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## COMMITMENT TO SCALING UP TB/HIV COLLABORATIVE ACTIVITIES MADE IN THE ASIA PACIFIC REGION

Catalyzing the implementation of collaborative HIV/TB activities in the Asia and Pacific regions is a key priority. This region has more than half the global burden of TB and 12% of the global burden of HIV. "From Mekong to Bali: scale up of HIV/TB collaborative activities in Asia Pacific," a meeting organized by the World Health Organization (WHO) in collaboration with the TB/HIV Working Group of the Stop TB Partnership brought together 127 people from 18 countries to share experiences and best practices to accelerate implementation of nation-wide scale up of collaborative HIV/TB activities.

Scale up of implementation of activities was discussed in detail including how to overcome barriers to nation wide scale up of collaborative activities, issues around advocacy, social mobilization, and supporting community efforts to raise awareness. Monitoring and evaluation and accurate data was a huge issue and all TB and HIV managers at the meeting identified the need to improve reporting and recording and HIV/TB cohort data analysis as an urgent priority. Other key areas of discussion and planning included resource mobilization, meeting the needs of the most at risk, developing a multisectoral response, and a rights based approach for TB.

Presentations showed that scale up of HIV testing and provision of ART & CPT for TB patients is possible and is



Director General, MoH Indonesia, WR WHO Indonesia, Javid Syed, activist

highly needed as only 20% of people living with HIV know their HIV status. Lack of access to HIV testing and counseling is the biggest barrier to access to comprehensive HIV prevention care and treatment.

Programmatic data from Indonesia show that most HIV positive TB patients are young males, who do not know their HIV status when diagnosed for TB. Although by 2007, overall scale up of HIV testing among TB patients in Asia Pacific was still low there has been a multifold year on year increase. Across the region, in 2004, only 0.3% of all TB patients were tested for HIV but this rose to 6% by 2007. In 2008, Cambodia tested 57% and Thailand 79% of all TB patients. India was testing over 126,000 TB patients in 2008, a four fold increase in 4 years.

### THE THREE IS: LONG WAY TO GO

Intensified TB case finding was reported in most countries as being available to people living with HIV though only 16 countries and territories reported data on this in 2007.

Data from Papua New Guinea for example, showed 67% of newly detected PLHIV screened for TB in 2008. However, in most countries the monitoring and evaluation of intensified case finding has not been incorporated into the HIV reporting and recording systems, and thus the data presented to WHO underreports country activities.

Isoniazid preventive therapy (IPT) is the "I" that is not being implemented as part of a national package of HIV/TB activities. Despite the evidence of the effectiveness of IPT, countries are still conducting pilot projects and no country in the region reported IPT scale-up at a national level by the end of 2008. In many countries prevailing concerns by medical personnel and other experts include the difficulty of ruling out active TB in HIV positive patients, the threat of magnifying INH resistance, the difficulty and cost of managing adherence to IPT, and the longer term efficacy of IPT. These concerns are being used as arguments to not implement IPT.

Of the Three Is, infection control, like IPT is not being implemented as a general practice in Asia and the Pacific. Much has been done in the region for infection control for blood-borne (HIV), respiratory infections (SARS and flu preparedness), however, there is still lack of a coordinated and integrated approach to TB infection control. Integrated policies and guidelines for all levels of health services now need to be developed.

The meeting concluded with a sense of urgency that TB/HIV collaborative activities and in particular the Three "I"s must be rapidly scaled up as soon as possible.

Read the full meeting report on the TB/HIV website soon.

# TB POINT OF CARE DIAGNOSTIC MOST IMPORTANT UNMET NEED IN TB RESEARCH SAY EXPERTS AT HIV/TB RESEARCH PRIORITIES MEETING

The World Health Organization and the TB/HIV Working Group of the Stop TB Partnership in collaboration with the Consortium to Respond Effectively to the AIDS/TB Epidemic (CREATE), International AIDS Society (IAS), Treatment Action Group and the Desmond Tutu HIV Centre of the University of Cape Town organized a highly visible meeting on research in conjunction with the 5th IAS Conference on HIV Pathogenesis, Treatment and Prevention in Cape Town, South Africa on July 18-19, 2009.



