with TB increases the magnitude of infection in the body. This is more so for HIV positive patients. They are at a high risk of getting infected by TB due to their poor immune system; the HIV positive patients should get themselves tested for TB at regular intervals. For a healthy human being, the probability of contacting TB in entire life span is 10% but for a HIV positive patient the probability of contacting TB is 10% in one year. Today, the advanced technology has made TB-HIV detection easier and faster; it is also possible to quickly find out if the TB is drug-resistant. So the earlier it is diagnosed, the faster it can be treated. **SOM: Indian medicines have helped Cuba eliminate mother-to-child transmission of HIV but in India, it is still common. What is preventing India from doing so?** Dr. Naidoo: Mother-to-Child transmission can be stopped completely if every single woman has access to HIV testing. The urban women have access to testing and treatment but in India, most of the child births, especially in rural areas, happen at home by ill-equipped and untrained health workers. At hindsight, home-births are better as home-birth mothers have much lower rates of intervention in labour. While some interventions are necessary for the safety and health of the mother or baby, many are overused, are lacking scientific evidence of benefit, and even carry their own risks. The health workers should be trained to counsel HIV positive mothers to prevent the transmission from mother-to-child. The twin approach to tackle this challenge is to improve awareness about HIV and also make testing more accessible. We need to educate women on HIV. Early treatment will surely help in controlling the transmission of disease. **SOM: What are the cornerstones of a successful HIV-TB control programme?** Dr. Naidoo: There is an urgent need to have an integrated approach. We can’t have HIV and TB as stand-alone programmes as it not only results in duplication and wasteful effort but also de-motivates the patients to go for treatment. HIV and TB should be tackled together under one programme. There should be a clear strategy to screen patients for HIV and counsel them to get tests done at regular intervals. Under the integrated package, it is important that the health care workers and nurses are trained in counselling patients. **Fact File** HIV and TB form a lethal combination, each speeding up the others’ progress. In 2015, 1 in 3 HIV deaths was due to TB. HIV-infected patients are 20 to 30 times more likely to develop active TB. In 2014, about 80% of reported TB cases occurred in 22 countries. The 6 countries having the largest number of cases in 2014 were India, Indonesia, Nigeria, Pakistan, People’s Republic of China and South Africa. *[Source: WHO Fact Sheet N0. 104, Updated Oct. 2015]*  |

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