DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

TB Notes
No. 2, 2003

Dear Colleague:

World TB Day was observed in a number of interesting and important ways by CDC and many other groups and institutions. On March 21, CDC published three items about TB in the *Morbidity and Mortality Weekly Report* (*MMWR*): a short piece about World TB Day, an article about *M. tuberculosis* transmission resulting from a failure to complete treatment for latent TB infection (LTBI) in Mississippi, and an analysis of preliminary U.S. surveillance data for 2002. Staff of the National Center for HIV, STD, and TB Prevention (NCHSTP) Office of Communications developed a media advisory relating to TB elimination in connection with the *MMWR* articles. On World TB Day, March 24, 2003, the US Agency for International Development (USAID) sponsored a press event in Washington, DC. HHS Secretary Tommy Thompson, Dr. Ann Peterson of USAID, Dr. Phil Hopewell of the World Health Organization (WHO), and I spoke at this event; a panel discussion followed these opening remarks. In addition, Dr. Zach Taylor of the Field Services Branch (FSB) participated in a press event on World TB Day in Chicago. Scott McCoy of the Communications and Education Branch (CEB) contributed substantively to a TB editorial for Secretary Thompson's signature that was published on World TB Day. On March 27, World TB Day was observed by the U.S.-Mexico Border Health Commission during a highly successful event in El Paso, Texas. That well-attended event featured the U.S.-Mexico Binational TB Referral and Case Management Pilot Project, which is a collaborative effort of the U.S.-Mexico Border Health Commission, the Mexican Ministry of Health, and numerous other state and local programs involved in TB control. Training has now been completed for providers involved with the pilot project of the Binational TB Card. Although World TB Day is over, information on related events, fact sheets, posters, and other materials are available at the World TB Day page of the DTBE Web site, http://www.cdc.gov/nchstp/tb/worldtb2003/default.htm.

I am very happy to convey the good news that, after a smaller-than-usual decline in 2001, the reduction in U.S. TB cases has apparently resumed its previous downward trend: DTBE has provisionally reported that TB cases dropped almost 6% from 2001 to 2002, as reported in the March 21, 2003, *MMWR* that I mentioned above. You are doing a remarkable job of controlling TB, despite the considerable challenges that are confronting all of us. However, a less favorable development is that the FY 2003 TB budget is undergoing additional reductions and adjustments resulting from a 0.65% Office of Management and Budget (OMB) rescission and a Congressionally-directed increase (from 1% to 2.1%) in the evaluation tap. The net gain from the $3.8 million increase in appropriations is approximately $500,000 in fiscal year (FY) 2003. This budgetary impact

on DTBE activities in FY 2003 is resulting in the curtailment of three new research projects we were planning to begin, and the tightening of budget projections related to direct assistance and support for TB outbreaks. A similar budgetary impact on Division of AIDS, STD, and TB Laboratory Research (DASTLR)-supported activities through the TB elimination cooperative agreements has resulted in a 7% reduction of funds for laboratory support.

In organizational matters, external consultants have recommended that DASTLR, currently housed in CDC's National Center for Infectious Disease (NCID), be organizationally relocated within NCHSTP. DASTLR is scheduled to be transferred to NCHSTP in June 2003; formal signatures and an announcement are forthcoming. Owing to the extensive collaborations between staff of DTBE and DASTLR, this is a very welcome and logical change, and will further program and laboratory collaborative efforts.

The Research and Evaluation Branch (REB) reports that TB Trials Consortium Study 27 is ready to enroll patients. This study will assess the impact on the 2-month sputum culture conversion rate of using moxifloxacin during the standard intensive phase of TB treatment. Please contact REB at (404) 639-8123 for more information about the trial.

Division staff have been busy planning and attending various meetings recently. Members of the TB Epidemiologic Studies Consortium (TBESC) met April 9-11 in Chicago for their third semiannual meeting. The majority of their time was devoted to discussion of the three TBESC priority studies in the following categories: 1) Foreign-born, 2) LTBI, and 3) contact investigations. For an update on TBESC activities, please see the article by Viva Combs of the Surveillance and Epidemiology Branch (SEB) in this issue. The regionalization project (TBESC task order 6) group met in Atlanta on April 28. DTBE convened a Model Centers Summit in Atlanta on April 29-30; representatives from the Model Centers and the NTCA attended. Dr. Lisa Rosenblum of SEB convened a consultation of genotyping experts on May 1-2 in Atlanta. The American Thoracic Society will convene its 99th International Conference May 16-21, 2003, in Seattle, Washington. In June, DTBE and the National TB Controllers Association (NTCA) will jointly hold the 2003 National TB Controllers Workshop in Washington, DC (more on that meeting in the next paragraph), and the TB Education and Training Network has begun preparations for the TB Education and Training Network (TB ETN) Annual Conference, which will convene in Atlanta, August 13-15, 2003. A brief article herein describes the conference, and a registration form for this conference has been included at the back of this issue.

The 2003 National TB Controllers Workshop is being held June 10-11, 2003, at the Capital Hilton in Washington, DC; in addition, preworkshop and postworkshop meetings will be held June 8-9 and June 12. The theme for this year's workshop is "Maintaining Momentum." The presentations and activities will highlight new strategies and initiatives that will enable us to maintain the momentum we have achieved in our goal of eliminating TB. The focus of this meeting will be in the context of our priority activities: case management; contact investigations; and targeted testing and treatment of latent TB

infection. As you know, the workshop committee has also invited TB control staff to submit poster abstracts. These posters are always a very important means of obtaining the input and contributions of TB control staff from across the nation in high- and low-morbidity states and cities. The 2003 workshop will be organized as it has been in previous years. I look forward to seeing you in June!

Please note the following updates on new publications/products of interest: the new ATS/CDC/IDSA guidelines on TB treatment will be printed soon in the *MMWR* with continuing medical education (CME) credits offered. The TB Information Resource Guide on CD-ROM has been updated and is available for ordering in May. In addition, new health information privacy standards have been issued by HHS in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and are effective April 14, 2003. The new standards may be accessed at www.cdc.gov/mmwr/pdf/other/m2e411.pdf.

Kenneth G. Castro, MD

In This Issue

Note: The use of trade names in this issue is for identification only and does not imply endorsement by the Public Health Service or the U.S. Department of Health and Human Services.

TB Notes

Centers for Disease Control and Prevention
Atlanta, Georgia 30333

Division of TB Elimination ◆ National Center for HIV, STD, and TB Prevention

Number 2, 2003

HIGHLIGHTS FROM STATE AND LOCAL PROGRAMS

Significant Program and Outcome Improvements in the Miami-Dade County TB Control Program

In 1999, the Florida Bureau of TB and Refugee Health (BTBRH) invited a team from CDC's Division of TB Elimination to conduct a program review of the Miami-Dade County TB Control Program. The main purposes of the review were to document areas in need of improvement, make recommendations for change, and influence key decision-makers that investment and changes in the TB program were needed. The review identified a number of areas of concern in all three high-priority activity areas: surveillance and completion of treatment for active TB cases, contact investigations, and targeted testing and treatment for latent TB infection (LTBI). Based on this review and a quality improvement review conducted by BTBRH in 2000, recommendations for improvement were made and an action plan with timeline was developed.

The Miami-Dade County TB Control Program has been reinvigorated over the past 2 years by following the recommendations and action steps outlined in the 1999 program review. Numerous personnel changes have been made; the nurse case management system has been fully implemented; additional office and clinic space have been acquired, which has had a positive effect on both staff morale and infection control; data systems have been developed; forms and record-keeping procedures have been streamlined and improved; clinical and operational procedures have been developed and implemented; and an increased emphasis has been placed on data quality and analysis. Another major change that impacted all three high-priority activity areas was the major reduction in low-risk tuberculin skin testing and treatment for LTBI. Screening for TB infection is now done by the immunization program using a risk assessment questionnaire, and only high-risk LTBI clients (e.g., contacts, HIV infected) are referred to the TB program for treatment and case management.

In addition, successful efforts have been made in securing additional local resources (both staff and funding), collaborating with the local lung association, and improving relationships and collaborating with the area hospitals and local jails. Perhaps most important has been the establishment of effective relationships between key program staff and the local health department administration staff. These relationships have significantly improved the credibility of the TB program and have led to

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additional local resources and support that had been absent for years.

On the next page is a chart comparing the key TB program indicators from the quality improvement review conducted in 2000 versus the follow-up review conducted in 2002. The chart shows Miami-Dade County results compared to the state of Florida as a whole and state goals.

Factors contributing to the improvements in the Miami-Dade Co. TB control program

The improvement of any program is not accomplished by one person or one strategy alone, but rather by many people who contribute many ideas and demonstrate an openness to change.

As was stated earlier in this article, the journey to success began several years ago when personnel changes occurred. The assignment of a new TB Director in July 2000, followed by the assignment of a Public Health Advisor and the recruitment and placement of a clinical director for the TB Program, were significant additions to the TB program and served to strengthen the managerial team that was in place. These assignments and a program reorganization improved communications throughout the TB program and the health department. Staff members soon felt comfortable with the new organization table, which clearly identified the person to consult when problems and issues came up. In addition, managers became more responsive to staff needs.

One of the early action steps that the management team undertook was to develop, revise, and implement TB program policies and procedures. Each policy and procedure was reviewed in its developmental stage with the key staff from the TB program. Prior to the implementation of any policy and procedure, a training session took place with all staff members so that each person understood what was required. Afterwards, each staff member was given a manual of all the program policies and procedures for reference.

Active TB Cases

Indicator	Miami-Dade County 1998/99*	Miami-Dade County 2000/01**	State 2002	State Goal
Percent of TB cases completing a recommended course of therapy (calendar year 2000)	81%	90%	85%	90%
Percent of TB cases receiving DOT (calendar year 2000)	68%	82%	77%	80%
Percent of TB cases placed on currently recommended treatment regimen (calendar year 2001)	83%	80%	75%	100%
Percent of TB cases with documented HIV status (calendar year 2001)	83%	84%	71%	100%

* Program review conducted in calendar year 2000
** Program review conducted in calendar year 2002

Concurrently, the managerial staff was working on improving other administrative elements of its program. Personnel activities included identifying vacant positions and filling them with the best-qualified applicants that the program was able to recruit. Fiscal activities included improving the capability of the program to generate additional billings from Medicare and Medicaid, thereby increasing the revenue for the Miami-Dade County Health Department (MDCHD). This also provided the program with additional resources in its general revenue budget for TB activities.

Evaluation

In early 2001, the Miami-Dade County TB Control Program started to plan a strategy for strengthening its program evaluation component. The senior staff of the TB program held several meetings regarding the need to identify program activities that would enable the program to evaluate specific activities around its cases, suspects, and contacts. These activities included the following program areas: surveillance, case management, workload, refugees / immigrants, and contacts. Additionally, meetings were held to include other key program staff such as nurse case managers, surveillance analysts, health service representative supervisors, and data analysts.

