For our readers: A special thank you to those of you who continue to provide feedback for the new combined format for the TB Wire and the TB-Related News and Journal Items Weekly Update. Contents now include: Announcements, Washington Update, Resources/Trainings, Selected TB Reports, linkable Journal Abstracts, Grants, Job Opportunities and Meetings/Conferences/Events. A Table of Contents will be linkable in the near future. This continues to be a work-in-progress and feedback to setkind@stopbusa.org is welcome and encouraged.

WORLD TB DAY COMMENTARIES

FROM THE AMERICAN THORACIC SOCIETY: ATS Commemorates World TB Day 2013

On March 24, the global health and scientific community will commemorate World TB Day, the day in 1882 when Dr. Robert Koch announced that he had discovered the cause of tuberculosis, the TB bacillus. The global Stop TB Partnership's theme for World TB Day 2013 is again "Stop TB in my lifetime," and ATS joins with the Partnership in asking members to become advocates. Globally, the continued spread of drug-resistant TB is a major concern. Totally drug-resistant TB, which emerged last year in India, has now spread to South Africa, where it threatens to kill many HIV-TB co-infected people very quickly. According to the CDC's Emerging Infectious Diseases journal, TDR-TB is becoming extensive throughout several South African provinces.

On the domestic TB front, key priorities for the TB community are raising awareness and finding ways to address acute TB drug shortages. There is currently a serious national shortage of isoniazid, one of the main first-line TB drugs used to treat drug susceptible TB and shortages of several second-line drugs used to treat drug resistant TB, including kanamycin, amikacin and capreomycin. These shortages are creating serious access barriers for patients. And if people with TB are not being appropriately treated, communities are at risk for outbreaks.

On top of drug shortages, some city and state TB programs, such as the one in Baltimore, are absorbing funding cuts of up to 40 percent in one year because of the redistribution of CDC funding for state TB programs. These funding cutbacks are compromising TB programs' capacity to provide medically necessary
patient services and conduct contact investigations to control and prevent further disease transmission.

Funding will continue to be an issue for both global and domestic TB programs through USAID and CDC as the continued threat of across-the-board sequestration funding cuts still loom. Cuts of 8 to 9 percent would have a substantial effect on USAID’s ability to provide technical assistance to highly burdened countries and on the capacity of state programs to maintain control of TB in communities. The TB research pipeline into diagnostic, treatment, and prevention tools—which recently started to yield innovative advancements in diagnostics such as Xpert—is also under serious threat from budget sequestration, as NIH faces steep funding cuts.

The ATS and its partners will be raising awareness of funding, drug shortages, and other issues, as we commemorate World TB Day with a series of events in Washington, D.C., including educational briefings in the House and Senate for congressional members and staff.

**FROM THE HILL BLOG**

The Hill.com/Blogs

"US is unprepared to face another TB epidemic" Lee B. Reichman, M.D., New Jersey Medical School Global Tuberculosis Institute - 03/21/13 02:15 PM ET

The U.S. Centers for Disease Control and Prevention just released new data showing that the number of people contracting tuberculosis in the U.S. has been declining for twenty years. Last year, 9,951 people in the U.S. became sick with TB, compared with 25,103 people in 1993. This should be good news. Yet as a physician and advisor working to control TB for more than forty years, I’m more concerned than ever before about our ability to protect the public from this deadly airborne disease.

There are two forces working against us. The first is diminishing resources. The current trend in funding for TB control clearly shows a dangerous public health phenomenon at work: the "U-shaped curve of concern." When a serious disease like TB catches the attention of the public and policymakers, more resources are directed to control it. New cases drop as those resources take effect and a measurable impact on the disease is reported. As cases come down, resources get reduced or appropriated elsewhere – and cases rise again. In other words, the program is eliminated rather than the disease. When this happens, the consequences can be dire.

In the late 1970’s and early 1980’s, TB rates fell nationally. Congress declared victory, cut funding, and the cost-effective programs that had worked so well were abolished. Just as the U-shaped curve predicted, between 1985 and 1992 we witnessed the most rapid increase in TB rates of any industrialized country ever: 20 percent in adults, 35 percent in children. Hundreds of millions of taxpayer dollars had to be appropriated to contain a completely avoidable epidemic. New York City was hit by an epidemic of multidrug-resistant TB, which cost more than a billion dollars to reverse. A frenzy on the floor of the New York Stock Exchange ensued after a stock trader was diagnosed. Media reports described widespread panic among the city’s residents, with long lines of patients waiting to be tested.

