

Nov
2007

TB/HIV Update

Stop TB Partnership

bi-monthly
newsletter
of the TB/HIV Working Group of
the Stop TB Partnership

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Latin America moves towards further implementation of TB/HIV collaborative activities

On 30–31st July a TB/HIV Expert Consultation was held in Guatemala City to review draft clinical guidelines on TB/HIV following PAHO and WHO recommendations. Twenty-four participants, mainly infectious disease specialists and pneumonologists from 10 countries (El Salvador, Nicaragua, Panamá, Guatemala, Honduras, Costa Rica, Mexico, Dominican Republic and Brazil) attended the meeting. Via conference call NTP and NAP staff from Panama

and El Salvador and the TB Regional Adviser also participated in some sessions. As a result of group work and plenary discussions, concrete suggestions were provided and a PAHO consultant prepared a revised version which is currently being circulated among participants before it is finalized and disseminated. This is another step forward in the Americas to facilitate the implementation of TB/HIV collaborative activities. □

TB/HIV Core Group holds its 12th meeting

The Core Group (CG) of the TB/HIV Working Group of the Stop TB Partnership which facilitates and accelerates decision making and guides strategic direction held its 12th meeting from October 25–26, 2007 in Amsterdam, The Netherlands. Over the two



Core Group Members, Amsterdam, The Netherlands

days there were presentations and discussions on the collaborative activities and the progress that countries such as India and Tanzania have made over the past year. The revised terms of reference of the Working Group was discussed and approved. The main purpose of the change in the terms of reference is to align the work of the Working Group and the global response with Universal access by 2010 and achievement of the MDGs by 2015. It also designed mechanisms to increase the engagement of HIV stakeholders in the Working Group. The meeting also reviewed and discussed issues around the implementation of IPT (Isoniazid Preventive Therapy) as a package of care for people living with HIV and the group developed a consensus statement for its implementation giving due consideration to the limitations that have been hindering its wider implementation. A full report of the meeting will be available shortly at <www.stoptb.org/wg/tbhiv>. □

letter to the Editor

Dear Editor,

Re: The September 2007 edition of the TB/HIV Newsletter

I am a bit concerned about the photo of the laboratory worker entitled "preparation of sputum smears for microscopy". The image of both gloves and respirator (or surgical mask as I have often seen myself) sends the wrong message to laboratory workers who see this picture and have not received proper TB infection control (bio-safety) training. This can work against our intention to provide appropriate bio-safety to laboratory workers. Doing the wrong things can result both in a false feeling of protection, and neglect of the measures that are most effective. It can also result in considerable waste of financial resources and inappropriate demands. The picture illustrates the need to give proper education to laboratory workers on bio-safety, and provide them with correct standard operating procedures, as one frequently observes this irrational behavior in the field.



Images are often much more powerful than words and it may be difficult to convince persons, who see them, otherwise.

Best regards,
Jeroen Van Gorkom
KNCV Tuberculosis Foundation

▶ more ...
ABOUT THE STOP TB
PARTNERSHIP
<www.stoptb.org>



The Secretariat of the TB/HIV Working Group is housed by WHO

CREATE Annual Meeting discusses progress and challenges ahead

Hosted by the Rio de Janeiro Municipal Health Secretariat, the 4th CREATE Annual Meeting was held September 24–26, 2007 in Rio de Janeiro, Brazil. Seventy participants represented the CREATE study projects and cores, the World Health Organization, the Gates Foundation and other collaborators.

The meeting opened with Professor Mauro Schechter who discussed Brazil's national program of universal access for antiretroviral therapy.

Updates on implementation of the main objectives of the CREATE studies were presented in detail, and substantial progress was demonstrated for each trial. Preliminary

results from the three CREATE studies (Zamstar, Thibela and ThRio) were presented and discussed. Studies presented ranged from animal studies on new drugs and combination treatment for TB, modeling exercises and social studies investigating the link between TB and poverty in the context of HIV. In Thibela over 10,000 people were enrolled for IPT with minimal side effects and intolerance. 11% were ineligible as they were considered to be suspects for TB. The importance of CXR (chest X-ray) to exclude active TB was also emphasized.