During the next several months many reports

were developed to assist the program in its evaluation process. All of these reports are completed and reviewed with key TB staff every month. During these meetings, staff make analyses, corrections, and updates. Each member of the managerial and supervisory staff has an opportunity to discuss each of the reports. Currently there are a total of 70 reports that are reviewed. The review session takes approximately 3 hours to complete. All involved feel that this is an extremely valuable session that provides timely input on the direction in which the program is headed. Several examples of these reports are as follows:

- TB cases and suspects by medical facility (monthly and annually)
- TB cases and suspects by zip codes
- Key indicators - lists the TB cases caused by drug-resistant strains (MDR and monoresistant), TB among children (by age group), and HIV status, which reflects positive, negative, refused, not offered, test done but results unknown, and unknown
- Basis of diagnosis - looks at culture positive, clinical diagnosis, and provider diagnosis
- TB cases by country of origin - assists the program in identifying a patient profile

The CDC Aggregate Reports for Program Evaluation (ARPEs) are also updated and reviewed on a monthly basis. This process provides timely feedback into the evaluation of the program's contact investigations. Several reports look at the case assignments by local region, by nurse case manager assignment, and by surveillance analyst by month and annual total. Other reports look at the number of cases open longer than 9 months and the number of cases that were closed by case manager per month. A Heath Service Representative Team report reflects the number of monthly assignments such as DOT, source investigations, interviews, and other types of field assignments by worker. These reports provide a very good picture of the workload and assist in making future staffing assignments.

The use of two data programs and of several clinic logs captures data for these reports. The two data systems are the Access-based TB Management Information System (TBMIS) developed by Miami-Dade County TB staff and the statewide Health Clinic Management System (HCMS). It should be noted that these reports are continuously reviewed and revised in order to meet the needs of the program. This will continue in order to meet the challenges of TB control in Miami-Dade County.

—Submitted by Harry Stern, Public Health Advisor and TB Program Operations Manager Miami-Dade TB Control Program, and Heather Duncan, Senior Public Health Advisor Florida Bureau of TB and Refugee Health

Successful TB Continuing Education Retreats Sponsored by the Virginia Division of TB Control

In the fall of 2002, the Division of Tuberculosis Control (DTC) of Virginia sponsored two highly successful training retreats for public health outreach workers and nurses working in TB control. Both retreats were held at the rustic Massanetta Springs Conference Center near Harrisonburg, Virginia. The goal of both retreats was to enable the participants to become better able to facilitate the successful detection, treatment, and cure of persons with TB disease and their infected contacts. The conferences


Three outreach workers enjoy a meal and conversation.

provided not only an opportunity for outreach workers and nurses to network with their colleagues, but also an orientation to TB control for newly hired outreach workers and nurses, and an update for those who have been working in the field for some time.

TB Outreach Worker Retreat

Twenty-five TB outreach workers from across the Commonwealth of Virginia attended the retreat in September 2002. The previous outreach worker training was held in 1998.

The retreat curriculum included topics such as epidemiology of TB, a TB skin testing practicum, infection control, contact investigation, directly observed therapy (practical and legal issues), safety in the field, and documentation. The faculty included staff from DTC, the American Lung Association of Virginia, the Central Shenandoah Health District of Virginia, the City of Harrisonburg (VA) Police Department, and the Washington, DC, TB Control Program. The outreach workers highly valued the didactic, practical, and professional development components of the program and commented as such in the program and course evaluations. Of the 23 outreach workers who completed the program evaluation form, the majority (78.3%) reported satisfaction with the retreat, all reported that the retreat provided information useful to their jobs, and 95.7% reported obtaining new skills as a result of their participation.


Two outreach workers with an instructor from the Harrisonburg Police Department

Tuberculosis in Retreat

October 28-31, 2002

Massanetta Springs
Harrisonburg, Virginia

Approaching the 5th Century

Group photo of the nurses who attended the TB nurse retreat.

In October 2002, 52 nurses working in TB control attended the TB nurse retreat, "TB in Retreat: Approaching the 5th Century," which was the very first of its kind in Virginia. (Virginia has fought the spread of tuberculosis since the English colonists landed on its shores in 1607, and TB possibly took the life of one of its most famous early residents, Pocahontas). Many of the nurses, like the outreach workers, sincerely valued this opportunity to network with their colleagues. The nurses represented diverse professional experiences, years of employment in health care and/or the health department, and knowledge and skills in TB control.

DTC implemented a comprehensive didactic and hands-on TB nurse curriculum that included topics such as epidemiology of TB, diagnosis and management of TB infection and disease, the new immigrant and TB, program evaluation, contact investigation, case management, and the Virginia TB control laws. In addition to the didactic component of the retreat, the nurses were divided into seven work groups to allow broad input on DTC activities; these work groups indeed yielded products useful to TB control efforts statewide. (Two groups developed process and outcome evaluation indicators, one group reviewed the Virginia Standards of Care for TB patients, another group reviewed patient education materials, and three groups developed new patient records for TB control.) In fact, the TB educational materials reviewed by one of these work groups are now complete and posted on the DTC Web site http://www.vdh.state.va.us/epi/tb/patinfo.htm.

Instructors at the TB nurse retreat included Karen Connelly, RN, MSN, Virginia Director of Public Health Nursing, who delivered the keynote address; John Marr, MD, MPH, Director of the Office of Epidemiology; Karen Galanowsky, RN, MPH, Nurse Consultant, New Jersey State Department of Health and Senior Services; Margaret Tipple, MD, Director of the Washington, DC, TB Control program; and staff members from DTC, the Virginia Refugee Health Program, the American Lung Association of Virginia, and Virginia local health departments.

The TB nurses reported overwhelming satisfaction with the retreat content and activities. Of the 48 nurses who completed the retreat

evaluation, 93.8% reported satisfaction with the retreat, 97.9% stated the retreat provided information useful to their jobs, and 91.7% reported obtaining new skills as a result of their retreat participation. As one nurse commented, the aspects of the retreat most useful to her were "meeting and talking with other nurses and VDH (Virginia Department of Health) staff and other speakers, information about labs…and contact (investigations)." Several participants expressed that the retreat was "wonderful, excellent…" and that they would like DTC to "do it again."

Participant feedback from the outreach worker and nurse retreats indicates the need for and potential success of future training programs for these two audiences. The Division of TB Control remains strongly committed to continually training its physicians, nurses, and outreach workers to ensure that public health professionals remain prepared to address the changing epidemiology of TB in the Commonwealth of Virginia.

—Reported by Vipra Ghimire, MPH, CHES
Health Education Coordinator
Division of TB Control
Virginia Department of Health

Four TB nurses with Dr. John Marr (center), Director of the Office of Epidemiology

A High TB Case-Fatality Rate in the Setting of Effective TB Control: Implications for Acceptable Treatment Success Rates

The following is abstracted from a previously published article (*Int J Tuberc Lung Dis* 2002;6:1114-7).

Directly observed therapy (DOT) has been implemented in Baltimore for over 20 years, resulting in declining case rates, high sputum conversion rates, and high rates of treatment completion, all consistent with effective TB control. However, we noted upon standard programmatic review that the TB case-fatality rate was high, so further investigation was undertaken. We conducted a retrospective cohort study to assess the case-fatality rate among smear-positive pulmonary TB patients in Baltimore between January 1993 and June 1998. During this time period, the TB incidence rate was less than 17/100,000 population, rates of multidrug-resistant TB were less than 1%, and 99% of patients received DOT. Of the 174 study patients, 42 (24%) died on treatment. Patients who died were older (mean age: 62 vs. 47 years; $P<0.001$) and more likely to have underlying medical conditions. In multivariate analyses, older age, diabetes mellitus, and renal failure were independently associated with an increased risk of death.

In contrast, in 1998, the global case-fatality rate of newly-diagnosed smear-positive pulmonary TB among persons on treatment was substantially lower

at 3.8%.[1] Although age and comorbid illness data are not available for global case-fatality rates, a study of 5,905 Peruvian patients treated with DOT revealed a case-fatality rate of 2.2%; the average age of persons in the cohort was 27 years, suggesting that the low case-fatality rate could be related to the younger patient population.[2] A study by the British Medical Research Council found a 15% fatality rate among patients from England and Wales, compared to 2% among patients from the Indian subcontinent; this difference was attributed in part to the older age of the patients from England and Wales.[3]

The high case-fatality rate in Baltimore in the setting of low tuberculosis incidence, compared to the global incidence rate of 141 per 100,000 population,[1] suggests that as incidence rates decline, TB will become concentrated in older persons with chronic debilitating conditions, which will be associated with higher case-fatality rates.

These results have implications for the World Health Organization (WHO) goal of successfully treating at least 85% of detected cases.[1] Treatment success is defined by WHO as the sum of cases that were either cured or completed treatment (two mutually exclusive categories).[1] The rate of treatment success is inversely related to the case-fatality rate, and in areas where TB patients have high median age and frequency of comorbid illness, either the formula for treatment success needs to be modified, or the goals for treatment success should be lowered. However, if the latter approach is taken, it must be clear that other indicators of program effectiveness must be present, such as high rates of treatment adherence and sputum conversion, and low rates of TB incidence and drug resistance.

—Submitted by Timothy R. Sterling, MD
Medical Director, Baltimore City Health Department Eastern Chest Clinic
Center for Tuberculosis Research
Johns Hopkins University School of Medicine

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Field Services Branch Brings the Real World of TB to Headquarters

The Field Services Branch (FSB) of DTBE would like to express appreciation to the health department representatives who participated in the 2002 brown bag sessions held in Atlanta. These weekly lunch time sessions consist of presentations on topics of interest to the division staff.

FSB was pleased to have the cooperation of the presenters and the health departments in sharing their expertise. As a result of this broad range of information, headquarters staff gained additional insight into various aspects of local TB prevention efforts.

The topics covered and the presenters were as follows:

- Targeted Tuberculin Testing of Foreign-born Persons in Tennessee, by Connie Haley and Roda Ferraro
- Elimination of Tuberculosis in the Workplace in Central New York, by Donald Blair
- The Challenges and Successes in Tuberculosis Education in Rural Alaska, by Leslie Hausman
- Challenges of Tuberculosis Prevention and Control in Alaska, by Elizabeth Funk
- The Status of Tuberculosis Prevention and Control in Large City and County Jails, by Cheryl Roberts

Again, FSB thanks the participants from the 2002 brown bag series and looks forward to hosting presenters from other health departments willing to share their knowledge with headquarters staff.

—Reported by Rita Varga
FSB Training Coordinator
Div of TB Elimination

New Jersey Medical School National Tuberculosis Center Celebrates 10-Year Anniversary

The New Jersey Medical School National Tuberculosis Center at the University of Medicine and Dentistry of New Jersey celebrated its tenth anniversary on January 13, 2003. In the 10 years since its formation, the New Jersey Medical School National Tuberculosis Center has achieved National Model Center designation, improved drug-taking adherence in our service delivery area (Newark and surrounding towns) from 62% to 98%, and reduced the Newark TB case rates by 62%. In addition, the Center has provided education and training opportunities to thousands of health care workers through the training programs it has offered and the TB educational products and resources it has developed.

The Center provides services at its new state-of-the-art clinical facility, the International Center for Public Health. This facility is the first in the country planned and built specifically for the safe and effective treatment of TB and multidrug-resistant (MDR) TB in over 30 years.

