TBHIV

JOINT NEWSLETTER OF THE TB/HIV AND MDR-TB WORKING GROUPS OF THE STOP TB PARTNERSHIP
UPDATE JUNE 2009

MDR TB

INSIDE:

2 RIFABUTIN NOW ON WHO EML

2 INFECTION CONTROL URGENTLY NEEDED IN CONGREGATE SETTINGS AND COMMUNITIES

3 TB/HIV AT HARM REDUCTION CONFERENCE

3 RAISING AWARENESS OF MDR-TB IN INDIA

3 JOINTLY AND EFFECTIVELY MEASURING WHAT WE DO

4 FROM MEKONG TO BALI: SCALING UP TB/HIV COLLABORATIVE ACTIVITIES IN ASIA PACIFIC

4 THE FORUM: INDIA FORGING AHEAD WITH SCALE UP OF COLLABORATIVE TB/HIV ACTIVITIES

5 UPCOMING EVENTS

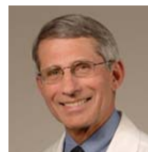
Stop TB Partnership

World Health Organization

The Secretariats of the TB/HIV and MDR-TB Working Groups are provided by WHO Stop TB Department

BREACHING THE FRONTIER - PRIORITIZING HIV/TB RESEARCH

Francoise Barre-Sinoussi, 2008 Nobel Laureate


Anthony Fauci, Director USA National Institute of Allergy and Infectious Diseases

Mark Harrington, Executive Director, Treatment Action Group

The TB/HIV Working Group of the Stop TB Partnership has been the prime driving force calling for HIV/TB research to be made a priority in HIV and TB research. In November 2008, the Core Group of the Working Group again acknowledged the unmet need of HIV/TB research and called for extraordinary actions to be carried out by funding agencies, researchers and national governments and called for the revision of the priority research agenda for HIV/TB.

In light of this, WHO and the TB/HIV Working Group in collaboration with the International AIDS Society, the Consortium to Respond Effectively to the AIDS/TB Epidemic (CREATE), Treatment Action Group and the Desmond Tutu HIV Center are organizing a highly visible meeting on HIV/TB research issues in conjunction with the upcoming 5th IAS Conference on HIV pathogenesis, treatment and prevention. The meeting will be held on July 18 (12:00-18:30) and July 19 (08:30-13:30), 2009 in Cape Town, South Africa.

Confirmed Plenary speakers include Francoise Barre-Sinoussi, 2008 Nobel Laureate, Anthony S. Fauci, Director of the USA National Institute of Allergy and Infectious Diseases, and Mark Harrington, international AIDS activist and Executive Director of Treatment Action Group.

Deadline for registration: registration to attend the meeting should be submitted no later than June 15, 2009 by emailing Ms Rosalie Edma at: edmar@who.int mention "HIV/TB research meeting" in the subject line.

COUNTRIES COMMIT TO ACHIEVE UNIVERSAL ACCESS TO DIAGNOSIS AND TREATMENT OF MDR-TB BY 2015

Health ministers, heads of agencies, WHO Director General Margaret Chan, President Sampaio and Bill Gates attended the ministerial meeting

The 62nd meeting of the World Health Assembly endorsed the resolution sponsored by the Chinese delegation on prevention and control of multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB). This showed the importance of MDR and XDR-TB to countries and the intensive debates during the WHA further pointed to the need to respond not only through national TB programs but through health systems as highlighted at the ministerial meeting on MDR and XDR-TB held from 1-3 April, in Beijing, China.

The ministerial meeting which was attended by Health Ministers from countries with the greatest burden of drug-resistant tuberculosis pledged to accelerate efforts to fight the disease at a recent and important. Along with ministers, technical experts and others, WHO Director-General, Dr Margaret Chan, and Co-Chair of the Bill & Melinda Gates Foundation, Mr Bill Gates, and the Vice Premier of the People's Republic of China, Mr Li Keqiang also participated.

The governments at the meeting endorsed a Call for Action, which was supported by senior representatives from international health and aid agencies, and non-governmental organizations. Particularly relevant was the acknowledgement by all participating governments that full control and care of MDR and XDR-TB is an issue that cuts across the health system and beyond and therefore cannot be addressed by national TB programs alone.