Sub-studies examining the effectiveness and cost-effectiveness of new diagnostic tools, use of geographic



information systems, and qualitative research on TB, HIV and poverty were also presented.

A highlight of the meeting included poster presentations of original research conducted by CREATE team leaders and study staff in the field. Many of these studies will be presented at the upcoming World Lung Health Conference in Cape Town, South Africa in November. □

►► For more information about CREATE and the participating studies, go to: <www.tbhiv-create.org>.

Rupert Everett raises awareness of TB/HIV in Russia

Rupert Everett Special Representative of UNAIDS visited Moscow and St Petersburg from September 23–26, to learn more about TB/HIV and raise awareness of the issues. The actor (*My Best Friend's Wedding*, *Another Country*) visited the Moscow Clinical TB Hospital N7, St. Petersburg City Infectious Hospital N30, the Republic Clinical Hospital for the Treatment of Infectious Diseases, which treats children who have been abandoned and/or are living with HIV, and “LaSky”, a project supported by Population Services International, the Global Fund and the Ford Foundation, which provides information and prevention services for men who have sex with men.

He also learned about working with HIV positive injecting drug users and met with HIV activists and NGOs including Humanitarian Action to learn more about PLHIV experiences with TB.

The number of officially registered PLHIV in Russia as of May 2007 was approximately 386,000, though it is widely believed that the actual number could be up to 1.1 million.

TB is the leading cause of death in people living with HIV in Russia, accounting for 59% of such deaths in 2006. Most of those who died were between the ages of 25 and 34.

At the end of his visit, the actor spoke of his hopes to develop his support: “I hope that UNAIDS can continue to play an active part in the future to bring the government, the NGOs and the advocacy groups closer together in a united response to AIDS and TB.”

“I’m very grateful to everyone in Moscow and in St Petersburg who took the time to meet and share their experiences with me,” said Mr Everett at the end of his visit.

“It has been a very busy three days: overwhelming and inspiring. Denial, pre-existing stigma and prejudices are nourished by the presence of HIV and TB in society as a whole. These are powerful forces that act as roadblocks on the journey towards an effective response to the spread of HIV and TB. □

►► UNAIDS: <www.unaids.org/en/MediaCentre/PressMaterials/FeatureStory/20071009_Overwhelming_and_Inspiring.asp>



Rupert Everett, Special Representative of UNAIDS, visiting The Russian Federation

Isoniazid Preventive Therapy – what do the experts think?

WHO Recommendations (Interim Policy on Collaborative TB/HIV activities)

- HIV/AIDS programmes should provide isoniazid preventive therapy as part of the package of care for people living with HIV/AIDS when active tuberculosis is safely excluded.**
- Information about isoniazid preventive therapy should be made available to all people living with HIV/AIDS.**

WHO/HTM/TB/2004.330

Preventive therapy for TB is safe and efficacious and is recommended for all people living with HIV (PLHIV) in areas with a prevalence of latent TB infection >30%, and for all PLHIV with documented latent TB infection or exposure to an infectious TB case, regardless of where they live. The recommended regimen is isoniazid 300 mg daily for 6–9 months. More recently, evidence showed that the combined use of isoniazid preventive therapy and antiretroviral therapy among people living with HIV significantly reduces the incidence of TB. Despite being one of the key recommended interventions to reduce the burden of TB in PLHIV, implementation of isoniazid preventive therapy (IPT) has been very low and only 25,000 PLHIV were reported to receive it globally in 2005, 19,000 of whom were reported from Botswana, which is the only country with IPT as a public health intervention. It is evident that reluctance to its implementation is driven primarily by the technical and logistical difficulties of excluding active TB and fear of development of drug resistance. The question now is what needs to be done to overcome these challenges? We asked key stakeholders including policy makers, activists and program managers to share their views on IPT. Also see page one for news on the Core Group Consensus Statement on IPT. □

Key policy makers, implementers and activists give their perspectives on IPT

“Exclusion of active TB before putting a PLHIV on IPT is a challenge, and looks to be the main reason for poor coverage of IPT in Ethiopia, despite having it as a national policy. Unfortunately, we don’t have a detailed, clear global policy and protocol on how to exclude active TB except the mandatory use of CXR. As such, we don’t have the infrastructure capacity to confidently rule out active TB in facilities where many PLHIV are seen. I would like to see some well designed studies in facilities where we believe we have the ability to rule out active TB and develop a locally applicable protocol to exclude active TB that takes the infrastructure development of the country into consideration. More contextual and locally-oriented operational research is needed to scale-up IPT as a practical public health intervention in Ethiopia.”