Dr Anthony Fauci, Director of NIAID presenting at the meeting in Cape Town, South Africa

The meeting attended by 250 HIV researchers, activists and representatives from funding agencies, focused on critical TB/HIV issues in the areas of TB prevention, diagnosis and

treatment, childhood TB and drug resistant TB. New and previously unreported data were shared, ongoing research efforts were highlighted and research priorities were defined. The meeting, which is part of a series of collaborative efforts between WHO, IAS and other partners to stimulate HIV/TB research, was also an opportunity to establish networking among researchers and policy makers.

The meeting highlighted the huge unmet research needs to deliver quality and integrated TB and HIV prevention, diagnosis, care and treatment services and save the unnecessary loss of lives, particularly in the context of scaling-up of collaborative TB/HIV activities. Dr Diane Havlir, Chair of the TB/HIV Working Group, opened the meeting saying "it is absolutely clear that TB represents one of the greatest threats to the success of the roll-out of antiretroviral therapy. This is because TB in HIV-infected patients is associated with a very high mortality and very complex

management issues." Dr Anthony Fauci, Director of NIAID described the neglect on TB research both in United States and globally as "shameful and tragic". In his view, this neglect was caused by the significant decrease in mortality due to TB in the United States in the last century, and by global complacency and misperception that there is an adequate armamentarium against TB already. Mark Harrington, Executive Director of Treatment Action Group and leading global HIV activist emphasized this by adding that massive research coupled with the willingness of HIV volunteer patients to undergo procedures to understand the pathogenesis of HIV was what led to breakthroughs in HIV diagnosis, prevention, and most dramatically, treatment. Nobel laureate, Dr Françoise Barre-Sinoussi, called for much better understanding of the pathogenesis of TB as leverage to generate new ideas and areas of TB research, particularly for diagnostics, drugs and vaccines.

During the meeting participants highlighted the point of care TB diagnostic (dipstick TB test) as the most important and urgent need in TB research. Reaching out beyond health facilities and optimal use of community structures was also underlined as a priority research area. The meeting underscored the neglect of children in overall HIV/TB research and suggested urgent interventions to ensure their inclusion in all research efforts. The research priorities discussions during the meeting also informed the ongoing revision of the TB/HIV research priorities agenda by the World Health Organization. Once finalized, this document will provide a framework for researchers and funding agencies to streamline their work.



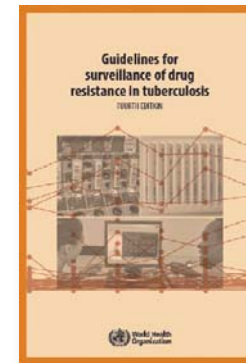
Dr Paul Nunn, WHO and Dr Françoise Barre-Sinoussi in a Q&A with participants

## MDR/TB IMPLEMENTATION PROGRESS

As a result of the MDR-TB meeting held in Beijing, China in April this year and the subsequent resolution on drug resistant TB passed at the World Health Assembly in May 2009, WHO is closely monitoring the progress of implementation of drug resistant TB services in high burden countries.

Pakistan, Belarus, Georgia, Armenia, Lithuania, Bulgaria, Latvia, Estonia, Indonesia, Myanmar, China, Philippines, and Viet Nam have all now reported that they have completed MDR-TB plans for implementation. There are several high priority countries who are in the process of developing full plans - Bangladesh, India, Indonesia, Myanmar, Thailand, China, Philippines, Viet Nam, Ukraine, Tadjikistan, Uzbekistan, Kazakhstan, Kyrgyzstan, Moldova, and Turkmenistan. These plans were shared at the MDR-TB Working Group meeting held on October 12, 2009.