Countries commit now to move towards universal access to MDR-TB prevention, treatment and care that ensures removal of financial barriers to high quality care. The Call for Action also calls for governments to address human resource issues, develop adequate laboratory networks with modern diagnostics for care and surveillance, and using technologies that can be extended to other priority conditions.

Another area of importance which needs to be addressed is the rational use of all drugs of public health importance and, in particular, limiting the use of second-line, last-resort drugs for MDR-TB to accredited private providers. All drugs including all first- and second-line anti-TB drugs must be quality assured by relevant authorities. This issue was intensely debated during the discussions on the resolution.

The need to strengthen TB/HIV collaboration, analyze and understand the extent of drug resistance among people living HIV, especially in sub-Saharan Africa, was emphasized. Participants agreed that the HIV community must take greater responsibility for preventing, diagnosing and treating TB and MDR and XDR-TB among people living with HIV.

Continued on Page 2 »

Continued from Page 1 »

The endorsement of the Call for Action signalled a major step forward in coordinated planning for MDR and XDR-TB prevention, treatment and care and a commitment to achieve universal access to diagnosis and treatment for MDR-TB patients by 2015. The WHA resolution compares well with the Beijing Call for Action and adds further language on the issue of research and drug accessibility. Although, human rights and the role of community in monitoring and evaluation was not included in the WHA resolution it was included in the Call for Action which 32 countries at the ministerial meeting supported.

In Beijing, the 27 high MDR-TB countries all committed to present national MDR-TB scale-up plans at the 7th meeting of the MDR-TB Working Group in Geneva, Switzerland which will be held on October 12, 2009. This meeting will be followed by the 1st Green Light Committee (GLC) Forum to be held from October 13-14, 2009, where countries with GLC approved projects will share best practice models for implementation.

For the meeting report and further information please see: www.who.int/tb_beijingmeeting/en

RIFABUTIN NOW ON WHO ESSENTIAL MEDICINES LIST FOR PEOPLE LIVING WITH HIV/TB CO-INFECTION

The WHO Antiretroviral Therapy for HIV Infection in Adults and Adolescents Guidelines (2006 revision) recommends a combination of two nucleoside reverse transcriptase inhibitors (NRTI) and one non-nucleoside reverse transcriptase inhibitor (NNRTI) as the preferred first-line options in developing countries and (ritonavir-boosted) protease inhibitor (PI)-based therapy as the preferred second-line therapy in patients no longer receiving benefit from their first-line HIV therapy. Although 70% of people living with HIV eligible for ART do not receive it, scale up of ART is rapidly expanding at a rate of around 80,000 per month, with an estimated 3.0 million people receiving ART at the end of 2007. Rapid scale-up also means that some patients will fail first-line ART and need (ritonavir-boosted) PI based therapy.

Currently, in low income settings with recently established ART programs, the annual migration from first to second-line therapy is ~ 2%, and in countries with more mature ART programs (i.e. Brazil, Mexico, Thailand), this rate is around 4% per year. People on ART have a greatly diminished risk of TB but that risk does not go back to baseline and as the number of people using second-line treatment in high TB and HIV prevalence settings increases, there will likely be hundreds of thousands of people needing treatment for both HIV and TB.

Proper dosing and correct usage of anti-TB drugs and ART is essential to prevent failure of therapy and rise of multi-drug resistant TB strains and HIV resistance. Problematic drug-interactions, between rifampicin and PIs, leading to sub-therapeutic concentrations of PIs mediated by CYP3A4, complicates the concomitant delivery of these essential medicines which form the backbone of successful TB and HIV treatment respectively, prohibiting large scale public-health delivery of these therapies in combination. In contrast, rifabutin has little effect on PI serum concentrations allowing concomitant use of rifabutin and PIs in a standardized programmatic approach.

This is why it was essential to get rifabutin on the WHO essential medicines list (EML). Although there is limited experience with rifabutin in developing country settings, WHO believes that listing rifabutin on the EML, as a first step towards expression of interest and prequalification would likely serve to increase the availability of rifabutin for specific uses at affordable cost in resource-limited settings.

