



All-Party Parliamentary Group on Global Tuberculosis

**Chairs: Andrew George MP
Nick Herbert MP
Julie Morgan MP**

Minutes from joint APPG on Global TB / APPG on AIDS meeting Wednesday 28 November 2007

Chair: Sheila Davie – Executive Director, RESULTS UK (SD)
Speakers: Nick Herbert MP – Co-Chair, APPG on Global TB (NH)
Alasdair Reid – TB/HIV adviser, UNAIDS (AR)
Paul Thorn – Director, TB Survival Project (PT)
Neil Gerrard MP – Chair, APPG on AIDS (NG)

Opening remarks – Sheila Davie

Sheila Davie welcomed everyone to the meeting and introduced herself as Executive Director of RESULTS UK, a citizen's advocacy organisation that has been doing advocacy work on the issue of tuberculosis (TB) for many years. SD acknowledged the vital work carried out by the APPGs to keep issues like HIV and TB on the political agenda. SD drew participant's attention to a report published by RESULTS UK on the response of the UK Government and civil society to the global TB/HIV co-epidemic, the issue that has brought both APPGs together today.

Presentation 1 – Nick Herbert MP

Nick Herbert MP explained that his interest in TB originated from an interest in HIV and AIDS. He was invited to join a cross-party delegation to Kenya in 2005 where he learnt about the scale and impact of TB in Africa and the close relationship with TB and HIV.

NH remarked that there were many similarities between TB and HIV:

- Both diseases are linked to poverty, preying on people in poor housing for example.
- Individuals affected by both diseases experience stigma and discrimination. People co-infected with TB and HIV experience 'double stigma'.
- Both diseases put immense strain on already weak health systems in developing countries.

However, there are also stark differences between the diseases. In particular, there is a big discrepancy in the level of attention given to TB and HIV. HIV has received much greater attention from drug companies resulting in the development of new diagnostic tools and therapies. By contrast, we are very behind in the development of new TB drugs. NH said that Western governments have an important role to play in the development of new tools for TB.

A common international approach is needed to address stigma and weaknesses in health systems and to interlink treatment programmes. NH remarked that we are still

a long way from achieving this. He has seen firsthand that limited resources are being wasted because TB and HIV programmes are not being coordinated and efforts duplicated. Efforts to TB and HIV need to be joined at all levels.

NH acknowledged the UK Government for its record in supporting TB and HIV efforts, in particular through the Global Fund to Fight AIDS, TB and Malaria. However all Western governments need to step up to the mark if progress is going to be made in tackling both diseases.

Presentation 2 – Alasdair Reid

Dr Reid gave a presentation on the TB/HIV co-epidemic and why HIV is so important to the TB response and vice versa.

One-third of the world's population is infected with TB but only 5-10% will develop the disease in their lifetime. In 2006 there were 9 million new TB infections and 1.6 million deaths (4,400 per day).

HIV is the single biggest risk factor for developing TB disease. Around 11 million people with HIV are at risk of developing TB. Up to 90% of TB patients in African countries are co-infected with HIV.

TB is the most common cause of illness, hospitalisation and death among people living with HIV. Most TB in people with HIV is curable with 1st line drugs but untreated TB in people living with HIV leads to death in weeks.

Underinvestment in TB control and research has led to the emergence and spread of drug resistant TB. Extensively drug-resistant TB (XDR-TB) is essentially untreatable in resource-poor settings. People with HIV are most vulnerable to this deadly strain of the disease - the cases of XDR-TB reported in Kwazulu Natal, South Africa are likely to have spread between patients attending an HIV support group. XDR causes even greater stigma because people fear being unable to protect themselves from it.

Drug-resistance has arisen as a result of poor investment in TB control and poor use of 2nd line drugs. Drug resistance is also a big problem in Eastern Europe where 2nd line drugs are freely available but are poorly used. Infection control is a big problem – overcrowded clinics with poor ventilation are unwittingly putting vulnerable people into an ideal environment for the spread of TB.

The World Health Organisation has developed recommendations for collaborative TB/HIV activities. However, only 7% of TB patients were tested for HIV in 2005; less than 0.5% of people living with HIV were screened for TB in 2005 and only 28,000 people living with HIV received TB preventive therapy.

The drug Coxtimoxazole has been shown to reduce death from TB among people with HIV by 40%.

India was initially reluctant to integrate TB and HIV programmes because of the double stigma but there is now a very successful programme to increase TB case finding in VCT clinics. Between 2005 and 2007 there was a two-fold increase in the number of TB cases diagnosed through VCT clinics.

The 'Global Plan to Stop TB, 2006-2015' includes targets to scale up TB/HIV activities but these are already way off track and the Global Plan is being greatly underfunded:

Global plan target - 2006	Actual coverage - 2006*
1.6 million TB patients tested for HIV	<0.5 million HIV tested (30% of target)
200 000 HIV positive TB patients started on ART	32 000 on ART (16% of target)
11 million PLHIV screened for TB	172 000 PLHIV screened (1.7% of target)

* Based on preliminary data from 160/211 countries

What are some of the barriers to addressing TB/HIV co-infection?

- Time – organisations are often already working at capacity.
- Weak health systems
- Lack of political commitment
- Tradition – TB is seen as someone else’s problem. 88% of TB proposals to the Global Fund in Round 6 contained TB/HIV components compared to 42% of HIV proposals.
- Territory – the TB programme doesn’t want to hand things over to the HIV programme and vice versa.
- Funding streams – earmarking for funding to address one disease or the other. PEPFAR money couldn’t initially be used for TB. They are now putting lots of money into TB/HIV because it brings about quick results.