On May 1, 2003, the University of Medicine and Dentistry of New Jersey hosted a special TB seminar in honor of the New Jersey Medical School National Tuberculosis Center's 10-year anniversary and accomplishments.

The Center may be reached by calling 1-800-4-TB-DOCS or at http://www.umdnj.edu/ntbcweb.

—Reported by Eileen C. Napolitano
Deputy Director
New Jersey Medical School National Tuberculosis Center

Timing of Tuberculosis Testing and Smallpox Vaccination

An important issue has been raised recently by some of our partners in various TB control programs, i.e., the timing of the administration of the tuberculin skin test and the smallpox vaccine. Some of the persons currently being targeted for vaccination against smallpox intersect populations in whom CDC recommends annual tuberculin skin testing (TST), such as health care workers.[1,2] In 2000,

guidance was given on this subject in the document entitled "Diagnostic standards and classification of tuberculosis in adults and children[3]":

> Vaccination with live-attenuated virus can cause suppression of the PPD response in patients known to be infected with *M. tuberculosis*. Live-attenuated vaccines that may cause false-negative PPD results are measles, mumps, rubella, oral polio, varicella, yellow fever, BCG, and oral typhoid. This suppression does not appear within the first 48 h after measles vaccination, so the Advisory Committee on Immunization Practices recommends that tuberculin testing be done either on the same day as vaccination with live virus or 4-6 wk later.[4-7]

A recent *MMWR Recommendations and Reports* article offers smallpox-specific guidance, with inclusion of a more current reference to CDC immunization guidelines[2]:

> Suppression of tuberculin skin test (purified protein derivative [PPD]) reactivity has been demonstrated after administration of smallpox vaccine,[8] as has been observed after administration of other parenteral live-virus vaccines.[9] Health-care workers scheduled to receive an annual PPD skin test should not receive the skin test for 1 month after smallpox vaccination to prevent possible false-negative reactions.

Please call the DTBE duty officer with any questions at (404) 639-8140.

—Reported by Michael Iademarco, MD, MPH
Div of TB Elimination

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THE TB EDUCATION AND TRAINING NETWORK

Welcome to a new section of *TB Notes*! Future issues of *TB Notes* will include a section dedicated to information and updates from the TB Education and Training Network (TB ETN).

The first 2 years of the TB ETN have been exciting and active. TB ETN was established in 2001 as a result of recommendations outlined in the Strategic Plan for Tuberculosis Training and Education to establish a network of persons involved in TB education and training. The TB ETN will help build a cadre of TB educators and trainers with improved skills and abilities, knowledge of available resources, and ability to serve as a resource for high-priority needs, such as outbreaks and implementation of new guidelines.

Goals of TB ETN

- Build, strengthen, and maintain collaboration among the key agencies and organizations in TB education and training
- Provide a mechanism for the sharing of TB education and training resources to avoid duplication of effort
- Develop, improve, and maintain access to TB training and education resources
- Provide updated information about TB courses and training initiatives
- Assist representatives in building education and training skills

There are many benefits of membership in TB ETN , such as the opportunity to network and collaborate with other TB education and training professionals; exchange ideas, information, and experiences; access and share resources; collaborate on training and education research; and receive updated information about TB courses and training initiatives. In addition, TB ETN provides an opportunity to build TB education and training-related skills, and pilot-test and preview new communication and education materials.

Listed below are just a few of the accomplishments of the TB ETN since its establishment:

- Brought together persons responsible for TB training and education in their TB programs for the sharing of resources and expertise.
- Increased membership from approximately 70 U.S. state and local members to 285 members worldwide representing state and local TB programs, correctional facilities, hospitals, nursing homes, federal agencies, universities, the American Lung Association, National TB Model Centers, and other U.S. and international organizations interested in TB education and training issues.
- Developed an electronic listserv to aid communication among any and all persons involved in TB education and training. This listserv provides subscribers with the opportunity to ask questions, share comments, and exchange information with other subscribers about TB education and training issues and resources.
- Sponsored two annual meetings and workshops. The theme of the 2001

workshop was "Culture, Language, and Literacy in TB Education and Training." The theme of the 2002 workshop was "Reaching Key Audiences Through Innovative TB Education and Training Methods." TB ETN members worldwide traveled to these workshops dedicated solely to health education, training, and communication issues. Plans are underway for the third annual TB ETN Conference, to be held in Atlanta August 13-15, 2003. Please see the article about the upcoming conference in the Update from the Communications and Education Branch.

- Identified needs and strategies for overcoming education and training barriers.
- Established a steering committee with representatives chosen by TB ETN members to guide Network activities.
- Created three subcommittees to carry out and guide TB ETN activities: Communications and Membership, Conference Planning, and Cultural Competency.

With the establishment of the three new subcommittees, the next year promises to be full of exciting opportunities for those involved in TB education and training. If interested in joining one of the subcommittees, you may send an e-mail to TBETN@cdc.gov. If you are not yet a member, we invite you to join and take advantage of all the benefits TB ETN has to offer. To do so, complete the registration form at the back of this issue and fax it to (404) 639-8960 or send an e-mail to TBETN@cdc.gov and request a membership form. Look for TB ETN news and updates in each edition of *TB Notes*.

—Reported by Maria Fraire, MPH, CHES
Div of TB Elimination

TB ETN Steering Committee Members

State Representatives:
Judi Bulmer
New York State Department of Health

Kathleen Hursen, RN, MS
Massachusetts Department of Public Health

Big City Representative:
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National TB Model Center Representative:
David Berger
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UPDATE FROM THE COMMUNICATIONS AND EDUCATION BRANCH

Third Annual TB ETN Conference

The TB Education and Training Network (TB ETN) conference planning committee is gearing up for the TB ETN Third Annual Conference. Details are provided below.

What: TB Education and Training Network Third Annual Conference: "Oh, the Places TB Education Can Go…"
When: August 13-15, 2003
Where: Atlanta, GA

Draft topics

< Needs Assessment
< Planning and Strategy Development
< Making Materials Appropriate to Your Audience
< Intensive Development of Courses and Materials
< Communicating Late-Breaking Information
< Conducting Training and Education with Limited Resources

Conference Objectives

By the end of this conference, you will be able to

P Conduct TB education and training needs assessments
P Develop a strategic plan for developing TB education and training products
P Use multiple methods to provide TB education and training
P Develop appropriate materials and courses for diverse audiences
P Use evaluation in the development and refinement of education and training products
P Communicate late-breaking information
P Identify innovative techniques for conducting TB training and education with limited resources

Conference Registration Form

If you'd like to attend the TB ETN conference, please fill out and submit the registration form at the back of this issue. If you would like more information about the conference or about the TB Education and Training Network, please send an e-mail to TBETN@cdc.gov or go to <http://www.cdc.gov/nchstp/tb/TBETN/conference.htm>

Hotel Information

The conference will be held at the Sheraton Colony Square Hotel (<http://www.sheratoncolonysquare.com/>) located at 188 14th Street NE, Atlanta, Georgia. A block of rooms has been reserved for Tuesday, August 12, through Thursday, August 14, assuming a Friday morning checkout. The room rate is $112.00, exclusive of applicable state and local taxes. To reserve your room, please contact the hotel directly at the toll-free number (866) 912-1171. In order to receive the special group rate, please identify yourself as an attendee of the CDC TB ETN conference. The reservation deadline is July 25. If you have any questions about hotel reservations, please feel free to contact Betsy Carter by e-mail at bkc9@cdc.gov or by phone at (404) 639-8386.

—Reported by Betsy Carter, MPH, CHES
Div of TB Elimination

UPDATE FROM THE INTERNATIONAL ACTIVITY OFFICE

Update on BOTUSA Project Research

Botswana is located in southern Africa and has a population of approximately 1.7 million. It has one of the lowest population densities in the world, at 2.3 per square kilometer. It has a typically young population base (43% are younger than 15 years old), mostly settled in the urban settings. It is considered a success story in Africa in terms of education (79% adult literacy rate), respect for human rights, civilian control of a professional military, economic growth, low level of corruption, and public health infrastructure. Yet, 47% of the population lives below internationally established poverty levels.

TB is a major health problem in Botswana. The Botswana National Tuberculosis Control Program (BNTP) was established in 1975 with technical assistance from the World Health Organization (WHO). The establishment of this program initiated a decline in TB cases that was further enhanced by the introduction of short-course chemotherapy administered as directly observed therapy (DOT) countrywide in 1986. However, since 1989, Botswana has experienced a three-fold increase in TB incidence from 202/100,000 to 620/100,000 in 2001. This increase has largely been attributed to the country's increasing HIV epidemic; in 2002, 35% of women attending prenatal clinics were HIV infected, an estimated 330,000 persons were living with HIV, and there were 24,000 AIDS deaths.

In 1995, the BOTUSA Project was established as a collaborative effort between the Botswana Ministry of Health (BMOH) and CDC to conduct TB/HIV research, provide epidemiologic program support, and build laboratory infrastructure. In 1998, the BOTUSA Project joined with the Global AIDS Program (GAP) for HIV/AIDS program support. BOTUSA conducts a range of basic, social science, epidemiologic, clinical, and operations research for contributions to Botswana TB control and international TB/HIV knowledge.

Since 1999, Dr. Elizabeth Talbot has been Associate Director for TB/HIV research at the BOTUSA Project. Under her leadership, the BOTUSA TB/HIV research team has conducted studies addressing several topics vital to controlling TB in settings with epidemic HIV. These include studies on 1)TB in congregate settings, 2) evaluation of TB control activities, 3) TB treatment interruption, and 4) new TB diagnostics.

TB in congregate settings

At the request of the BMOH, BOTUSA conducted TB prevalence surveys and needs assessments and made screening/TB control recommendations at the country's largest prisons and at the refugee camp in Dukwe, Botswana.

Prison survey

Prisoners and guards were screened with a short questionnaire, and anyone with a cough of more than 2 weeks' duration was asked to produce three sputum specimens for smear and culture. Persons found to have TB were administered a more extensive questionnaire

and voluntary HIV testing and counseling was offered to them.

Of 1461 prisoners and guards at the prisons, 1,290 (88%) were screened. Forty-seven persons with TB were found among prisoners and guards; 22 of these were newly diagnosed cases identified by the screening alone. Risk factors for having TB in this population included a cough greater than 2 weeks, incarceration for more than 1 year, being in the first offenders prison, and having a prior history of TB in prison. DNA fingerprinting of isolates has identified several clusters suggesting TB transmission is occurring in the prisons. As a result, it was recommended that the prisons begin screening all incoming prisoners for active TB to prevent further transmission within this setting.

Refugee survey

A similar survey is underway now at Dukwe, a large refugee settlement in northeast Botswana, housing refugees from several other African countries including Angola, Zimbabwe, the Democratic Republic of the Congo (DRC), and Rwanda. Currently over 1,000 refugees have completed screening and several TB cases have been identified. These results will help the BNTP determine a policy for TB control in the camp.