## NEW WHO DRUG RESISTANCE SURVEILLANCE GUIDELINES RELEASED



Guidelines for Surveillance of Drug Resistance in Tuberculosis

A new edition of the WHO Guidelines for surveillance of drug resistance in tuberculosis is being released in October. These guidelines present up-to-date methods on drug resistance surveillance, including how to design and conduct a setting-specific survey that measures the burden of drug-resistant tuberculosis. The guidelines address recent advancements in drug susceptibility testing, including testing for second-line drugs, the use of rapid diagnostics and the inclusion of HIV testing. The document also presents strengthened guidance on survey design, data management and analysis, and ethical considerations in surveys and surveillance of drug resistance.

Since its launch in 1994, the Global Project on Anti-tuberculosis Drug Resistance Surveillance has systematically collected and analysed data on drug resistance from surveys of sampled patients and from national surveillance systems from an ever increasing number of settings around the world. The 4th Global Report Anti-tuberculosis drug resistance in the world, published in 2008, encompassed data provided from over 100 geographical settings that have been included in the project. Since the inclusion of MDR-TB management in the new and comprehensive Stop TB Strategy, a new and fundamental role of the Global Project has been to assist countries in planning the scale-up of MDR-TB management via the provision of essential data on national burden and prevalence of drug resistance patterns.

For more details on the Global Project on Anti-tuberculosis Drug Resistance Surveillance and a downloadable copy of the guidelines, visit [www.who.int/tb/challenges/mdr/surveillance](http://www.who.int/tb/challenges/mdr/surveillance) or contact the Global Project secretariat at [TBDRS@who.int](mailto:TBDRS@who.int).

## ICAAP 9 - WHERE WAS TB?

The International Congress on AIDS in Asia Pacific conference (ICAAP9) was held from August 9-13, 2009 in Indonesia. TB was not highly visible at the conference, however, there was a plenary session on TB/HIV which was excellent (presented by Jintana Ngamvithayapong-Yanai) a few posters, a skills building session on TB infection control and a satellite by TAG and MSF on the importance of including TB in activists' work HIV. Much more work needs to be done on raising awareness of TB and TB/HIV in this region as many attending still did not know the basics of TB and in particular infection control, in spite of the global burden of TB in this region.

The meeting was well attended with 3000 participants and many speakers mentioned TB/HIV in their opening speeches. UNAIDS Executive Director, Michael Sidibe (in a video presentation) said, "It is encouraging to know that stronger links between the TB and HIV communities are delivering results. In Cambodia in 2008, 57% of TB patients knew their HIV status, up from 13% in 2006. But we still have a long way to go. As a Cambodian colleague stated recently, "when the TB bacteria and the HIV virus work so well together, it begs the question why can't we?"

The conference focused on marginalized groups as this is the main HIV at risk group in this region. The language and direction of the conference themes were epitomised in the opening statement by Professor Michel Kazatchkine of the Global Fund who called for the need for donor resources to flow more towards services for risk groups in particular drug users. Not only resources but decriminalization are needed to allow access to these services, particularly as same sex-relations are illegal in at least 12 countries in this region and drug use is subject to the death penalty in at least 10 countries.

The sessions on drug users demonstrated good progress in the introduction of harm reduction measures in the Asia Pacific region, however, it was striking that tuberculosis was hardly mentioned in the main harm reduction session presentations. The HIV community is embracing harm reduction but TB as a major challenge within that package of measures needs further emphasis.

## GREEN LIGHT COMMITTEE (GLC) UPDATE



## MESSAGE FROM THE GLC CHAIR

**On October 13-14, 2009, the Green Light Committee (GLC) Initiative will host the first GLC Forum in Geneva. The meeting will follow the MDR-TB Working group meeting.**

The GLC Forum was organized in response to the call from high-MDR-TB burden countries for rapid scale-up of high-quality MDR-TB treatment globally (Beijing, April 2009) and the World Health Assembly resolution (Geneva, May 2009) calling on the World Health Organization "to provide support to Member States in developing and implementing strategies to engage all relevant public, voluntary, corporate and private health-care providers in the training for and scaling up of prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis and all aspects of tuberculosis-HIV co-infection."