America is woefully unprepared to face another TB epidemic today, particularly of the drug-resistant variety.
Accounting for inflation, domestic TB funding has dropped by half since 1994. As a result of the federal government’s "sequester," the CDC’s Division of TB Elimination, which administers TB resources, will see additional cuts between five and nine percent this year. The Global Fund to Fight AIDS, Tuberculosis and Malaria, which protects Americans from TB by fighting it abroad, will see similar cuts. This drop in funding has opened the door for another TB resurgence. We’re already seeing signs.

Take what happened last year in Florida. Though the state faced its largest TB outbreak in 20 years, it closed its last remaining TB hospital to save money. Thirteen people died in the outbreak and many more were infected. Officials continue to watch for new cases they might have missed. Los Angeles is now grappling with the city’s largest TB outbreak in a decade, in which 4,500 people have been exposed. CDC is helping to contain the outbreak, but the agency may have to pull back if the sequester’s cuts go through.

The second force working against us is accelerating drug resistance. The World Health Organization reports that from 2009 to 2011 cases of multidrug-resistant TB doubled in the 27 countries most affected. Meanwhile, the severity of the resistance is increasing. Since the last U.S. epidemic, we’ve seen the emergence of extensively drug-resistant TB. This strain of the disease overpowers not only the two most powerful first-line drugs, but at least two of the backup drugs used solely to treat resistant strains. Totally drug-resistant TB was discovered in the last year, first in India then in South Africa. Such cases resist all available antibiotics and are sure to be found elsewhere – an unavoidable fact when one can travel almost anywhere by plane within 24 hours. Americans are no less vulnerable. U.S. immigration officials are currently holding a Nepalese man with extensively drug-resistant TB in medical isolation. He’s merely one of more than 300 people in the U.S. diagnosed in the past year with some strain of drug-resistant TB.

The only way to protect the public from a dangerous disease like tuberculosis is by providing public health workers the resources they need to sustain the fight against it. For too long Congress has withheld these resources, putting the nation at risk of another TB epidemic.

Reichman is a professor of Medicine and executive director of the New Jersey Medical School Global Tuberculosis Institute and author of Timebomb: The Global Epidemic of Multi-drug Resistant Tuberculosis.

blog.AIDS.gov – ADDRESSING THE NEEDS OF INDIVIDUALS COINFECTED WITH HIV AND TB
This weekend, we observed World Tuberculosis (TB) Day (Sunday, March 24), a day to remember that the global burden of TB remains enormous, particularly among people with HIV/AIDS, among whom TB is the leading cause of death, worldwide. According to the World Health Organization (WHO), in 2011, 1.4 million people died from TB, including 430,000 deaths among people who were HIV-positive. TB is also one of the top killers of women around the globe, with 300,000 deaths among HIV-negative women and 200,000 deaths among HIV-positive women in 2011. TB is also a health threat among people living with HIV in the United States. In 2011, the Centers for Disease Control and Prevention (CDC) estimates that 6% of all TB cases in the U.S. and 10% of TB cases among people aged 25–44 occurred among people who are living with HIV.

FROM WHO/Global Fund
Attached is the link to the WHO/Global Fund press release, related factsheet and infographic released in
commemoration of World TB Day and reporting on estimated funding needs, gaps and priorities especially for low and middle-income countries in need of international support. The figures were developed by WHO and the Global Fund, out of work with selected high-burden countries (including the workshop organized with the Stop TB Partnership earlier this year) and further analytic work on domestic financing and global financing.

WHO Media Center

http://www.who.int/en/


www.who.int/tb/WTBD_finance_Infographic.png.

http://www.who.int/tb/en/

FROM FORBES

"To Stop Tuberculosis In Its Tracks, Urgent Global Action Is Needed" Dr. John C. Lechleiter, President, Chairman and Chief Executive Officer of Eli Lilly and Company, Forbes, March 19, 2013

As we marked World TB Day on Sunday March 24, there can be no denying that TB, fueled by drug resistance, continues to pose a serious global health threat – one that must be urgently addressed. An outbreak of drug-resistant TB in New York City in the early 1990s cost more than $1 billion and killed 29 Americans. With resistance spreading, we need a renewed global commitment that combines public and private efforts to defeat TB. According to the World Health Organization, more than eight million people became infected with TB and 1.4 million died in 2011 – that’s about the entire population of Greater Indianapolis, the city where I live. And between 2009 and 2011, drug-resistant TB cases doubled in the 27 most-affected countries.