Yibeltal Assefa

Yibeltal Assefa
Head, Health Programs Department
(National AIDS Program Manager)
National HIV/AIDS Prevention and
Control Office, Ethiopia

“IPT is an effective intervention on an individual basis if patients can complete the 6-9 months regimen and if there is a system to support them. However as a public health intervention the requirements in terms of resources are on the high side and may be out of the capacity of poor countries to implement. The cheapest component of the policy is the drugs but screening, sensitizing the HIV community and ensuring that people living with TB/HIV can complete the entire duration of treatment is resource intensive. Given the magnitude of potential benefits from the whole range of the TB/HIV interventions, one is bound to ask whether IPT should be among the highest priorities at this material time.”



Saidi Egwaga

Saidi Egwaga
National TB Program Manager
Tanzania

“I think any functioning HIV treatment program should use isoniazid preventive therapy in all HIV infected persons, as long as the possibility of active TB disease has been ruled out. It is scandalous that in 2005 only 0.5% of HIV infected Africans received IPT especially given that over the same period antiretroviral therapy (ART) was being rapidly scaled up in many African countries. Many think that a barrier to IPT uptake is adherence, but I do not feel most programs have really tried. We know that adherence to ART among HIV infected individuals is very high, so IPT adherence should be considered as a part of ART adherence counseling and support.”



Mark Harrington

Mark Harrington
Treatment Action Group, Global HIV Activist since 1988
New York

“IPT prevents tuberculosis in HIV positive persons, but concerning HIV questions (such as protection time conferred by IPT, the best time to introduce IPT according to immune status etc.) are still without answers. In Brazil national recommendations for IPT in HIV+ haven’t been followed in clinical practice, due to difficulty in asking for and performing TST and difficulty of adherence to a 6 months treatment (3 pills daily dose). However, there are ways to deal with these problems in order for IPT to work. We must be able to guarantee efficient logistics of purchase and distribution of TST and isoniazide 300mg INH pill. We also need research to determine the best time to introduce/re-introduce IPT related to immunological status.”



Leda Jamal

Leda Jamal
National AIDS Program, Brazil

“IPT is one of the few available interventions that has the potential to impact greatly on the life of PLHIV. No doubt about efficacy, but feasibility in the field is under question. And it is under question only because the target for the delivery of IPT has been, so far, the TB “services”, which are busy and often overwhelmed in dealing with sick TB patients. They do not see healthy candidates for IPT: they attend to the sick already. Therefore, I am fully convinced that IPT will never be scaled up and accessible to those who need it unless it is taken up by those services handling PLHIV: from VCTs and ARV clinics and to general primary care services. Hence, the paramount key strategic move must consist in getting those components of the health sector delivering HIV and primary care services fully engaged in the implementation of IPT.”



Mario Raviglione

Mario Raviglione
Director of Stop TB Department of WHO
Geneva, Switzerland

TBTEAM: the Technical Assistance Mechanism of the Stop TB Partnership

The unprecedented amount of resources made available through bilateral and multilateral agencies, in particular the Global Fund to Fight AIDS, TB and Malaria (the Global Fund) to implement the Stop TB Global Plan 2006–2015 and the Stop TB Strategy, have led to an increased demand by countries for technical assistance by the various Stop TB partners. However, the increase in financial resources available to countries has not been matched by an adequate increase in funding to technical agencies in the Stop TB Partnership to provide such technical assistance. In order to maximize the use of available resources for the provision of technical assistance, the Stop TB partners have decided to strengthen and formalize the coordination of technical assistance through TBTEAM – the Stop TB Technical Assistance Mechanism. The TBTEAM global secretariat is hosted by the WHO Stop TB Department. It is the global secretariat of a network of Stop TB partners, including national TB programmes, local and international NGOs, financial partners, and WHO at country, regional and global levels. TBTEAM facilitates the sharing of information among partners at all levels and determines appropriate technical support in consultation with all interested parties.