In order to achieve universal access to MDR-TB services, countries will face many challenges around diagnosis, access to quality-assured second-line anti-TB drugs, and the ability to implement integrated DR-TB programs and successfully deliver treatment of appropriate quality to patients. The GLC forum provided an opportunity for countries to share their experiences and participate in a dialogue with the GLC and other policy makers about problems that they face at the country level, current gaps/needs, and experiences with existing global mechanisms. Participants at the Forum will discuss different approaches that can help countries achieve their expansion and treatment goals.

**Salmaan Keshavjee**  
MD, PhD  
Chair, Green Light Committee

### THE 56TH GLC MEETING

The 56th GLC meeting took place at WHO in Geneva, Switzerland from August 19-21, 2009. The first day was devoted to a workshop for GLC members and key partners in the GLC Initiative on Scaling up the supply of second-line anti-TB drugs to GLC-approved projects. Workshop participants included GLC members, the secretariat, MSF, the UNION, the Global Fund, and UNITAID.

Discussions reviewed drug quality issues and definitions, for example, the difference between batch testing and quality assurance. Second-line drug quality assurance and how drug sources are currently selected as well as different quality assurance schemes such as the Global Fund approach were presented. The Global Drug Facility (GDF) is now

creating a price-negotiation task-force for active price negotiation with manufacturers and will look at sensible negotiation, and accounting for volumes/tender potential.

Pharmacovigilance issues were also introduced and participants learned about information exchange, guidelines and policy, technical and political support to countries, training, technical advice. A global strategy is being developed for TB pharmacovigilance, particularly as 80% of drug resistant TB patients have adverse effects.

Nine GLC monitoring and evaluation reports were also reviewed at the meeting and all endorsed by members. Two new applications (Guinea and Zambia) and seven expansion requests were approved - these approvals cover 2872 new patients.

### GLC UPDATES AT A GLANCE

As the end of 56th GLC review cycle:

<b>New approved projects during this cycle</b>	<b>5</b>
<b>Expansion requests approved during this cycle</b>	<b>7</b>
<b>New approved patients in 56th meeting</b>	<b>2632</b>
<b>Total approved application</b>	<b>166</b>
<b>Total approved countries</b>	<b>68</b>
<b>Total approved projects</b>	<b>108</b>
<b>Total approved patients</b>	<b>59,274</b>
<b>Total countries started projects (Drug received)</b>	<b>49 countries</b>
<b>Patient treated (including on treatment)</b>	<b>A total of 17'984 MDR-TB cases have been enrolled in 65 GLC-approved projects from 2000 to 2008.</b>
<b>M&amp;E and TA mission</b>	<b>49 countries (69 missions)</b>

GLC project updates can be found on the GLC Website and is updated bi-monthly following the GLC meetings.

[www.who.int/tb/challenges/mdr/greenlightcommittee/en/](http://www.who.int/tb/challenges/mdr/greenlightcommittee/en/)

### 9TH TECHNICAL MEMBERS OF GLC: REVIEW AND SELECTION OF NEW MEMBER

The call for nominations of a technical member to serve on the Committee in 2009-2011 was issued on July 24, 2009. The Secretariat received eight applications from various technical institutes and after a review based on institutional participation/reach, individual knowledge, experience and other criteria the Indus Hospital in Pakistan was selected as the 9th technical GLC member. The Indus Hospital is a non government organization in Pakistan.