Yet there are plenty of reasons to be optimistic. New partnership models are marshaling the resources and knowledge required to produce new TB innovations that can outflank the disease – and ensure that patients benefit from them. For example, Cepheid has developed a rapid diagnostic test, GeneXpert, which can identify TB – and the presence of drug-resistant bacteria – in about two hours. The U.S. government and the Bill & Melinda Gates Foundation are now collaborating in countries with high TB burdens to subsidize the purchase of these state-of-the-art tools. Lilly is collaborating on early-stage research with six other pharmaceutical companies – Abbott, AstraZeneca, Bayer, GlaxoSmithKline, Merck and Sanofi – and four academic institutions to identify faster-acting TB drug candidates. Shortening treatment time from the current minimum of six to two months would keep an additional one million people on TB treatment each year, reducing deaths and slowing the development of drug resistance. Furthermore, the FDA just fast-tracked approval for Sirturo, a treatment for drug-resistant TB produced by Janssen Pharmaceuticals – and the first new TB medicine in five decades. There are several agencies that could now facilitate access to the drug in low-income countries, including the Stop TB Partnership’s Global Drug Facility and the Global Fund to Fight AIDS, TB and Malaria.
While these are important pieces in the fight against TB, much more is needed. For starters, we must do better at the basic blocking and tackling of TB strains that we can treat and cure today – with prevention and proper treatment being paramount. More healthcare professionals must be trained in high-burden countries to deliver quality TB care. And we must improve access to internationally quality-assured medicines. A study published last month in the International Journal of Tuberculosis and Lung Disease found that nearly one in 10 TB drugs sold in 17 low- and middle-income countries was either falsified or substandard. This trend is likely contributing to drug resistance. With political momentum gathering to address non-communicable diseases, public and private actors should be also be looking to integrate TB control with programs targeting diabetes, for example. According to researchers at the Harvard School of Public Health, diabetes may be responsible for more than 10 percent of TB cases in India and China. Like HIV/AIDS, it weakens the immune system, making patients more vulnerable to TB. With that in mind, healthcare workers that are screening for diabetes should be trained to identify TB’s telltale cough and refer patients appropriately.

The countries hit hardest by TB must commit more resources to the fight. The BRICS countries – Brazil, Russia, India, China and South Africa, which account for about 60 percent of global TB cases – have announced a coordinated effort to tackle drug-resistant TB. This is a welcome step that must now be followed by concrete actions to strengthen health systems. In India and China, fewer than 10 percent of drug-resistant cases were confirmed by diagnosis in 2011. We must do a better job of identifying drug-resistant TB in these countries, giving patients the right treatment, and limiting the spread of this disease that can be passed through a simple cough.

From a decade of experience through Lilly’s own MDR-TB Partnership, I can tell you that none of this will be easy. And that’s why above all, we need more coordinated, high-profile global advocacy for TB control. The tide began to turn against HIV/AIDS when a critical mass of voices coalesced to demand action. With drug resistance accelerating, that time is now for TB.

ANNOUNCEMENTS

FROM THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

CDC reports lowest US TB rate in 20 years

New provisional data from the Centers for Disease Control and Prevention (CDC) show the rate of tuberculosis disease (TB) fell to an all-time low in 2012. Published in today’s Morbidity and Mortality Weekly Report, Trends in Tuberculosis — United States, 2012 CDC reports that in 2012 there were 9,951 cases of TB reported in the U.S., a rate of 3.2 cases per 100,000 population; this compares with 10,528 cases and rate of 3.4 in 2011.

The report also shows that:

- While TB cases are spread across the U.S., 4 states (California, Texas, New York, and Florida) account
for 50% of the reported cases of TB in 2012.

- More than half of all U.S. counties (56%) reported at least one new case of TB in 2012.
- TB continues to take a high toll among certain populations, including racial/ethnic minorities, foreign-born persons, persons living with HIV, and the homeless.
- TB rates for Hispanics and blacks are 7 times higher than for whites and 25 times higher for Asians.
- TB rates are 12 times higher among the foreign-born than among those born in the U.S., with more than half of the cases among the foreign-born in 2012 reported from those born in 5 countries (Mexico, Philippines, India, Vietnam, and China).
- Homeless individuals are particularly vulnerable because of crowded living situations, poor nutrition, and alcohol and substance abuse, and treating TB in this population is challenging.