Stop TB partners have built a wealth of experience and expertise in countries around the world. Many partners are recruiting and training local staff which substantively increases national capacity for TB management and control. Technical assistance coordinated through TBTEAM is contributing and has the potential to contribute to rapid implementation of the Stop TB Strategy and therefore to improved case detection and cure rates. Technical assistance coordinated through

TBTEAM has demonstrated improved success of TB proposals submitted to the Global Fund from 38% in Round 1 to 64% in Round 6.

TBTEAM offers a variety of technical assistance including technical assistance and ad hoc emergency support during the life cycle of Global Fund grants. Most recently TBTEAM arranged direct support to 41 countries who requested assistance with Global Fund round 7 proposal preparation. A further 21 countries were supported via the email hotline: <tbproposalhelp@who.int>. With regard to ad hoc emergency support TBTEAM has received over 30 requests from the Global Fund and organized missions to countries accordingly (i.e. Chad, Uganda, Indonesia, The Russian Federation, Thailand, Madagascar).

TBTEAM also organizes technical assistance for the assessment of phase 1 of Global Fund grants and has worked with countries such as Burundi, Rwanda, and Burkina Faso.

The Global Fund requested TBTEAM to arrange a pilot test of the Monitoring & Evaluation Strengthening System (M&ESS) in Tanzania and identify TB experts to facilitate M&ESS workshops in Cote Ivoire, Guatemala, Nepal, Bhutan and Jordan. In June 2007, TBTEAM successfully applied to a Request for Proposal to pilot test the Data Quality Assessment (DQA) tool in Rwanda and organized the mission accordingly.

Countries are invited to send their requests for technical assistance to the WHO Country Office or other Stop TB Partner present in the country. The TBTEAM at country level will link with TBTEAM at the regional and/or global level(s) for adequate follow up. □

▶ The global TBTEAM contact is:
<tbteam@who.int>.



All Africa Leprosy, Tuberculosis and Rehabilitation Training Centre (ALERT)

The All Africa Leprosy, Tuberculosis and Rehabilitation Training Centre (ALERT) was established in 1965 in Addis Ababa, Ethiopia. It was founded by the Ministry of Public Health, Addis Ababa University and the International Federation of Anti-Leprosy Association (ILEP) to provide comprehensive training for African health workers in the control, treatment and rehabilitation aspects of leprosy. In 1981, ALERT was designated as a WHO collaborating center for training in leprosy. Since 1995, ALERT has expanded its services to include TB, HIV and most recently TB/HIV.



The All Africa Leprosy, Tuberculosis and Rehabilitation Training Centre (ALERT) in Addis Ababa, Ethiopia

ALERT was the first governmental institution in Ethiopia to provide free anti-retroviral therapy (ART) combined with community linked comprehensive HIV care in December 2004. This was possible due to a collaboration with the Christian Children's Fund of Canada who provided the drugs and the Ethiopian North American Health Professional Association who provided technical assistance. It was this initiative that prompted US President Clinton to support a new pediatric ward for HIV care at ALERT in 2006. There are now more than 7,000 PLHIV who receive care at ALERT, five thousand of whom are on ART.

ALERT offers several types of international and national short courses lasting 1 to four weeks including TB/HIV Collaborative activities and program management. The TB/HIV course began in 2004 and has been conducted once a year since then. One hundred and sixteen National TB Program and National AIDS Program managers have been trained since then. In the future ALERT plans to conduct the course twice a year (in March and August).

ALERT's services include interventions for leprosy, dermatology, ophthalmology, reconstructive & plastic surgery, physiotherapy and HIV/AIDS. The presence of the Armauer Hanson Research Institute contributes to ALERT being an excellent training centre. ALERT has also recently been identified by TB CAP as a potential regional training centre for TB. □

Website: <www.telecom.net.et/~tdalert/about_ethiopia.htm>

Information provided by: Dr. Fuad Temam, Director of the Training Division at ALERT

Share experiences in TB/HIV implementation and research — Working Group members can send their contributions to the Forum (*no more than 1000 words and no more than three authors*) to <tbhiv@who.int>.