For more information regarding the final decision of the EML committee please see: www.who.int/selection_medicines/committees/expert/17/en/index.html

For questions contact:
Reuben Granich at: granichr@who.int

Infection control urgently needed in congregate settings and communities

The soon to be released WHO policy on TB infection control is an evidence-based document for the implementation of sound tuberculosis (TB) infection control in health care facilities, congregate settings and households by all stakeholders. TB infection control requires and complements implementation of core activities in TB control, HIV control and health systems strengthening. It should be part of national infection prevention and control policies. The following outlines those measures that need to be implemented at various levels in order to work to prevent further TB transmission.

Set of measures for national and sub-national TB infection control

1. Identify and strengthen a coordinating body, and develop a comprehensive budgeted plan that includes human resources requirements for implementation of TB infection control at all levels.
2. Ensure that health facility design, construction, renovation, and use are appropriate.
3. Conduct surveillance of TB disease among health workers and assessment at all levels of the health system and congregate settings.
4. Address advocacy, communication and social mobilization (ACSM), including engagement of civil society.
5. Conduct monitoring and evaluation of the set of TB infection control measures.
6. Enable and conduct operational research.

Set of measures for facility-level TB infection control

Facility-level measures

7. Implement the set of facility-level managerial activities:
   - 7a) Identify and strengthen a coordinating body, and develop a facility plan (including human resources, and policies and procedures to ensure proper implementation of the controls listed below) for implementation.
   - 7b) Rethink the use of available spaces and consider renovation of existing or construction to optimise implementation of controls.
   - 7c) Conduct on-site surveillance of TB disease among health workers and assessment of facility.
   - 7d) Address advocacy, communication and social mobilization (ACSM) – for health workers, patients and visitors.
   - 7e) Conduct monitoring and evaluation of the set of TB infection control measures.
   - 7f) Participate in research efforts.

Administrative controls

8. Promptly identify people with TB symptoms (triage), separate infectious cases, control the spread of pathogens (cough etiquette) and minimize time in health-care facilities.
9. Provide a package of prevention and care for health workers, including HIV prevention, antiretroviral therapy and isoniazid preventive therapy for HIV-positive health workers.

Environmental controls

10. Use ventilation systems.
11. Use ultraviolet germicidal irradiation (UVGI) fixtures.

Personal protective equipment

12. Use particulate respirators.

Making integrated TB and HIV services available to Drug users as part of the Harm Reduction Package

The 20th international conference on harm reduction took place in Bangkok from April 20-23, 2009, attracting some 1000 delegates from 80 countries. WHO organized a session on Collaborative TB and HIV services for Drug users where the WHO, UNODC and UNAIDS joint policy guide on collaborative HIV and TB services for injecting and other drug users was presented. WHO also organized a TB skills building workshop to share country experiences. Participants learned of the challenges such as symptom screening for TB in drug users, and the difficulties of continuing TB treatment services when clients are placed in jail and how these were overcome.

Organized by the International Harm Reduction Association (IHRA), the conference's theme was on human rights, underscoring the necessity of injecting drug users' universal access to the comprehensive harm reduction package. This includes clean needles and syringes, substitution therapy, condoms, HIV testing and counselling and provision of TB treatment and prevention services. Laws criminalizing the possession of injecting equipment or substitution therapy are major barriers in responding to TB and HIV treatment of drug users, as the fear of criminal measures and prosecution force many drug users underground.

Drug users account for 10% of the HIV epidemic globally and up to 30% outside sub-Saharan Africa. Drug users even without HIV have high rates of TB, and around 20% of them have HIV globally. TB/HIV morbidity and mortality in drug users is made worse by poor treatment access, lower tuberculosis treatment completion rates, and exposure to prison settings. Ensuring harm reduction measures in and out of prison and integrating these with TB and HIV services is critical to the health of drug users and to the fight against the TB and HIV epidemic.

This is the first time that TB has been featured at a major session at the IHRA conference, and it is envisaged to be the beginning of increased TB/HIV advocacy and training activities linked to harm reduction in the next period.