Evaluation of TB control activities

From September to November 2002, the first in a series of annual TB skin test surveys was conducted in primary schoolchildren throughout the country. These surveys are being conducted to assess the burden of TB in the country, determine if the increasing TB case rate is increasing TB transmission at the community level, and evaluate TB control activities.

This survey was conducted in 56 schools and included more than 3,200 children across the country. The prevalence of TB infection (defined as greater than 15-mm induration) was measured as 6.8%, and the annual risk of infection (ARI) was 0.71%. This is a sharp increase since the last survey, conducted in 1989, which measured a prevalence of 0.75% and an ARI of 0.1%. The continued series of surveys will allow the BNTP to monitor future trends in TB infection and to evaluate TB/HIV control initiatives just beginning in Botswana (i.e., antiretroviral therapy and isoniazid preventive therapy).

TB treatment interruption

In 1998 in Botswana, 10% of those who started TB treatment did not complete it. BOTUSA staff conducted a case-control study to investigate risk factors for defaulting from TB treatment and to assess knowledge, attitudes, and beliefs about antiretroviral therapy (ART). Cases (treatment interrupters) and controls (treatment completers) were identified from the national electronic TB registry.

Of the 266 cases identified from the database, 170 (56%) were incorrectly classified. Many had actually died while on treatment, completed treatment, or transferred during treatment After reclassification, 63 cases and 173 controls were found and interviewed. In this population, being male, drinking alcohol, having a chaotic lifestyle, and having a deficit of TB knowledge were risk factors for treatment interruption.

Also, it was found that 75% of respondents overall would take an HIV test to see if they were eligible for ART, 89% would be willing to take ART if they qualified, 70% would even take directly administered ART (DAART), and 78% of the cases stated that they would have completed their TB treatment if ART had been offered to them at the end of TB treatment. Therefore, it seems that DAART would be highly acceptable and may be an incentive for HIV testing and TB treatment completion.

New TB diagnostics

Smear microscopy is the TB diagnostic tool used in most developing countries. It is inexpensive, but requires a microscope and has low sensitivity for detecting cases. There is a need for inexpensive, highly sensitive TB diagnostic tests to be available to high-burden countries. The objective of this study was to fieldtest commercially available serodiagnostic TB tests and a new immunochromatographic strip (ICS) serodiagnostic test for TB diagnosis in an HIV-positive population, using culture as the gold standard.

Data were collected on 444 consecutively enrolled inpatient TB suspects; 91% of these persons were found to be HIV positive and 32% had confirmed TB. In 23 (5%) of these patients, mycobacterial blood culture was the sole source of TB diagnosis. The sensitivities of the five serodiagnostic tests ranged from 0% to 37%, specificities from 62% to 99%, and positive predictive values from 0% to 50%. This study shows that TB is prevalent in the inpatient population, that HIV coinfection is common, and that blood cultures may be a useful adjunct for TB diagnosis in this population. Unfortunately, all five tests lacked sufficient sensitivity as a sole test for diagnosing TB. These tests will be further assessed in a pediatric population in an upcoming BOTUSA study.

Future plans

The BOTUSA TB/HIV research group is about to launch a large clinical trial comparing 6 months of isoniazid preventive therapy (IPT) to lifetime IPT (defined as 3 years) in a large HIV-positive cohort. This study will be very important in guiding TB preventive therapy for HIV-positive persons in the international community.

Unfortunately, after 2 1/2 years of exemplary leadership at BOTUSA, Elizabeth Talbot has left Botswana. She and her family will travel back to the United States, stopping en route for a 3-month temporary duty assignment in Switzerland, where she will assist WHO in developing guidelines for Global Fund–recipient countries for preventing drug resistance for TB, HIV, and malaria. Elizabeth will be sorely missed at BOTUSA by her collaborators and colleagues, and especially by the TB/HIV research staff. However, she will continue to collaborate on the IPT trial and other new studies just getting underway. The BOTUSA staff wish her well in her future endeavors and look forward to having her come back to Botswana to consult on research projects and to visit old friends.

—Submitted by Tracy Agerton, RN, MPH
Div of TB Elimination

UPDATE FROM THE RESEARCH AND EVALUATION BRANCH

What's Up with the Prevention Effectiveness Team in 2003?

The Prevention Effectiveness (PE) Team in the Research and Evaluation Branch consists of a behavioral scientist (Robin Shrestha-Kuwahara), an epidemiologist (Suzanne Marks), and two health scientists (Heather Joseph and Noreen Qualls). We also have two prevention specialists (Sheila Jain and Diane Lowry) working with us until mid-August, and will be recruiting for a second behavioral scientist in the near future. As noted below, our projects in 2003 (for which we have lead responsibility) focus on behavioral, economic, epidemiologic, evaluation, and health services research. We also serve as co-project officers or collaborators on eight other projects in the Communications and Education Branch, Field Services Branch, International Activities office, and Surveillance and Epidemiology Branch, which are not listed here. If you would like more information about a specific PE Team project, please feel free to contact the designated lead project officer at (404) 639-8123.

—Submitted by Noreen L. Qualls, DrPH
Div of TB Elimination

PE Team Projects in 2003

Title	Primary Objective	Status	Participating Sites	Lead Project Officer
Using a Private Claims Database for TB Health Services Research, Evaluation, and Analysis	To describe the types and costs of medical encounters of persons accessing TB services through private insurance plans	New	N/A	H. Joseph
Model for Incorporating Voluntary HIV Counseling, Testing, and Referral into TB Contact Investigations	To compare the outcomes and costs of offering HIV CTR to close contacts of infectious TB cases in the Manhattan Network	Continuing TBESC Task Order #4	New York City, NY	S. Marks
Improving TB Services for Persons with HIV Infection: Documenting Success	To assess LTBI screening and treatment policies and practices among select Ryan White HIV/AIDS CARE providers	New	3 sites TBD	S. Marks
Assessing TB Program Resources for TB Elimination	To measure the current supply of TB program resources in high and low demand areas and compare with forecasted TB resources demand	New	20 sites TBD	S. Marks
Evaluation of CDC-Funded Targeted Testing and Treatment of LTBI Programs in Select State and Local TB Control Programs	To develop a prototype systematic approach to evaluate targeted testing and treatment of LTBI programs for high-risk persons	New	6 sites TBD	N. Qualls
Perceptions of TB among Foreign-Born Persons: An Ethnographic Study	To ascertain TB-related beliefs, attitudes, and behaviors among select foreign-born communities	Continuing	Denver, CO Atlanta, GA St. Paul, MN 1 additional site TBD	R. Shrestha-Kuwahara

UPDATE FROM THE LABORATORY

4th National Conference on Laboratory Aspects of Tuberculosis

On December 10-13, 2002, mycobacteriology laboratorians gathered in San Francisco, California, for the 4th National Conference on Laboratory Aspects of Tuberculosis. The Association of Public Health Laboratories and CDC sponsored the meeting, which was attended by approximately 200 persons representing state and city public health laboratories, federal agencies, hospital clinical laboratories, and international laboratories interested in TB laboratory issues.

The conference focused on critical technical and programmatic issues of clinical and public health laboratory practice, including quality assurance, delivery of optimal TB laboratory services in response to the changing epidemiology of TB in the United States, and the applications and impact of new technologies and recommendations for drug susceptibility testing. Highlights of the workshop included a session on international collaboration featuring a presentation on the WHO/International Union Against TB and Lung Disease (IUATLD) recommendations for TB laboratory services by Armand van Duen from the Insititute of Tropical Medicine in Belgium and presentations on international consulting experiences by Yvonne Hale (Florida), Ken Jost (Texas), and John Ridderhof (CDC). The participants also enjoyed a presentation from Tanya Oemig, Wisconsin Department of Health, about the perspectives of TB laboratory testing from a TB controller. Participants also were able to share and discuss information at the poster session and the vendor exhibits.

—Reported by Beverly Metchock, Dr.P.H.
National Center for Infectious Diseases

UPDATES FROM THE SURVEILLANCE AND EPIDEMIOLOGY BRANCH

CDC Investigates TB Cases at a Community Hospital in Guatemala City

In November and December 2002, CDC collaborated with officials at a Guatemala City hospital in an investigation of an outbreak of *M. tuberculosis* largely among HIV-coinfected patients, which had the potential risk of nosocomial transmission to hospital staff and patients. Concern about the perceived increase in the number of patients being diagnosed with active TB among patients attending the HIV clinic and inpatient medicine wards prompted the Chief of Infectious Diseases at the hospital and the Ministry of Health to request CDC assistance in the investigation.

In November 2002, a team from CDC visited Guatemala. The team consisted of Drs. Kenneth G. Castro, Thomas R. Navin, Idalia M. González, and Abraham Miranda of DTBE and Mr. Edwin Rodriguez of the State of New York Department of Health. The team principally met with officials from the hospital and Ministry of Health National TB Control Program and assessed the situation at the hospital, a tertiary-care referral center with approximately 42,000 annual discharges. In addition, the team met with officials from another HIV clinic run by a nongovernment organization in Guatemala City,

as well as with senior members of the U.S. Agency for International Development (USAID) mission in Guatemala and the Pan American Health Organization (PAHO).

Based on preliminary findings and discussions, the team felt that CDC could offer immediate assistance in an epidemiologic investigation of the possible nosocomial transmission of TB at the hospital, as well as with an environmental assessment of the factors that could be contributing to such transmission.

A week after returning from the initial assessment visit, Drs. González and Miranda and Mr. Rodriguez departed to Guatemala to conduct the epidemiologic investigation. They were later joined by Dr. Paul A. Jensen, a DTBE occupational safety engineer for the environmental assessment, and by Dr. Soju Chang from CDC's Division of Healthcare Quality and Promotion to assist with the ongoing investigation.

The microbiologic diagnosis of TB at this hospital is done mostly by acid-fast bacilli smear of sputum or other tissues, or by biopsy of a tissue specimen. The laboratory did not have the capacity to do microbiologic identification or susceptibility testing. Therefore, several TB isolates that were stored at the hospital microbiology laboratory from the last several years were sent to CDC for identification and microbiologic susceptibility testing. The specimens have been evaluated; all isolates were susceptible to first-line antituberculosis medications, except two isolates that were resistant to streptomycin.

The hospital does not have a computerized medical records system, which made it difficult to ascertain the number of patients who were hospitalized or treated as outpatients with a diagnosis of TB. Eight separate lists from different sources (e.g., pharmacy, laboratory, medical wards, outpatient HIV clinics, pathology) were generated to try to arrive at an incidence figure of TB cases. Review of medical records revealed that 71 patients were either hospitalized or treated as outpatients with a diagnosis of active TB during the previous 12 months.

Preliminary results showed that 59 (83%) of these patients had pulmonary involvement, 35 (49%) were HIV coinfected, and 14 (20%) died. Deficiencies in engineering and administrative controls essential to the prevention of TB transmission were found. Some of these included the absence of a written TB infection control plan, the lack of surveillance for TB, multiple patients with different isolation needs occupying the same room, the lack of respirators for staff use, and the lack of negative air-pressure rooms.

In addition, a survey on the knowledge, attitudes, and practices of a convenience sample of health care workers was conducted. As a consequence of this investigation, we expect to be able to recommend several relatively inexpensive interventions to decrease the risk of nosocomial transmission of TB in the hospital. An in-depth analysis of the findings of this investigation is under way.