The dramatic increase in the number of people living with HIV in the past decade has fuelled the South African TB epidemic and national estimates of HIV among TB patients now range from 60% to 80%. A joint review by the South African government and the World Health Organization (WHO) and other partners in July 2009, did however, find that the TB program has seen some improvements. The good news is that there are now fewer people defaulting on treatment and more than 90 percent of patients in some clinics were tested for HIV. However much more needs to be done to address TB and HIV co-infection and the added complexity of MDR and XDR-TB. TB and HIV co-infection still poses the greatest threat to the country's progress in curbing its TB epidemic.

One of the key issues in access to early diagnosis, treatment and prevention for TB and HIV are the location of facilities. Currently, tuberculosis services are provided at the primary health facility level and antiretroviral treatment (ART) is provided in "wellness clinics," which must be accredited and are usually located in more centralized settings, including some of the MDR-TB hospitals. People living with HIV who do not yet qualify for ART receive care in a variety of settings, but often do not have continuous HIV care. At the national level, TB and HIV programs were split in 2005. The TB Directorate was elevated to a cluster (chief directorate) and the National TB/HIV Unit was placed within the HIV cluster to promote collaborative TB/HIV activities within HIV services. Addressing a simple issue of location - decentralized versus centralized services could increase access to services dramatically, however this is something that must be addressed at all levels beginning with the national programs all the way down to the health care facility.

There has been a marked increase in uptake of HIV counselling and testing, using the voluntary counselling and testing model (VCT), among TB patients in most provinces and in many of the facilities visited had more than 90% of TB patients tested for HIV. There was also a reported increase in use of co-trimoxazole prophylaxis for HIV-infected TB patients.

In general, there are problems linking HIV-infected TB patients to HIV care and treatment services. However there are some examples of successful models such as in the Western

## "TB HAS HITCHED A RIDE ON HIV'S RUNAWAY TRAIN"

NEWSHOUR JOURNALIST  
RAY SUAREZ, ON A RECENT  
TRIP TO SOUTH AFRICA 2009



Cape. Here they have had success in managing patients dually infected with HIV and TB in primary health clinics; using the PALSA plus approach to promote integrated management; and using "stretch" nurse-run doctor supported clinics for stable patients on ART and including TB patients.



Members of the review team, South Africa

### CONSTRAINTS AND CHALLENGES

The key constraint to the rapid and nation-wide scale up of TB/HIV collaborative activities is the limited engagement of HIV stakeholders and general health service providers in the implementation of the Three Is (intensified/active case finding, provision of IPT, infection control measures), services which if implemented would reduce the incidence of TB among people living with HIV. TB screening among HIV-infected persons is not a consistent practice in HIV care and treatment services and when it is done, it is not captured in any routinely collected and monitored data set. Monitoring and evaluation is an area that needs much more attention and investment.

As with many other places, there are still only pilot projects to implement isoniazid preventive therapy (IPT) even in the face of all the evidence showing this cost effective measure can make a difference.

In one provincial capital, the team visited a hospital first constructed at the beginning of the 20th century, (high ceilings, broad corridors etc), and questions were raised as to whether they are fit for the 21st century complexities of TB and HIV in South Africa. HIV-associated TB was the most

common condition in the male medical ward, with many other patients also HIV infected. Yet, the windows were closed (it was near freezing outside on a clear morning), there was no ventilation system, not all TB suspects had had a sputum smear done on arrival, smear positive TB patients were not wearing masks, and while boxes of N95 respirators were available, no staff were using them. In short, there was no reason here why another Church of Scotland disaster could not happen. On the second floor of this hospital was the Wellness Clinic, with 15,000 patients on its anti-retroviral treatment register, well-staffed, well-resourced with several clerks each at their computers, and patients attended regularly. Yet, only a handful of the patients were on IPT. Doctors were enthusiastic about offering it to all the patients and yet weren't doing so - what was stopping them? Merely the absence of a clear policy. They were well aware that isoniazid costs about one Rand for a bucketful! Surely here there is plenty of room for making a major step towards preventing TB among people living with HIV. If this situation is repeated across the country, what an impact IPT could make!