Read the WHO policy on drug users and TB/HIV:
http://whqlibdoc.who.int/publications/2008/9789241596930_eng.pdf

RAISING AWARENESS OF MDR-TB IN INDIA

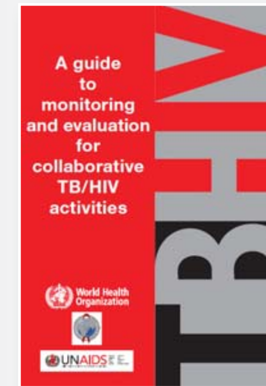
Varshaben Chauhan taking her medicines at DOTS centre at Ahmedabad, Gujarat, managed by an organization of self-employed women

The Lilly MDR-TB Partnership sought to raise awareness of MDR-TB through a Media Study Tour to India in March 2009. Journalists from Germany, Poland, Hungary, Belgium, The Czech Republic, Slovakia, Switzerland, and the Netherlands participated in this educational visit. The tour brought them to one of the largest hospitals in Asia and they had the opportunity to learn more about tuberculosis by interacting with doctors, nurses and patients.

Journalists also visited a DOTS centre supported by the Partnership and met with patients who had completed and patients who were on treatment, as well as support groups, (i.e. women volunteers who work as DOTS Providers, increase awareness and also mobilise housewives in the community). Participants were able to visit a school where awareness programs for children and painting competitions are organized to increase their knowledge about the disease and take home messages on TB and MDR TB.

The Media Study Tour also coincided with the inauguration of the Lilly MDR-TB Photo Essay Exhibition by the Minister of Health, Delhi State and was accompanied by an information kiosk on TB, which answers the queries of local people and distributes leaflets and other IEC materials. The media tour generated many articles on TB in the following weeks.

Contribution provided by Tristan Piguet
Project Manager, Lilly



Revised TB/HIV Monitoring & Evaluation Guide

Jointly and effectively measuring what we do

Indicators for monitoring and evaluating the implementation of collaborative TB/HIV activities were originally developed by WHO in 2004 and are being implemented by AIDS and TB control programs. The implementation of these indicators has been impeded by the lack of prior experience with TB&HIV indicators, the need for sound collaboration between HIV and TB program stakeholders at all levels, and the dearth of sound technical expertise and resources. In addition, the increasing number of TB and HIV stakeholders working on TB/HIV, particularly in HIV prevalent countries who monitor their activities with systems that do not incorporate these indicators has posed an additional challenge. There is an urgent need to ensure alignment and standardization of indicators used for national monitoring and evaluation systems, and among global TB and HIV stakeholders to avoid duplication of efforts and reports. Harmonisation allows countries to simplify and streamline their reporting requirements nationally, internationally to WHO and UNAIDS, and to donors such as PEPFAR and the Global Fund. Indicator harmonization also allows comparison of performance data and monitoring of trends, locally and globally. The lessons learned and the experiences over the years since the first publication of the TB/HIV indicators have to be drawn and used to update the indicators and harmonize the efforts.

There has been increasing awareness about the importance of addressing these challenges through an inclusive and broad based approach. This led to the initiation of the harmonisation process of TB/HIV indictors among the WHO Stop TB and HIV Departments, UNAIDS, PEPFAR and the Global Fund. As a result the core TB/HIV indicators were agreed among these different stakeholders. The Global Fund also adopted these indicators into the revision of their Monitoring and Evaluation toolkit.

A global consultation meeting was conducted in Geneva in September 2009, to revise the TB/HIV monitoring guidelines incorporating the harmonised indicators. Extensive consultation among HIV and TB stakeholders including national program managers, implementers and policy makers was conducted to finalise the guidelines. The changes in the revised guidelines include a reduction in the indicators from 20 to 13 modified indicators, including two new ones: the first (B.3.2) on the monitoring of TB disease among health-care workers and the second (C.1.2.2) on the detection of HIV-positive TB patients, as a percentage of the estimated HIV positive TB cases in a country.

It is now essential that work at the country level begins immediately in order to adapt current M&E systems and tools for HIV/TB. This consensus on what should be measured is the first step to streamline reporting and recording at country level for national, international, PEPFAR and Global Fund reporting purposes.