What is Advocacy?

A major challenge in continuing to harmonize the response to TB & HIV is how to attract and maintain attention for TB on the part of the AIDS community and vice versa. There are as many definitions of advocacy as there are groups and networks advocating. However, each definition shares common language and concepts. Advocacy is first and foremost a process, occurring over unspecified amounts of time, sometimes brief and often lengthy. Advocacy is also strategic and targets well-designed activities to key stakeholders and decision makers. And lastly, advocacy is always directed at influencing policy, laws, regulations, programs, or funding – decisions made at the upper-most levels of public or private sector institutions. Definitions of advocacy are also based on an organization or network's vision or goals and objectives.

Advocacy is both a science and an art. It includes both single- issue, time limited campaigns as well as ongoing work undertaken around a range of issues. Advocacy activities may be conducted at the national, regional, or local level.

Advocacy and Related Concepts

The following chart illustrates the difference between advocacy and several related concepts. Advocacy can usually be distinguished from other approaches in that the objective of advocacy is policy change.

This excerpt is taken from the handbook, **Networking for Policy Change: TB/HIV Participant's Guide**. This participant's guide is to be used in conjunction with "Networking for Policy Change: TB/HIV Advocacy Training Manual." This publication for TB/HIV advocacy is particularly designed for country and local level advocacy to accelerate the implementation of collaborative TB/HIV activities. The target audience includes individuals and institutions that work either on TB and HIV/AIDS, and advocates and those who intend to advocate for TB/HIV issues, mainly at national and local levels. "Networking for Policy Change: TB/HIV Advocacy Training Manual" and "Networking for Policy Change: TB/HIV Participant's Guide" can be accessed at both the Constella Futures and World Health Organization's websites. □

» http://www.stoptb.org/wg/tb_hiv/assets/documents/Participant%20Guide%20TB_HIV_edited.pdf

Advocacy and Related Concepts					
Approach	Actors/Organizers	Target Audience	Objective	Strategies	Measuring Success
Information, Education, Communication (IEC)	• Service providers	• Individuals • Segments of a community (women, men, youth)	• Raise awareness and change behavior	• Sorting by audience • Mass media campaigns • Community outreach • Traditional media	• Change in knowledge or skills (behavior change) • Process indicators • Focus groups • Service logistics
Public Relations	• Commercial institutions	• Consumers	• Improve the company's image and increase sales	• Large scale advertising (radio, TV, print media) • Public events • Sponsoring a "charity"	• Improved public perception • Increased sales • Increased market share
Community mobilization	• Community members and organizations	• Community members and leaders	• Build a community's capacity to rank needs and take action	• Door-to-door visits • Village meetings • Participatory Rural Appraisal (PRA)	• Issue-specific process and outcome indicators • Quality of participation
Advocacy	• NGOs/networks • Special interest groups • Professional associations	• Public institutions and policy makers • Communities/ community leaders	• Change policies, programs and resource allocation	• Focus on policymakers with the power to affect advocacy objective • High level meetings • Public events (debates, protests etc.)	• Process indicators • Media scans • Key informant interviews • Focus groups • Opinion surveys

Definitions of Advocacy

"Advocacy is winning the support of key constituencies in order to influence policies and spending, and bring about social change. Successful advocates usually start by identifying the people they need to influence and planning the best ways to communicate with them. They do their homework on an issue and build a persuasive case. They organize networks and coalitions to create a groundswell of support that can influence key decision-makers. They work with the media to help communicate the message."

WHO, Practical Guide to TB Advocacy

"Advocacy is the act or process of supporting a cause or issue. An advocacy campaign is a set of targeted actions in support of a cause or issue. We advocate a cause or issue because we want to build support for that cause or issues, influence others to support it or try to influence or change legislation that affects it."

International Planned Parenthood Federation, IPPF Advocacy Guide

"Advocacy is the art of influencing individuals or collective decision- or policy-making to effect a positive change in an issue or situation".