—Submitted by Idalia M. González, MD, MPH
Div of TB Elimination

Summary of the BTEP Project

The Biotechnology Engagement Program (BTEP) seeks to establish collaborations between US government scientists and former Soviet bioweapons scientists to address urgent public health concerns in Russia and the northern Eurasia region. Additional background information on BTEP was provided in the last *TB Notes*. Here we describe a BTEP project that is being developed by CDC staff from DTBE and the Division of HIV, STD, and TB Laboratory Research (DASTLR) in collaboration with scientists from the Moscow Research Institute of Phthisiopulmonology (RIPP) and the State Research Center for Applied Microbiology (SRCAM) in Obolensk.

In November 2002, the CDC collaborators (Rachel Albalak, Rick O'Brien, Jack Crawford, and Peter Cegielski) met with their Russian scientist counterparts in Moscow and Obolensk to develop ideas for a TB clinical trial to be proposed under BTEP, and assess the infrastructure requirements of RIPP and SRCAM for carrying out a TB clinical trial.

Based on discussions held during the site visit, the collaborators agreed that there would be two phases to the project. Phase I would include infrastructure enhancements of the laboratory and computer facilities at SRCAM and infrastructure enhancements of the laboratory, computer, and clinical facilities at RIPP. It would also include training in laboratory processes and in data management and statistics for clinical trials. This phase would also be used for development of the clinical trial protocol. Phase II would be the conduct of the clinical trial.

The proposed clinical trial for Phase II is an evaluation of the safety and microbiological activity of a moxifloxacin-containing regimen administered during the first 2 months of treatment of patients with sputum smear-positive pulmonary TB. The primary outcomes would be the culture-conversion rate at 2 months of therapy and discontinuation of therapy due to drug toxicity or intolerance.

This year, the CDC Tuberculosis Trials Consortium will begin a study to evaluate moxifloxacin in place of ethambutol in the initial phase of TB therapy. Results of this study would be expected to inform the design of the proposed BTEP study. Moreover, studies of moxifloxacin in an experimental (mouse) model of TB, which include moxifloxacin replacement of pyrazinimide and isoniazid, are underway at Johns Hopkins University. Results of these studies, which will be available this year, would likewise inform the design of this study.

These proposal ideas are pending final approval from the Russian collaborators. An additional site visit was conducted in February 2003 to write the proposal, which will be submitted to the BTEP Secretariat.

—Reported by Rachel Albalak, PhD
Div of TB Elimination

Tuberculosis Epidemiologic Studies Consortium Update

The Tuberculosis Epidemiologic Studies Consortium (TBESC) was established in September 2001. The purpose of TBESC is to conduct programmatically relevant TB research and to strengthen TB public health infrastructure in the United States and Canada, ultimately

contributing to the goal of TB elimination. TBESC is composed of 22 sites across the United States and Canada (Figure 1). Each site has a formal partnership between an academic institution and a TB control program. TBESC conducts epidemiologic, behavioral, economic, laboratory, and operational research. This research entails the identification, diagnosis, prevention, and control of active TB disease and latent TB infection (LTBI). Over the past year TBESC has completed several activities that support its mission, goals and purpose.

Thirteen research projects (task orders) have been approved for further development by DTBE, each at different stages of progress (Table 1). Since the last TBESC update (*TB Notes* No. 1, 2002), TBESC convened for a second time in Denver, Colorado, August 7-9, 2002, and a third time April 9-11, 2003, in Chicago, Illinois. The second meeting was convened to prioritize and further develop research proposals in the areas of latent TB infection, contact investigation, and TB among foreign-born persons. The proposal to examine TB among foreign-born persons will be the first consortium-wide study. The purposes of the study are to a) conduct enhanced surveillance to describe the epidemiology of TB among persons who were born outside of the US or Canada; b) identify missed opportunities to diagnose active TB in foreign-born persons before their arrival in either the US or Canada; and c) find approaches that quickly diagnose active and latent TB in foreign-born persons in the United States and Canada in order to reduce the risk of disease transmission and the risk of progression from LTBI to active TB.

TBESC is in the process of completing its bylaws. Currently, five committees are operating:

- The Steering Committee, which includes all 22 sites and one CDC representative (the TBESC project officer, who serves as one of the co-chairs), oversees all TBESC activities, both scientific and administrative
- The Research Committee, consisting of nine members, is responsible for developing the research agenda and overseeing the development and conduct of research protocols for the TBESC
- The Bylaws Committee, consisting of eight members, is responsible for drafting and updating the bylaws and facilitating voting (motions, nominations, and elections)
- The Meetings Committee, consisting of four members, is responsible for coordinating future TBESC general meetings, i.e., developing agendas, identifying and scheduling presenters, collecting relevant materials, specifying meeting dates and times, and identifying locations for meetings
- The Executive Committee, consisting of the chairs of all TBESC committees, serves as the executive arm of the steering committee, managing the day-to-day activities of the steering committee

At the third meeting, the Bylaws Committee proposed and the Steering Committee accepted three additional committees to build on the Consortium's infrastructure. They include the following:

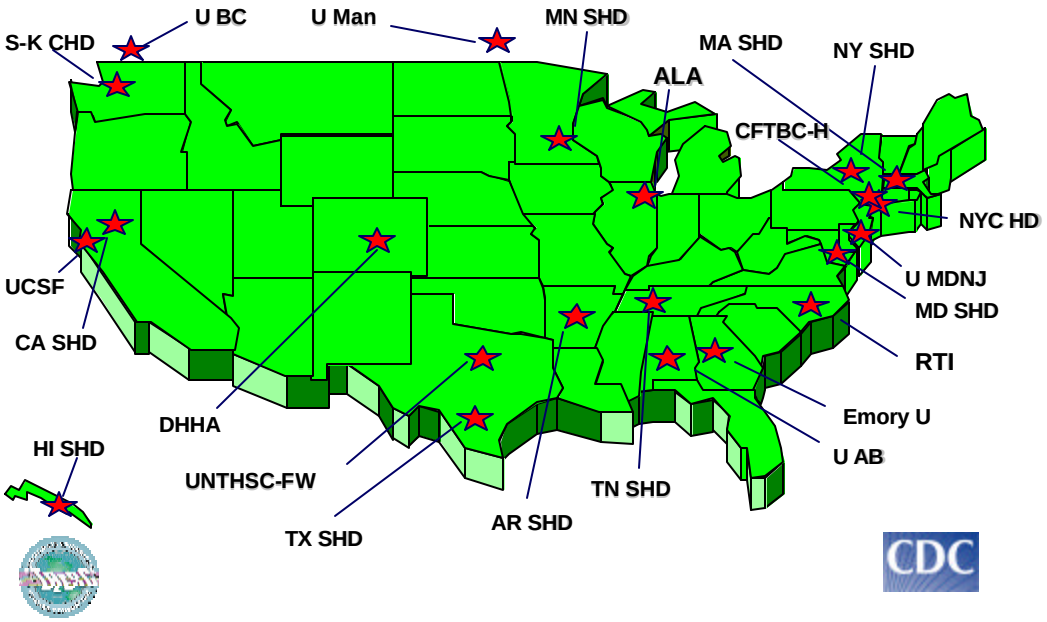
- The External Relations Committee will be responsible for disseminating results of research conducted by TBESC for the purpose of advocating for additional TB research and to promote the goals of TB elimination

- The Publications and Presentations Committee will be responsible for coordinating the development and progress of presentations, publications, and special issues or supplements highlighting TBESC research
- The Process Evaluation Committee will be responsible for overseeing the conduct and quality of ongoing studies

The composition, activities, and purpose of each committee will be finalized at a later date. In addition to the bylaws, TBESC discussed funded and future research projects and long-term objectives of the Consortium. Look for further details about the meeting in Chicago in *TB Notes* No. 3, 2003.

—Reported by Viva Combs, MPH
Div of TB Elimination

Tuberculosis Epidemiologic Studies Consortium Sites



Research sites of the TBESC

Table 1. Current TBESC Research Activities

Task Order No.	Title	Principal Investigator(s)	No. Participating Sites	Stage/Phase
2	Prospective evaluation of immunogenetic and immunologic markers for susceptibility to TB infection and progression from *M. tuberculosis* infection to active TB	Mary Reichler, MD	8	Data collection
3	Zero tolerance for pediatric TB	Mark Lobato, MD	3	Finalizing protocol
4	Models for incorporating HIV counseling, testing, and referral into TB contact investigations	Suzanne Marks, MPH, MA	1	Data collection
5	Prevalence of LTBI among high –risk populations in the US	Rachel Albalak, PhD	5	Protocol development
6	Regional capacity-building in low-incidence areas	Paul Tribble, MPH	1	Site selection
7	Use of network analysis methods to characterize *M. tuberculosis* transmission patterns among women and other high-risk populations	Peter McElroy, PhD & Maureen Wilce, MPH	Sites have not been selected yet	Site selection
8	A national genotyping registry for a molecular epidemiologic analysis of multi-drug resistant *M. tuberculosis*	Kashef Ijaz MD	Sites have not been selected yet	Task Order has been announced
9	Enhanced surveillance to identify missed opportunities for TB prevention in foreign-born populations in US and Canada	Amy Davidow, PhD Dolly Katz, PhD, and Randall Reves, MD	22	Protocol development
10	Applying a New Conceptual Framework to Evaluate Tuberculosis Surveillance and Action Performance and Measure Costs	Scott McNabb, PhD, MS	TBD	Task Order Development
11	Addressing TB Among African Americans in the Southeast: Identifying and Overcoming Barriers to Treatment Adherence for LTBI and TB Disease	Nickolas DeLuca, MA	TBD	Task Order Development
12	Assessing the Tuberculosis (TB) Knowledge, Attitudes, Beliefs, and Practices Among Private Providers Serving Foreign-born Populations at Risk for TB	Nickolas DeLuca, MA	TBD	Task Order Development
13	Prospective cohort study of risk factors for acceptance of, adherence to, and toxicity from treatment for LTBI	C. Robert Horsburgh, MD, MUS	TBD	Task Order Development

TRAINING AND EDUCATIONAL MATERIALS

TB Information CD-ROM, Version 3

The TB Information CD-ROM has been updated and given a new look. Being released in May 2003, the CD-ROM includes CDC materials, such as educational materials, major TB guidelines, *Morbidity & Mortality Weekly Reports*, surveillance reports, and slide sets.

The TB Information CD-ROM can be requested in the following ways:

- Through the DTBE's on-line ordering system: www.cdc.gov/tb
- By mailing or faxing a DTBE Educational and Training Materials Order Form
- Through the CDC Voice and Fax Information System by calling, toll-free, 1-888-232-3228 and requesting the TB Information CD-ROM, order #99-6879

Fact Sheets

DTBE fact sheets are under revision. A new format will be used to give all of the fact sheets the same appearance. Fact sheets that are now available in the new format include the following:

- QuantiFERON-TB Test (Document #250103)
- Treatment of Drug-Susceptible Tuberculosis Disease in Persons Not Infected with HIV (Document #250111)
- Treatment of Drug-Susceptible Tuberculosis Disease in HIV-Infected Persons (Document #250113)

These fact sheets are available on the CDC/DTBE Internet site (www.cdc.gov/tb) and through the FAX Information System. To receive the document by fax, call toll-free, 1-888-CDC-FAXX (888-232-3299). At the prompt, enter the document number.