The guide to monitoring and evaluation for collaborative TB/HIV activities is available at:
www.who.int/tb/publications/2009/en/index.html

FROM MEKONG TO BALI:

SCALING UP TB/HIV COLLABORATIVE ACTIVITIES IN ASIA PACIFIC

Although sub-Saharan Africa carries the brunt of the global TB/HIV burden, evidence shows that mortality rates are higher in people living with HIV in Asia than sub-Saharan Africa. HIV-positive TB patients in the Asia Pacific region are generally more advanced in their HIV disease than what is observed in other regions and about 30-50% die during the course of TB treatment when they do not receive adequate HIV care. Although HIV testing is recommended for all TB patients, its uptake in the region is very low. Preliminary data showed that in 2007, 1.8% and 5.8% of notified TB patients were tested for HIV in WHO SEARO and WPRO regions respectively. Of those patients tested for HIV in the TB clinics in both regions 18% of them were positive. The Asia region is characterized with an increasing HIV epidemic and constitutes more than half of the global burden of TB.

As a result of this evidence, a two day experience sharing and planning meeting for Asia Pacific countries will be held to accelerate the implementation of collaborative TB/HIV activities. The meeting will be held in conjunction with the International Conference on AIDS in the Asia Pacific (ICAAP) and will be held on August 8-9, 2009 in Bali, Indonesia. This meeting builds on a previous TB/HIV meeting for the Mekong Sub-region, held in Ho Chi Minh City, Vietnam October 10-14, 2004. The Bali meeting will help countries to ensure the coherent inclusion of key activities including relevant policy and program changes into national strategic and operational plans.

Participants include national TB and AIDS program managers, funders, technical agencies, civil society and other key stakeholders. They will come together to share best practices and experiences in implementing collaborative TB/HIV activities in the region. The engagement of key national stakeholders, including national TB and HIV control programs and other partners is essential to ensure the exchange of these experiences and best practices and the inclusion of TB/HIV into National TB and HIV Strategic and other operational plans, and accelerate their implementation.

INDIA FORGING AHEAD WITH SCALE UP OF COLLABORATIVE TB/HIV ACTIVITIES

NATIONWIDE COVERAGE WITH AN INTENSIFIED PACKAGE OF SERVICES PLANNED FOR 2012

A TB clinic in Una province, India

The fourth Joint Monitoring Mission of the Revised National TB Control Program of India was held from May 15-28, 2009. International and national technical experts travelled around the country - from rural to urban areas, and from hospitals to health facilities to review progress in the implementation of India's Revised National Tuberculosis Control Program (RNTCP) and offer guidance on the design, implementation and sustainability of the Program, and its place within the Government's overall health plans. The Mission visited five randomly selected states and 16 districts, and reviewed the implementation of all components of the Stop TB Strategy.

About 5% of TB patients in India are estimated to have HIV co-infection, though the level varies greatly across states and districts. India has developed a National Framework for Joint TB/HIV Collaborative Activities in line with the WHO policy on collaborative TB/HIV activities that defined the package of services for high and low HIV prevalence settings. The Framework has leveraged nationwide implementation of joint TB/HIV collaborative activities in all States. Nine high HIV prevalence States (out of the 35 States and Union Territories in India) implement the intensified TB/HIV package of services which includes routine HIV counseling and testing of TB patients, provision of co-trimoxazole preventive therapy and ART, and intensified TB case finding at HIV services centers (integrated counselling and testing centers, ART centres and Care and Support centers), training of program officials and field staff and expanded recording and reporting. An additional two states recently initiated implementation of the Intensified TB/HIV Package. The remaining states currently implement a basic package of TB/HIV collaborative activities.

Between 2006 and 2008, the number of TB patients tested for HIV increased two fold and the number of people living with HIV referred for TB diagnosis - three fold. Six ART centers are now planning to pilot isoniazid preventive treatment (IPT) implementation and nationwide coverage of the Intensified TB/HIV Package is planned for implementation by 2012.

TB/HIV was identified as a priority area by the National AIDS Control Organization (NACO) and the Central TB Division (CTD), and in accordance with the recommendations of the 2006 Joint Monitoring Mission a national TB/HIV Technical Working Group was established to promote better collaboration and planning for TB/HIV activities. National performance indicators and targets for TB/HIV collaborative activities were developed and a fulltime TB/HIV focal point is in place at both NACO and the CTD.