POLICY Project workshop participants, March 1997, Accra, Ghana

upcoming events

38th Union World Conference on Lung Health

IUATLD

Venue: Cape Town International Convention Center, Cape Town, South Africa

Dates: 8–12 November 2007

- **Stop TB Symposium: XDR-TB and TB-HIV: a threat or opportunity for TB control?**

Union and WHO

Venue: Cape Town International Convention Centre, Room TBD

Date: 8 November 2007 **Time:** 8:30–17:30

- **Advocacy to Control TB Internationally: Innovative Ways to Mobilize Political Will and Funding for TB ACTION**

ACTION

Venue: Cape Town International Convention Centre, Room TBD

Date: 8 November 2007 **Time:** 14:00–18:00

Advocacy to Control Tuberculosis Internationally (ACTION) is hosting an interactive training and planning workshop. During the workshop, participants will discuss best practices in advanced advocacy, review case studies of successful, cutting-edge advocacy efforts, and develop partnerships and strategic plans for upcoming opportunities.

To RSVP or for questions contact Emily Mintz at <emintz@results.org> or 001-202-783-4800 ext 143.

- **Global TB and HIV March**
AIDS Law Project, AIDS and Rights Alliance of Southern Africa (ARASA), Treatment Action Campaign

Venue: St Georges Cathedral, Cape Town

Date: 8 November 2007 **Time:** 17:00

More information: Regis Mtutu +27 8 4310 8614 or Jo Gorton <jogorton@gmail.com>.

- **Time for Change: New Approaches for Managing Drug-Resistant TB in Regions with High TB Rates**

AIDS and Rights Alliance for Southern Africa, Open Society Institute, Mediciens Sans Frontieres, Partners in Health and Treatment Action Campaign

Venue: Arabella Sheraton Hotel, Convention Square, Lower Long Street, Cape Town

Date: 9 November 2007 **Time:** 13:00–15:30

Representatives of the World Health Organization, national TB programs, field-based medical NGOs, and activists will discuss the merits and challenges of decentralized, community-based, drug resistant TB management in Southern Africa.

For more information and agenda please see <www.soros.org/timeforchange>.

TB/HIV Roadmap Union Conference Cape Town

Saturday, 10 November

Poster Discussion, TB/HIV

08:00 – 10:15, Room 1.41

- PC-71329-10 Comparing TB-HIV collaborative activities in two TB control intervention areas in Zambia
- PC-72108-10 Performance of response-to-therapy parameters in out-patient South African smear-negative TB suspects
- PS-71437-10 Non-tuberculous mycobacteria recovered during a prevalence survey in areas with high TB prevalence in RSA
- PS-71729-10 A comparison of MGIT versus LJ culture by smear status in pulmonary TB in gold miners in South Africa
- PS-71800-10 Physician adherence to HIV and TB guidelines in Rio de Janeiro, Brazil
- PS-71342-10 Cost-effectiveness analysis of TB cultures using LJ compared to MGIT liquid media to diagnose TB in Zambia
- PS-71284-10 Annual risk of TB infection as determined by tuberculin skin test surveys in Zambia and South Africa
- PS-71930-11 Interpreting good clinical practice for a community study
- PS-71223-11 Is it possible to cure TB in weeks instead of months?

10:30 – 13:45, Room Hall 1

- PS-71544-10 Tuberculosis: an additional tipping stress on poor households in South Africa and Zambia?
- PS-71601-11 Ultra-potent regimens with rifapentine and moxifloxacin yield stable cure by 3 months in a murine model of TB

14:00 – 13:45, Room 2.44

- TS-71788-10 Lack of hepatotoxicity in patients on isoniazid preventive therapy (IPT) and antiretroviral therapy (ART).

Sunday, 11 November

14:00 – 16:15, Room 1.41

- PC-71329-10 Comparing TB-HIV collaborative activities in two TB control intervention areas in Zambia
- Symposium #23: "Lessons Learnt: Community Participation in provision of TB services and in operational research on TB-HIV"

Monday, 12 November

Latebreaker Session

09:00 – 16:15, Room 1.41

- Symposium #37: "Community monitoring of national TB and TB-HIV policies in Africa"
- Symposium #30: "Vulnerable populations affected by TB and TB-HIV"