While progress has been made in addressing TB disease, drug resistant TB remains a serious threat to treating and controlling TB. New tests to diagnose TB, particularly drug resistant strains, more rapidly are needed, as are new treatments. Other challenges include shortages of first-line TB drugs and addressing latent TB infection (LTBI). People with LTBI have no symptoms and are not contagious, but an estimated 5 – 10% of people with LTBI will develop TB disease if their LTBI is not treated. Approximately 4% of the U.S. population (11 million people) has LTBI.

CDC is taking steps to accelerate progress against TB and guard against the kind of resurgence that occurred in the 1990s. These steps include strengthening global partnerships, addressing TB in the parts of the U.S. hardest hit by this disease, working with other government agencies and the private sector to support the development of new tests and treatment regimens, and helping maintain capacity at state and local health departments for diagnosis and assurance of completion of treatment.

**CDC: The Public Health Associate Program (PHAP)**

Improve your ability to deliver public health services and become a Host Site. PHAP currently has 158 public health associates fulfilling workforce needs in public health agencies across 34 states, two tribes, one territory, and the District of Columbia. While PHAP offers tremendous benefits to the associates through training and support, the host site also receives numerous benefits, including:

- CDC-funded field assignees who bring valuable skills to host agencies and who are well-rounded, energetic, flexible, and career-minded individuals with unlimited potential
- Access to CDC materials, information, and subject matter expertise
- Online learning opportunities for host site supervisors shortages

**APPLY TO HOST AN ASSOCIATE TODAY!**

Visit [www.cdc.gov/phap](http://www.cdc.gov/phap) for application instructions and for more information about this training and service.
program. The application period will be open **March 1–April 5, 2013**. PHAP is offering application technical assistance for prospective host sites in March 2013. Details will be shared via email and posted on the host site application process page. Email: phap@cdc.gov

**WASHINGTON UPDATE**

Thanks to Nuala Moore for the following updated information. Nuala is the Senior Legislative Representative at the American Thoracic Society Washington Office.

**Domestic Funding Update**

On March 1, the deadline officially passed for the implementation of budget sequestration funding cuts. Federal agencies including the CDC are now developing plans for how to implement across the board funding cuts of 5 - 7%. Although the technical deadline has passed, there is a possibility that Congress and the Administration could work out a new agreement to mitigate some of the cuts, but at this point, there is no such plan. The House and Senate have passed a continuing resolution to fund government programs for the rest of Fy2013 at the FY2012 level. New members have been selected for the House Appropriations subcommittee that allocates TB funding for CDC. The new subcommittee chair is Jack Kingston (R-Savannah, GA). Rep. Lowey (D-NY) remains as the Democratic Ranking member. The new democratic member is Congressman Honda from California. This is good news because of his demonstrated support of TB.

Other new subcommittee members include Reps. Joyce of Ohio (Cleveland), Fleischman (Chattanooga, Tennessee) and Womack (R-AR). In the Senate, Iowa Senator Harkin remains the Chair of the Labor-HHS Appropriations subcommittee. New members on the subcommittee are Merkley (D-OR), Tester (D-MT), Shaheen (D-NH) and Boozeman (R-AR).

The TB caucus now has 17 members. We urge Stop TB USA members to ask their House Representatives to join the Caucus in order to expand support for TB funding in the House.

Regarding reauthorization, a work group is drafting an update to the current TB authorizing legislation - the Comprehensive TB Elimination Act that will be expiring in 2013. They aim to draft a bill that addresses all the emerging and ongoing issues (drug resistance, foreign born TB, etc.) and present to potential sponsors in 2013.

**NEW RESOURCES**

**FROM RESULTS**

*Conference on Retroviruses and Opportunistic Infections* (CROI) webcasts available for viewing

Please see the link below for a complete listing of webcasts from this year’s CROI meeting. It also includes webcasts from prior years meetings for those who are interested. [http://webcasts.retroconference.org/](http://webcasts.retroconference.org/)
There are several TB specific sessions, including the data from the RIFAQUIN and High-RIF trials and the article that is highlighted below.

**FROM TREATMENT ACTION GROUP (TAG)**

- Do you have questions about bedaquiline, the new drug to fight tuberculosis (TB)? If so, please see *An Activist’s Guide to Bedaquiline*, a new guide from Treatment Action Group (TAG): [HERE](#) As bedaquiline (also called Sirturo or TMC207) is filed for marketing approval in countries all over the world, now is the time to learn more about bedaquiline. The guide is designed to explain the safety and efficacy of bedaquiline. It also describes what you as an activist can do to help ensure access, fair pricing and further research. The guide provides messages that regulatory authorities need to hear to prepare for bedaquiline and other new TB drugs.