There are cultural differences between TB and HIV communities. The AIDS epidemic began 25 years ago but strong community activism has already resulted in a rapid diagnostic test, dozens of new drugs and a US research budget of \$2900million. By contrast, TB has been around for thousands of years but uses a 120 year-old diagnostic test, 40 year-old drugs and a US research budget of \$158million.

Presentation 3 – Paul Thorn

Patient advocate Paul Thorn said that it feels like the HIV community has its head buried in the sand in relation to TB. He urged the HIV community to recognise that TB has is a major part of the HIV problem but also an important part of the HIV response.

In 1995 PT experienced MDR-TB himself. He went to HIV organisations for support but was told that TB wasn’t a problem that they dealt with. More recently at the International AIDS Society conference in 2007, he was told that he was “at the wrong conference” when he tried to advocate for better collaboration between TB and HIV communities.

PT also remarked on the paternalistic relationship between doctors and patients when it comes to TB. Under the DOTS strategy, TB patients need to be observed taking their drugs whereas HIV patients are responsible for adhering to their regimen. The TB community has a lot to learn from the HIV community who have been able to mobilise political commitment and resources through activism. TB activists are still few in number often because once someone has been cured of TB they prefer to forget all about it.

Paul's message to the HIV community was that people living with HIV need to acknowledge their own vulnerability to TB and to engage with other communities who are also vulnerable to TB.

Presentation 4 – Neil Gerrard

Neil Gerrard MP reiterated that not enough is being done to address TB/HIV. We all recognise the links but need to take them beyond statistics and translate them into practice. Commitments have been made, but not delivered.

Previous speakers had commented on what governments and civil society can do to address the co-epidemic but clinicians also have an important role to play and knowledge gaps of people working on TB and HIV need to be filled.

NG attended a recent conference in Moscow on Public Private Partnerships to address TB and HIV in emerging economies. This highlighted additional challenges in countries where civil society is not well established e.g. Russia and China.

Russia has a high burden of TB and MDR-TB. One of the main drivers is the prison system – 1% of the population is in prison and 10% of those have TB. DOTS doesn't necessarily continue after patients leave prison. HIV rates are 75 times higher in prisons. This problem is on the doorstep of the EU so we can't ignore the problem. But DFID no longer has a presence in Russia so what can we play?

In China, DFID have helped to make a significant impact on TB but there has been poor integration of TB and HIV programmes. HIV rates are going up quickly. No money committed to China beyond 2010.

In the UK, there are 73,000 PLWHA. Increase on previous year, situation not improving. 8,500 TB cases reported in 2006. There are concentrated epidemics in parts of London with rates that match some high TB burden countries. NG noted that even Health Protection Agency reports on HIV/STDS and TB aren't linked.

More conversations are needed between NGOs, MPs and other stakeholders to discuss role and territories – need to get out of set ways of thinking. DFID are preparing a new AIDS strategy in early 2008 which presents an opportunity to integrate TB into DFID's AIDS policy. More research is needed into the role of the Department of Health on TB/HIV.

Questions and comments

1. Concern about how TB is counted globally. TB rates will be seen to go down if HIV-positive people dying of TB are counted as HIV deaths.

AR – The WHO counts HIV-related TB deaths as TB. However different countries (and regions of countries) will have different methods for registering deaths. In South Africa, the opposite is true where TB is often written as a cause of death instead of HIV because of the stigma attached.

2. Was Paul Thorn's TB treated seriously by others?

PT – His was the first recorded outbreak of TB on an HIV unit. He had to spend three months in an isolation unit – so, perhaps it was taken too seriously!

3. (Referring back to question 1) Many cases are not reported at all so how can we be sure that statistics are accurate?

AR – WHO measures notified cases. Total estimated incidence takes into account that data received may be incomplete.

NG – Quoting bold figures causes problems especially when there is a revision. We should not get hung up on statistics, whether there are 30 or 40 million people with HIV it is too many!

4. In response to NG's comment about Health Protection Agency reports, a representative from the HPA said that data for TB and HIV in the UK is combined but is not reported together in their main reports.

5. An audit of TB/HIV co-infection in the UK is being carried out in 2008. There are concerns about the management of both. Not automatic that people with TB are offered HIV testing and vice versa. Also, TB contact testing doesn't factor in the possibility of HIV links.

AR – UNAIDS is working with civil society to try and improve data collection and case findings. The British Thoracic Society in the UK does not recommend HIV testing for TB patients (a member of the audience commented that it is policy for people in London with TB to be tested for HIV).

6. Re-emphasising the lack of funding for research and development. As well as trying to develop new drugs for TB we also need to try and reduce the duration of the current regimen. It should be possible to manipulate current regimens to 2/3 months but researchers cannot get the support they need from DFID and others.

7. There is not enough communication about TB and TB/HIV on different platforms. What are the barriers?

AR – HIV is about sex; TB is about phlegm! XDR-TB has helped to raise the profile but we need to be careful about stigma. The Stop TB Partnership has offered journalism prizes in order to encourage more and better coverage of the issue. There are a number of international events/meetings coming up in 2008 which should be of interest to the media.

8. Comment that we need people to feel that TB does affect them. One way to engage people would be to have them focus on their own vulnerability.

9. Is there still an opportunity to input into the new DFID AIDS strategy? Could the APPGs make a joint statement on the need for TB to be included in it?

NG – Agrees that the APPGs should raise this issue with the Secretary of State for International Development. A joint letter was sent to Douglas Alexander by Neil Gerrard and Nick Herbert on behalf of both APPGs outlining the points raised in this meeting and requesting that TB be incorporated in DFID's updated AIDS strategy.