—Reported by Betsy Carter, MPH, CHES
Div of TB Elimination

NEW CDC PUBLICATIONS

American Thoracic Society/CDC/Infectious Diseases Society of America: Treatment of Tuberculosis. *Am J Respir Crit Care Med* 2003; 167: 603-662.

CDC. Mazurek GH, Villarino ME. Guidelines for using the QuantiFERON-TB test for diagnosing latent *Mycobacterium tuberculosis* infection. *MMWR* 2003; 52(RR-2): 15-18.

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CDC. Transmission of *Mycobacterium tuberculosis* associated with failed completion of treatment for latent tuberculosis infection—Chickasaw County, Mississippi, June 1999-March 2002. *MMWR* 2003; 52: 222-224.

Driver CR, Cordova IM, Munsiff SS. Targeting tuberculosis testing: the yield of source case investigations for young children with reactive tuberculin skin tests. *Public Health Rep* 2002 Jul-Aug; 117(4): 366-72.

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Koppaka VR, Harvey E, Mertz B, Johnson BA. Risk factors associated with tuberculin skin test positivity among university students and the use of such factors in the development of a targeted screening program. *Clin Infect Dis* 2003 Mar 1; 36(5): 599-607.

Lobato MN, Leary L, Simone P. Treatment of latent TB in correctional facilities, a challenge for TB elimination. *Am J Prev Med* 2003; 24(3): 249-253.

LoBue PA, Betacourt W, Peter C, Moser KS. Epidemiology of *Mycobacterium bovis* disease in San Diego County, 1994-2000. *Int J Tuberc Lung Dis* 2003 Feb; 7(2): 180-5.

Narayanan S, Das S, Garg R, Hari L, Rao VB, Frieden TR, Narayanan PR. Molecular epidemiology of tuberculosis in a rural area of high prevalence in south India: implications for disease control and prevention. *J Clin Microbiol* 2002 Dec; 40(12): 4785-8.

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PERSONNEL NOTES

Karen Allen has joined DTBE and FSB/Field Operations Section II. Karen will be the new Program Operations Assistant for FOS II. Karen began her federal government career with the Department of Defense, Naval Research Laboratory, Washington, DC, as a Employee Development Assistant from 1987 to1999. She moved to Atlanta in 1999 and worked in the private industry before rejoining the federal government. She joined CDC in July 2001 and worked with the National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health, Maternal and Infant Health Branch in administrative support.

McKenzie Andre, MD. Epidemic Intelligence Service Officer in the Surveillance and Epidemiology Branch, has been accepted into CDC's Preventive Medicine Residency (PMR) Program. Mac will begin his new assignment (away from CDC headquarters as required by the program) in July.

Lori Armstrong, PhD. joined the Surveillance Section of the Surveillance and Epidemiology Branch as a Senior Epidemiologist on March 10. Prior to joining DTBE, Lori had worked in the Cancer Surveillance Branch, Division of Cancer Prevention and Control, CDC, since 1999. Her duties there included serving as a project officer for several state cancer registries, lead for an analysis to compare mortality rates of colorectal cancer in Appalachia and elsewhere in the United States, and principal investigator in a large study of eight state-wide central cancer registries to study patterns of care in breast, colorectal, and prostate cancer in the United States and a study looking at the end-of-life

care for men with prostate cancer in two large managed care organizations. Lori also supervised an EIS officer in analyzing cervical cancer incidence in Hispanic women in the United States and socioeconomic factors for women with cervical cancer in California. Lori received her PhD in Epidemiologic Science from Rackham School of Graduate Studies, University of Michigan, in 1990. Her other educational achievements include an MS degree in toxicology, also from the University of Michigan (1985), a BS degree in biology from Eastern Michigan University (1981), and an RN degree (1976). Following her postdoctoral research fellowship in the Department of Pulmonary and Critical Care Medicine, University of Michigan Medical School, Lori joined the Epidemic Intelligence Service (Class of 1993), Special Pathogens Branch, Division of Viral and Rickettsial Diseases, CDC, and then worked in Viral Exanthems and Herpesvirus Branch through mid-1999. Lori has been a first author or co-author on more than 20 scientific articles published in peer-reviewed journals and the *MMWR* on topics including hantavirus, juvenile respiratory papillomatosis, and ebola viral hemorraghic fever. In DTBE, Lori will be developing several analytic projects using the national surveillance database to help disseminate information on high-priority topics, and contributing to the development of sureillance-related applied research and evaluation projects. We are pleased that the addition of a senior epidemiologist will help the Surveillance Section expand its analytic, research /evaluation, and technical assistance capacity.

Subroto Banerji, MPH, was selected for a program consultant position with DTBE Field Services Branch (FSB). He began this assignment on May 5, 2003. In this new role, Subroto will be representing FSB on several projects. These include collaborating with CDC Division of Global Migration and Quarantine to continue progress on the Electronic Disease Notification project for Class Bs; partnering with staff from DTBE's CSB and SEB to coordinate the groundwork for the development of a TB information system that will support core patient management and mandated surveillance activities; and participating on the DTBE TB Program Evaluation work group. Subroto joined CDC in June 2000 as a Public Health Advisor assigned to the California Department of Health Services (CDHS), TB Control Branch (TBCB), Surveillance and Epidemiology Section (SES). In this assignment, Subroto directed the TBCB's Class B Surveillance Project, supported California's statewide TB information systems development initiative, and assisted in the development of a strategic plan that identified interventions to prevent and control TB among Mexican-born persons in California. Additionally, Subroto provided programmatic and technical assistance to the TBCB and SES chiefs. Prior to joining CDC, Subroto spent 3 years with the Alameda County TB Control Program, located in Oakland, CA. Subroto served as the Assistant Director and Epidemiologist for the TB Program. In this capacity, he was responsible for all program operations, management, and epidemiologic analysis. From January 1996 to April 1997, Subroto worked as a Public Health Epidemiologist with the San Bernardino County Public Health Department, in the TB and STD/HIV control programs. His responsibilities included surveillance, reporting, and investigative activities as well as database

development and data management. Between August 1993 and December 1995, Subroto completed graduate work towards an MPH in epidemiology at the San Diego State University School of Public Health and also worked with the San Diego County TB Control Program on various epidemiologic and programmatic projects. His masters thesis describing the epidemiology of TB in San Diego County and its impact on a border community was published in *Public Health Reports*.

Lorna Bozeman, MS, was promoted in April 2003 to the position of Lead Epidemiologist of the Data Management Team for the Research and Evaluation Branch (REB), DTBE. Lorna has been with the division since April 1996, when she came to REB to work as an epidemiologist on Study 22 of the TB Trials Consortium. Before joining REB, Lorna worked for 6 years in the Agency for Toxic Substances and Disease Registry (ATSDR) in the Federal Facilities Branch, conducting health assessments at military installations. From 1984 to 1990, she was on the staff of the Clinical Immunology Branch of the National Center for Infectious Diseases (NCID), where she worked as a microbiologist on AIDS-related projects; before that, she worked briefly as a chemist in the Division of Bacterial Diseases of NCID. Lorna's expertise and skills as a laboratorian and an epidemiologist have made her an invaluable member of the branch, and her easy-going and friendly nature allows effective collaboration with disparate groups and organizations.

Dave Crowder, MPH, has been selected for the Field Services Branch, Field Operations Section 1 chief. Dave started his career with CDC in 1988 as a Public Health Associate in the Florida Sexually Transmitted Disease Program. Dave was promoted to front-line supervisor in 1990 working in the Orlando, Florida, area. After gaining expertise in programmatic issues, Dave left the STD Program and transferred to TB in 1991. Dave was assigned to the New Orleans, Louisiana, area managing the city's TB program. After 2 years, Dave was transferred to the Tennessee TB Program, where he was the state TB program manager. In 1997, he transferred to the headquarters position of program consultant where he become the main link to his program areas and headquarter. In 2001, Dave was promoted to team leader and program consultant for the southeastern region of the United States. Dave has a masters degree in public health from Emory University, Atlanta, Georgia.

Derrick Felix, joined the Field Services Branch as a Public Health Advisor assigned to the Chicago, Illinois, TB Program on April 7, 2003. Derrick brings his recent experience gained while working in the TB program of Palm Beach County Department of Health in Florida. In his work as a health services representative, he was assigned a TB case work towards completion of therapy. Before joining the Florida Department of Health, Derrick worked as a health fitness specialist for Johnson and Johnson Health Care in Juno Beach, Florida. Derrick, a graduate of the University of Florida, has a BS degree in health science education.

Gloria Gambale of DTBE's Computer and Statistics Branch received a promotion in November 2002. In her new position Gloria will help improve the branch's information technology (IT) business processes. She will triage and assign all requests for assistance

received in the DTBE LAN Support Help Desk, develop and analyze databases to evaluate Help Desk performance, and report the findings to the Branch Chief, CSB, DTBE. In addition, she will become the technical monitor for the DTBE microcomputer support services contract, assist in the IT procurement process, and monitor the management of computer property in DTBE.

Regina Gore was selected for the position of Frankfort, Kentucky, special projects coordinator for the TB Control Program. Regina began her new assignment in late January 2003. Regina started her CDC career in 1989 as a public health associate assigned to the Fulton County Sexually Transmitted Disease (STD) control program in Atlanta, Georgia. She also held STD positions in Tampa, Florida, from June 1990 until January 1992 when she was promoted to a first-line supervisor position in Kansas City, Missouri. After resigning from CDC in the summer of 1994, she moved to Miami, Florida, where she became the program coordinator for a mobile HIV testing team until September 1998. In 1998, she relocated to Atlanta, Georgia, and became a research interviewer for Emory University, providing STD services for clients enrolled in a program called Project Prevent, which provided assistance for expectant mothers who had substance abuse problems. She was rehired by CDC in the DTBE program in January 2000 and has been on assignment in Palm Beach County, Delray Beach Health Department, TB Program since that time. Her duties in Delray Beach have included providing DOT and DOPT therapy, presenting cases in chart review with the regional consultant, and conducting contact investigations and case management.

Sherry Hussain has been selected as a Training Specialist in the Communications and Education Branch. Sherry first came to DTBE in 1981 in the Research and Evaluation Branch under Dr. Dixie Snider. Since 1998, she has served as Program Specialist in the Communications and Education Branch. In Sherry's new position, she will serve as a lead point of contact in the development and implementation of training, education, and communication materials; CEB workshops and education/training courses; and other training- and education-related activities for the division. Sherry started in her new position on March 23.