The lack of respiratory infection control best practices in most in-patient and outpatient settings continues to promote transmission of TB (including MDR-TB) to people living with HIV and this needs to be addressed urgently.

Other areas of concern include the late initiation of ART in TB patients and the fact for those known to be infected, eligibility for ART is generally for those with CD4 < 200. Further, approximately 50% of adults have never had an HIV test (HSRC/Mandela Foundation 2008) and do not know their status. The dual stigma of TB and HIV/AIDS remains a significant barrier to patients accessing VCT and TB services.

### WHAT NEXT?

Clear recommendations were made by the reviewers, they include the need for much more leadership from all HIV stakeholders for joint TB/HIV activities at national, provincial and district levels. They also called on the government to evaluate the current organizational structure at all levels



IEC materials in  
Blomfontein, South  
Africa

with regard to facilitating joint ownership. This is also reflected in the call for the decentralization of ART services to increase access of HIV-infected TB patients to HIV care and treatment.

Much more aggressive promotion of intensified TB case finding in wellness clinics, pre-ART and ART services is needed as well as follow up with TB diagnostic and treatment services. The diagnosis of pulmonary TB in HIV-infected persons should be considered as an automatic eligibility criterion for access to ART, regardless of CD4 count, and ART must be provided early in TB treatment to reduce mortality.

South Africa continues to struggle with an uncontrolled TB epidemic which has "hitched a ride" on the HIV epidemic. It will not be possible to control the TB epidemic without making significant progress on addressing HIV. Promoting intensified TB case finding in HIV service settings and broad scale-up of IPT among people living with HIV, widespread scale-up of VCT in the general population and treatment of people living with HIV at higher CD4 count levels (<350) should be strongly pushed as a TB control strategy in this emergency situation.

After the review a Stop TB Partnership delegation also made a high-level visit to South Africa in July, greeted by Deputy President Kgalema Motlanthe and meeting at length with Health Minister Dr Aaron Motsoaledi. The findings of the review were discussed and Dr Motsoaledi expressed his confidence on the ability of the country's health system to continue to respond to the TB pandemic even in the context of HIV and AIDS. The delegation and the Minister then discussed the way forward for accelerating action on TB and TB/HIV, and issued a joint statement.

[www.doh.gov.za/docs/pr/pr0716-f.html](http://www.doh.gov.za/docs/pr/pr0716-f.html)

# UPCOMING EVENTS

## NOVEMBER

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### TB/HIV CORE GROUP

When: 3-4  
Where: Geneva, Switzerland

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### STOP TB PARTNERSHIP COORDINATING BOARD MEETING

When: 5-6  
Where: Geneva, Switzerland

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### STAG - STRATEGIC TECHNICAL ADVISORY GROUP FOR TB

When: 9-11  
Where: Geneva, Switzerland

## DECEMBER

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### WORLD AIDS DAY

When: 1  
Where: Various locations globally

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### UNION CONFERENCE

When: 3-7  
Where: Cancun, Mexico

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### ADDRESSING CRITICAL CHALLENGES IN TB/HIV RESEARCH AND PROGRAM IMPLEMENTATION TAG, STOP TB PARTNERSHIP, VIVIR PRE-UNION WORLD LUNG HEALTH CONFERENCE SATELLITE

When: 1 (9:00 – 17:00)  
Where: TBD

Please complete the RSVP form at [www.treatmentactiongroup.org/form.aspx?ekfrm=3346](http://www.treatmentactiongroup.org/form.aspx?ekfrm=3346)

The goals of this meeting are to:

- Highlight current challenges for TB and TB/HIV programs and research questions that are critical to help address those challenges
- Bring attention to important research initiatives that are attempting to address these program challenges
- Highlight the role activists and NGOs play in addressing scale up of 3Is and MDR-TB
- Strategize to increase the available funding and trial site capacity for TB R&D.