HIV counseling & testing offered

Expansion of HIV testing services has been rapid and by January 2009, there were more than 5000 Integrated Counseling and Testing Centers and 197 ART Centers nationwide. In HIV prevalent states, the number of HIV testing centers are nearly comparable to the number of Designated Microscopy Centers (TB diagnosis units), and they are usually co-located in the same health facility. Very high level acceptance of HIV testing among those TB patients who reached integrated counseling and testing centers was observed. For example, in facilities visited in Tamil Nadu State, HIV test acceptance among new TB patients ranged between 80-100% during the first quarter of 2009. Monitoring and evaluation of the implementation of joint TB/HIV collaborative activities is in place and TB registers have been revised to include recording of HIV status and treatment information.

Between 2005-2007, there was a five-fold increase in the number of TB suspects referred from VCT centers (23,950 to 132,146 people referred). This resulted in a two-fold increase in the number of VCT clients diagnosed with TB in 2007.

However, there is still work to be done. Linkages with treatment services once TB patients are found to be HIV-positive, particularly in low HIV prevalence districts is sub-optimal. ART services are still centralized at the district hospital level and absent in many low HIV districts, though the country has a plan to expand ART centers into at least all HIV prevalence districts by 2010. Revised TB registers are being utilized in most states. However, clear standardized systems for the transfer of HIV treatment information between ART and TB treatment centers needs to be implemented. Weaknesses in the quality of HIV testing were observed in some settings and need to be addressed as a matter of priority. TB infection control was also another area which needs priority intervention as poor ventilation and lack of triage was observed in HIV testing and care centers.

Overall the strides made to implement TB/HIV collaborative activities across India have been vast and with a goal of nationwide expansion by 2012, should be seen as a leader in the region.

Upcoming events

JUNE - NOVEMBER 2009

JUNE

HIV/AIDS IMPLEMENTERS' MEETING

When: **10-15**
Where: **Windhoek, Namibia**
More Information:
www.hivimplementers.org/default.asp

GREEN LIGHT COMMITTEE MEETING

When: **10-12**
Where: **Riga, Latvia**
More information: Martins Pavelsons
pavelsonsm@who.int

JULY

INTERNATIONAL MEETING ON HIV/TB RESEARCH AND NETWORKING

When: **18-19**
Where: **Cape Town, South Africa**
More information: **tbhiv@who.int**

5TH INTERNATIONAL CONFERENCE ON HIV PATHOGENESIS, TREATMENT AND PREVENTION

When: **19-22**
Where: **Cape Town, South Africa**
More Information: **www.ias2009.org**

AUGUST

FROM MEKONG TO BALI: ACCELERATING TB/HIV COLLABORATIVE ACTIVITIES SCALE UP IN ASIA PACIFIC

When: **8-9**
Where: **Bali, Indonesia**
More Information: **tbhiv@who.int**

9TH INTERNATIONAL CONGRESS ON AIDS IN ASIA AND THE PACIFIC (ICAAP 9)

When: **9-13**
Where: **Bali, Indonesia**
More Information:
www.icaap9.org/index.php?id_pages=1

GREEN LIGHT COMMITTEE MEETING

When: **19-21**
Where: **Boston, USA**
More Information: Martins Pavelsons
pavelsonsm@who.int

OCTOBER

CREATE ANNUAL MEETING

When: **12-15**
Where: **Cape Town, South Africa**
More information: **www.tbhiv-create.org**

MDR-TB WORKING GROUP MEETING

WHEN: **12**
WHERE: **Geneva, Switzerland**
More Information: Ernesto Jaramillo
jaramilloe@who.int

GREEN LIGHT COMMITTEE MEETING

When: **12-14**
Where: **Geneva, Switzerland**
More Information: Martins Pavelsons
pavelsonsm@who.int

NOVEMBER

TB AND NUTRITION MEETING

When: **12-13**
Where: **Geneva, Switzerland**
More information: Knut Lonnroth
Lonnrothk@who.int

The meeting will bring together experts to discuss under-nutrition as a risk factor for TB.