Amera Khan, MPH, has joined the Communications and Education Branch as a Health Education Specialist. Amera, who is originally from Illinois, has an undergraduate degree from the University of Illinois at Urbana-Champaign, and a masters degree in public health from the University of North Carolina at Chapel Hill. Amera has extensive experience as a Health Educator at CDC. She has worked for the National Center for Infectious Disease (NCID) in the Division of Parasitic Diseases, as well as in the Special Pathogens Branch. She has a wide range of experience in the development of educational materials for health care professionals as well as for the general public on issues related to viral and hemorrhagic fervers. In addition, Amera has designed, maintained, and evaluated Web sites and various databases.

Venkatarama (Ram) Rao Koppaka, MD, PhD, recently transferred to DTBE headquarters after a 4 1/2 year assignment in Richmond, Virginia. Ram will be the liaison between the field medical staff and headquarters in Atlanta. Ram will also have responsibility for policy

development. He will first address the issue of maintaining medical expertise for oversight of TB care and treatment. Ram graduated from the University of Florida in 1986 with a BS degree in microbiology. He earned his MD degree and a PhD degree in microbiology from the same institution in 1992. He completed an internship and residency in internal medicine at Barnes Hospital at Washington University in St. Louis, Missouri, followed by a fellowship in pulmonary and critical care medicine, also at Washington University. Ram joined FSB/DTBE in July 1998 and was assigned as Medical Director for the TB control program in Virginia. In 2000, he became Director of the Division of TB Control and TB Control Officer for the Commonwealth of Virginia, a position he held until January 21, 2003. The accomplishments of the Division under Ram's leadership included enactment of the Virginia TB Control Act of 2001, which expanded reporting requirements and strengthened the health department's ability to mandate complete treatment of all patients with TB disease. In addition, the Division led a successful effort to establish risk-based targeted tuberculin testing as the official TB screening policy for all state agencies throughout Virginia. A major reorganization, carried out between 2000 and 2002, expanded the Division staff to include full-time education, refugee health, and surveillance and epidemiology coordinators. Most recently, legislation that will expand the authority of public health nurses to use their discretion in administration of the tuberculin skin test and ordering collection and submission of specimens for AFB smear and culture was introduced in the Virginia General Assembly and is under consideration. As FSB Field Medical Officer, he has been involved in a number of special assignments for the Division of Quarantine, including the screening of Kosovar refugees at Ft. Dix, New Jersey, in 1999, the evaluation of immigrant screening in India in 2000, and the evaluation of asylees from Burma on Guam in 2001. Dr. Koppaka was the Chest Physician for the City of Richmond Department of Public Health from 1998 to 2003 and holds an appointment as Clinical Assistant Professor of Pulmonary Medicine Medical College of Virginia, where he plans to continue to serve as attending pulmonary consultant a few weeks each year. He is an officer in the US Public Health Service and holds the rank of Commander.

Lauren Lambert, Program Analyst in the Outbreak Investigations Section of the Surveillance and Epidemiology Branch, was selected for an assignment with the "Stop Transmission of Polio" (STOP) program to Ethiopia from February 2 through April 26, 2003. Lauren conducted surveillance for acute flaccid paralysis (AFP, "not to be confused with AFB," Lauren reminds us) and helped to arrange National Immunization Days in Ethiopia.

Diane Lowry, MPH, MSW joined the Prevention Effectiveness (PE) Team, Research and Evaluation Branch, DTBE, on March 10, 2003, to complete her second 6-month headquarters assignment with CDC's Public Health Prevention Service (PHPS) Program. She is working with PE Team members on the health care workers adherence study and an evaluation of targeted testing and treatment of LTBI programs. Diane obtained her graduate degrees from the University of Washington and, before joining the PHPS Program last fall, worked for 3 years with immigrant and refugee communities in Seattle.

Her first CDC headquarters assignment was with the Division of International Health, EPO, where she developed an evaluation plan for outbreak investigations conducted by Field Epidemiology Training Program participants.

Kelly Martin, Program Specialist in the Surveillance and Epidemiology Branch, has accepted a promotion to the position of Management and Program Analyst in the Division of HIV/AIDS Prevention - Surveillance and Epidemiology after having been on a temporary assignment in this position. Kelly has provided many years of outstanding service and dedication to the branch and the division. She played an important part in maintaining continuity and "institutional memory" as SEB experienced significant turnover about 3 years ago. We will miss Kelly's professional attitude, team spirit, and friendly personality, but we are proud that she has been able to achieve this goal in her career with CDC.

David Montanez, MPA, MA, was selected for the public health advisor (PHA) Texas border position with the Texas TB Program. He started the job on February 9, 2003. David comes from the National Center for Chronic Disease Prevention and Health Promotion, where he served as a program consultant in the REACH 2010 Program. He provided guidance and technical assistance to community-based coalitions in developing, implementing, and evaluating community action plans that address health disparities in communities of color. From 1993 to 1999, David served as a PHA in the National Center for Environmental Health's (NCEH) Birth Defects and Genetic Diseases Branch before it became part of the new Center. There, he advanced to the position of principal management official for the proposed Division. During his stay at NCEH, he oversaw a Texas-Mexico Border cooperative agreement with the Texas Department of Health, which promoted the prevention of neural tube defects (e.g., spina bifida) through the consumption of folic acid. From the beginning of his CDC career in 1988 to 1993, David held field assignments with the STD Program in Los Angeles and with the National Immunization Program (NIP) in Florida and Texas. He holds a bachelors degree in business administration, a masters degree in public administration, and a master of arts degree in urban and regional affairs from the University of Texas.

John Oeltmann, MPH, PhD, will join the Outbreak Investigation Section, Surveillance and Epidemiology Branch (SEB), as its new EIS officer. He will start in August and be with DTBE for 2 years. Dr. Oeltmann received both his PhD in epidemiology and his masters degree in public health in health promotion, education, and behavior from the University of South Carolina in Columbia, SC. He has had a wide range of experience in directing or participating in public health projects involving diabetes control, alcoholism, cancer prevention, and health services for American Indians, and from 1997 to 1998 he was an ASPH Fellow with the Division of Adolescent and School Health at CDC. His goal is to make a contribution "in a position where I can blend my interests in public health promotion/education and epidemiologic research, specifically surveillance."

David Patlan joined the Field Services Branch as a Public Health Advisor assigned to the Miami, Florida, TB Program on April 22, 2003.

David brings 9 years of experience in public health from his work in the Dallas, Texas, HIV/STD program. David, who is fluent in Spanish, earned a BA degree from the University of Texas at Austin.

Margaret Patterson joined the Field Services Branch as a Public Health Advisor assigned to the West Palm Beach, Florida, TB Program on April 22, 2003. Margaret has over 15 years of public health experience, working mostly in the South Carolina STD Program. In 2001 Margaret was hired by CDC and continued her work in STD, when she was assigned to the Washington, DC, STD Program. Margaret has a BS in biology from the College of Charleston, SC.

Vivian Siler has accepted a Management and Program Analyst position with FSB. Vivian will be responsible for analyzing and establishing management systems related to personnel, support needs, meetings, and guideline development. Vivian started her career with CDC in 1993 employed by the Viral & Rickettsial Disease Branch as a Call Management Operator. From 1995 to 1999, she worked with the National Prevention Information Network (NPIN) as a Senior Information Specialist within the NCHSTP Office of Communications providing support to the Information/Dissemination Section. In 1999, Vivian joined the Division of TB Elimination, Communications and Education Branch, as a Program Operations Assistant.

Elizabeth Talbot, MD, will be leaving DTBE and CDC to pursue a new opportunity in New Hampshire. She has accepted a new position as the New Hampshire Deputy State Epidemiologist with a joint appointment in the Infectious Disease (ID) Section of Dartmouth-Hitchcock Medical Center and Dartmouth Medical School. For the State, she will be responsible for infectious disease outbreak investigations and for disease prevention and control activities, and will serve as liaison between State agencies and Dartmouth-Hitchcock Medical Center on bioterrorism activities. In addition to teaching and clinical consulting for Dartmouth, she'll be able to keep her hand in international TB research, since the ID section has an established TB research field site in Tanzania, under the direction of Fordham Von Reyn. She'll be leaving DTBE on June 15 and will be starting her new position around July 1. Elizabeth began her career at CDC in July 1998 as an Epidemic Intelligence Service (EIS) officer, at which time she was assigned to the International Activity unit of DTBE. During her time as an EIS officer she made very significant contributions to DTBE research and TB program support efforts in Botswana at BOTUSA, as well as to other important projects in DTBE. Among her many activities during that period, she lead efforts to conduct the second national anti-TB drug resistance survey of Botswana as part of the WHO/IUATLD global project, and she conducted a very important case-control study looking at risk-factors for HIV among TB patients (60% of TB patients in Botswana are HIV-positive). Additionally, she evaluated the evolving epidemiology of TB among foreign-born persons in the U.S., among other domestic-oriented projects. Subsequent to EIS, she remained on staff with DTBE, accepting a position as the Associate Director for TB Research at BOTUSA. She and her family then moved to Gaborone, Botswana, in September 2000. While serving as the Associate Director at

BOTUSA, Elizabeth made tremendous contributions to the rapidly evolving field of TB/HIV. Among her many contributions was validation of the use of rapid HIV testing (Oraquick®) directly on sputum of TB patients as a means of performing HIV surveillance; evaluating risk factors for TB patient treatment interruption; determining knowledge, attitudes, and beliefs regarding antiretroviral therapy for HIV among TB patients; supporting the Botswana national isoniazid preventive therapy pilot project focused on preventing TB among HIV-positive persons; and determining that nonresponse to antibiotics predicts TB in AFB smear-negative patients. Also in that role, she managed a staff of nearly 20 persons involved in the BOTUSA TB/HIV project work, and she supervised a number of medical students on rotations at BOTUSA as well as EIS officers. Additionally, Elizabeth contributed a great deal to the anthrax investigation in 2001 involving the U.S. Embassy in Gaborone. She moved on February 14 from her role as Associate Director of TB Research at the BOTUSA Project to a 3-month assignment with WHO in Geneva, where she assisted in finalizing and consolidating the draft operational guidelines on TB, HIV, Malaria, and Gonococcal resistance monitoring into a technical document. We will miss Elizabeth very much and wish her and her family all the best with this new opportunity.

Peg Tipple, MD, transferred to Richmond, Virginia, in January 2003 to serve as Director of the Virginia TB Control Program. Peg earned her medical degree at the State University of New York (SUNY) - Downstate Medical Center in Brooklyn, New York. She trained as a pediatrician and as a fellow in infectious diseases at the Medical College of Virginia. She received additional training in pediatric infectious diseases at the University of Chicago. She was an EIS Officer in the Hospital Infections Program, and continued her work at CDC in the NCID Division of Viral and Rickettsial Diseases, followed by assignments to the Division of Quarantine and the Office of Health and Safety. She joined the Field Services Branch in July 1999 and was assigned to the District of Columbia Department of Health, serving as chief of the DC TB Control Program.

Vic Tomlinson was recently selected for a program consultant position with Field Services Branch (FSB) effective May 4, 2003. He started his public health career as a TB investigator with the Virginia Department of Health in the eastern part of Virginia in 1970-1971. Vic began his career with CDC as a public health advisor in the Sexually Transmitted Disease (STD) program in 1972 in Washington, DC, and also worked in the STD program in Baltimore (1974-75). His next two federal assignments were with DTBE in Norristown, PA (1975-77) and Boston, MA (1977). In the latter assignment, Vic was assigned to the City of Boston and also served as a liaison to the state TB program. Vic accepted a position as a project officer with the Bureau of Community Health Services in the Regional Office in Philadelphia (1977-81). This position involved working with communities to establish federally funded primary health care centers in medically underserved areas of Pennsylvania and to place health professionals in these communities through the National Health Service Corp program. Vic left federal service in 1981 and returned to the State of Virginia where he worked in the state's certificate of need program and then as a

budget analyst in local government before he returned to CDC/DTBE, in January 1990. From 1990 to 1992, he served as the program manager for a statewide tuberculosis control program while assigned to Missouri's state health department. From 1992 to 1994, Vic was assigned to the Texas Department of Health's TB control program. In his role as a Public Health Advisor, Vic supervised a few program staff directly and also worked with the division director to establish a coalition to address TB issues. For the period 1994-1996, Vic was assigned to the Louisiana Department of Health in New Orleans and served in the role of program manager. In 1996, he accepted a transfer back to Missouri and again served in the role of the program manager for TB control for most of his tenure there (1996-2003). In addition to his work with TB control, Vic was also asked to accept the dual role of managing the Immunization program in Missouri from 1998 to 2003. In terms of his TB responsibilities, Vic initiated the first TB collaborative case conferences, which are videoconferenced every 4 or 5 months across the state. Vic initiated a screening project in local jails that included implementing a signs and symptoms checklist for TB. Vic also played an active role in Missouri's TB Awareness Fortnight/World TB Day activities each year by planning and participating in TB seminars around the state and conducting interviews with the media to draw attention to TB. Other activities included working with the department's bioterrorism unit to coordinate smallpox vaccinations for the Division of Environmental Health and Communicable Disease Prevention and establishing an advisory committee for communicable diseases, which holds its first meeting on May 13, 2003.

Maureen Wilce, MS, has transferred within DTBE, accepting a health scientist position with the Field Services Branch (FSB). Maureen will be responsible for program evaluation activities. She will provide technical assistance and assist in the development of policy and procedures on how to implement and evaluate TB elimination programs. Maureen brings to the position 14 years of experience in evaluation and health and human services research. She is a skilled evaluator with experience in survey instrument design, data collection and analysis, site visiting, and database manipulation. For the last 4 years Maureen has worked in the Research and Evaluation Branch at DTBE leading/coleading projects evaluating case management practices in TB control programs, developing self-evaluation tools designed to improve their contact investigation processes, assessing policies related to contact investigations, assessing health care worker adherence to TB screening recommendations, and examining the contributions of social science to TB control. In addition, she has worked to develop two training courses, based on the 6 Steps in the Framework for Program Evaluation to help prepare TB program staff to conduct evaluations. Most recently, she is coleading a major effort to help expand evaluation capacity for TB program staff - a role that will expand in her new position. Prior to joining DTBE, Maureen worked as an evaluator for a private consulting firm and for the Office of the Inspector General, HHS. She is active in the Atlanta-area Evaluation Association and the American Evaluation Association.

Cheryl Williams, MPH, joined the DTBE Field Services Branch (FSB) as a Public Health Advisor assigned to the New York City TB

program on April 7, 2003. Cheryl will be working out of the Brooklyn office with network managers implementing latent TB infection (LTBI) activities. Her duties will consist of collaborating with community leaders, area service providers, and other key persons to provide education, outreach, treatment, follow-up, and referrals of persons needing services offered by the program. Cheryl holds a bachelor of arts degree in biology from the University of Virginia, and an MPH degree in epidemiology and international health from the Rollins School of Public Health at Emory University. With CDC since 1997, Cheryl has worked as an epidemiologist with the National Center for Infectious Diseases, Division of Viral Hepatitis (DVH), Epidemiology Branch. While at DVH, Cheryl conducted studies of the sexual transmission of hepatitis C virus and the role of foodborne transmission of hepatitis A virus, supported a variety of epidemiologic investigations and studies of viral hepatitis, and managed the national Viral Hepatitis Surveillance Project. Since 1999, she has served as project manager for the Sentinel Counties Acute Viral Hepatitis Surveillance Study, which is conducted in six county health departments across the United States and provides data used to estimate national incidence of acute viral hepatitis, to monitor trends in incidence and risk factors, and to form recommendations for prevention and control of viral hepatitis. Cheryl has provided oversight and technical assistance to the counties and coordinated study activities, including case and contact investigation, data collection and management, epidemiologic analysis, and development of survey instruments and annual data summary reports. Cheryl is a founding member of Forging New Tomorrows, an international health and environmental nongovernmental organization (NGO) with health, training, and development projects in several African countries. Prior to earning her MPH degree, Cheryl worked for 10 years as an environmental health scientist and consultant in the private sector, where she investigated Superfund and RCRA hazardous waste sites, conducted baseline public health risk assessments for waste sites, prepared toxicological profiles of hazardous chemicals, conducted lead and asbestos contamination assessments and abatement oversight, and developed guidelines and remediation plans for toxic substances in environmental media.

CALENDAR OF EVENTS

May 16-21, 2003
ATS 2003-99th International Conference
Seattle, Washington
American Thoracic Society
Web site for more information:
http://www.thoracic.org/ic/ic2003/default.asp.

June 10-11, 2003
National TB Controllers Workshop
Washington, DC
National TB Controllers Association
Web site for more information:
http://sec.cdcmeetings.com/tb03/index.asp

July 15-17, 2003
TB Intensive course
San Francisco, California
Francis J. Curry National Tuberculosis Center
Contact: Training Coordinator
Tel: (415) 502-4600; fax: (415) 502-4620
E-mail: tbcenter@nationaltbcenter.edu
Web site for more information:
www.nationaltbcenter.edu

August 13-15, 2002
TB Education and Training Network Third Annual Conference
Atlanta, Georgia
Contact: Betsy Carter
Tel: (404) 639-8135
Fax: (404) 639-8960
E-mail: tbetn@cdc.gov
Web site for more information:
http://www.cdc.gov/nchstp/tb/tbetn

September 10, 2003
TB Case Management and Contact Investigation
Anaheim, California
Francis J. Curry National Tuberculosis Center
Contact: Training Coordinator
Tel: (415) 502-4600; fax: (415) 502-4620
E-mail: tbcenter@nationaltbcenter.edu
Web site for more information:
www.nationaltbcenter.edu

September 15-17, 2003
Effective TB Interviewing and Contact Investigation
Newark, New Jersey
NJMS National Tuberculosis Center
Contact: Anita Khilall
Tel: (973) 972-9102
Web site for more information:
www.umdnj.edu/ntbcweb/et_frame.html

October 9 - 12, 2003
41st Meeting of IDSA
San Diego, California
Infectious Diseases Society of America
Web site for more further information:
http://www.idsociety.org/

October 15, 2003
Medical Management of TB in the Person Living with HIV
Location to be announced
NJMS National Tuberculosis Center
Contact: Rajita Bhavaraju
Tel: (973) 972-4811
Web site for more information:
www.umdnj.edu/ntbcweb/et_frame.html

October 29 - November 2, 2003
34th IUATLD World Conference on Lung Health
Paris, FRANCE
Web site for more information: www.iuatld.org
Note: Please see the following letter about the IUATLD/CDC latebreaker session.

November 4-7, 2003
TB Case Management and Contact Investigation
San Francisco, California
Francis J. Curry National Tuberculosis Center
Contact: Training Coordinator
Tel: (415) 502-4600; fax: (415) 502-4620
E-mail: tbcenter@nationaltbcenter.edu
Web site for more information:
www.nationaltbcenter.edu

November 10-11, 2003
First-Line Supervisor's Course
Newark, New Jersey
NJMS National Tuberculosis Center
Contact: Lauren Moschetta
Tel: (973) 972-1261
Web site for more information:
www.umdnj.edu/ntbcweb/et_frame.html

November 15-19, 2003
APHA 131st Annual Meeting
San Francisco, California
American Public Health Association
Theme: Behavior, Lifestyle, and Social Determinants of Health
Web site for more information:
www.apha.org/meetings

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control
and Prevention (CDC)

December 11, 2002

The 34th IUATLD World Conference on Lung Health and the Centers for Disease Control and Prevention are pleased to announce co-sponsorship of a LATE-BREAKER session related to tuberculosis (TB).

All aspects of TB control, elimination, and research (including basic and clinical science, epidemiology, social, behavioral, psychosocial, educational aspects, health care delivery and public health) are welcomed for presentation during the late-breaker session. In keeping with the spirit of a late-breaker session we ask that only new, innovative, and significant findings that have occurred as of May 1, 2003, or for which information has just become available, be submitted for late-breaker presentations in the form of a 1-page electronic file.

The late-breaker session will consist of 8 oral presentations of 10 minutes each, followed by 5 minutes of questions. The presentations will be selected from abstracts submitted to the late-breaker co-chairs by July 18, 2003. Persons submitting abstracts will be notified of acceptance or rejection of their abstract by August 4, 2003.

A small number of travel grants are available for presenters of accepted abstracts who require funding to attend the conference. **If you intend to request support, an indication of your desire and rationale for consideration for a travel grant must be submitted with the abstract.** The reviewing committee will be blinded to the request for travel funds.

Submissions should include a cover letter with i) a statement that the work has not been previously submitted for consideration to the general portion of the IUATLD meeting, ii) the date by which the work/analysis was mostly complete, iii) a request and rationale for travel support if so desired, and iv) the address, phone and FAX number, and e-mail address where the submitter may be contacted the week of July 21, 2003.

Dr. Elsa Villarino and Dr. Michael Iademarco
TB Late-Breaker Session
Mailstop E-10
Division of Tuberculosis Elimination
Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, Georgia 30333 USA
Tel: (404) 639-8123
Fax: (404) 639-8961
E-mail: Evillarino@cdc.gov and Miademarco@cdc.gov

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Registration Form

Name _____
Title _____
Organization _____
Address _____
_____

_____ _____ _____
Business telephone number Fax number E-mail address

We are offering break-out sessions at this year's conference. To help us plan for space, please identify your preferences from the following tentative break-out sessions.

Needs Assessments (check *one*):
9 Focus Groups
9 Surveys
9 Interviewing
9 Nominal Group Process (informal process for prioritizing needs)

Intensive Development of Materials (check *two*):
9 Art of Video Production
9 Web design
9 Print Materials (layout, printing services)
9 PowerPoint
9 Presentation skills

Please check the appropriate box if you plan to apply for continuing education credits.
9 CMEs 9 CEUs
9 CNEs 9 CHES

Are you a member of TB ETN? 9 Yes 9 No

Space is limited. Registration preference will be given to TB ETN members. To join TB ETN, please send an e-mail to tbetn@cdc.gov and request a registration form.

Please return your conference registration form no later than July 25, 2003 to:
Teresa Goss
Centers for Disease Control and Prevention
Division of TB Elimination
1600 Clifton Road, NE, Mailstop E-10
Atlanta, GA 30333
Fax: (404) 639-8960
E-mail: tbetn@cdc.gov