- **Children with Drug-Resistant Tuberculosis Require Urgent Attention**
  — *Research and access required to achieve zero deaths, new infections, and suffering* —

NEW YORK, NY – Treatment Action Group (TAG), in partnership with the Sentinel Project on Pediatric Drug-Resistant Tuberculosis (Sentinel Project) released today *We Can Heal: Prevention, Diagnosis, Treatment, Care and Support: Addressing Drug-Resistant Tuberculosis in Children* ([HERE](#)).

This collection, released in anticipation of World TB Day on March 24, calls for urgent attention to the global problem of pediatric drug-resistant tuberculosis (DR-TB). The stories of 30 children with DR-TB in 30 countries are a testament to the need for improved programs, policies, and tools to reach the goal of zero TB deaths, new infections, and suffering. "Children are sentinels both for recent transmission of DR-TB and for our collective response to this disease," said Dr. Mercedes Becerra, cofounder of the Sentinel Project. "Each child's story shows us how our current inadequate tools and practices make children with TB invisible and helps us discern how to reverse this neglect."

For example, DR-TB killed Lebogang, a three-year-old from Botswana who did not receive effective therapy until nearly a year after his TB diagnosis. His story reveals unacceptably long lag times between diagnosis and appropriate treatment for DR-TB. Menkhu, a 15-year-old from Nepal, struggles to keep down 13 pills each day and has lost her hearing due to her medications, showing the pressing need for more tolerable TB drugs in child-friendly formulations.

In the absence of reliable data on pediatric DR-TB, these stories are critical. "*We Can Heal* is vital to our understanding of this global threat to children," said Colleen Daniels, TAG’s TB/HIV Project Director. "Until adequate investments are made to gather data about the real numbers of children affected by DR-TB, these individual cases are our richest source of information.* We Can Heal also bears witness to the courage of children who fight against DR-TB, and the crucial support of family members and care providers. Pediatric DR-TB is preventable and curable. As Sofia, a DR-TB survivor from Colombia states, "We can heal." To get to zero child deaths from TB, however, the global community must commit long overdue political will and resources to address the gaps identified in this collection.
FROM DOCTORS WITHOUT BORDERS (MEDECINS SANS FRONTIERES - MSF)

HISTORIC OPPORTUNITY TO TACKLE DRUG-RESISTANT TUBERCULOSIS AT RISK (Call to sign the Manifesto)
People on DR-TB treatment and their caregivers from around the world outline their demands in the Test me, treat me manifesto, and urge others to join their call for urgent action.

Geneva/New York, March 19, 2013 — Two new drugs effective against drug-resistant tuberculosis (DR-TB) must be introduced in a way that offers shorter and less toxic treatment regimens in countries with a high burden of the devastating disease, a group of people living with DR-TB and the international medical humanitarian organization Doctors Without Borders/Medecins Sans Frontieres announced in a public manifesto issued today. After close to five decades of insufficient research and development into TB, the new medicines—bedaquiline and delamanid—have recently been or are about to be approved. Research is urgently required to determine the best way to use these new drugs so that treatment can be made shorter and more effective, and provided to the growing number of people with DR-TB. If measures to tackle DR-TB are not immediately expanded, rates of the disease will continue to increase worldwide, and a historic opportunity to improve abysmal cure rates will have been squandered, MSF warned.

"We have been waiting for half a century for new drugs that are effective against tuberculosis," said Dr. Erkin Chinasylovam, TB doctor for MSF in Swaziland. "Must we wait another fifty years to seize this historic opportunity to improve and roll out treatment for drug-resistant TB? Getting better treatment is beyond urgent, but we are not seeing anything like the level of prioritization required to make this a reality."

"It’s 2013 and I’m beginning a fourth year of living with TB, when I should be in my fourth year at university," said Phumeza Tisile, a 22-year-old woman who receives treatment for extensively drug-resistant TB from MSF in Khayelitsha, South Africa, and is one of the signatories of the manifesto. "I’ve swallowed around 20,000 pills and received over 200 daily painful injections since I started treatment in June 2010, and the drugs have left me deaf. I wish I could take just two tablets a day for a month or so and be cured."

The number of people receiving DR-TB treatment globally remains shockingly low, at less than one in five. Greater political and financial support from the international community is needed to address this gap.

FROM THE UNION

The Union offers hope and practical advice on multidrug-resistant tuberculosis
The Union is marking World TB Day this year by publishing a new guide that offers clear, practical advice on one of the trickiest aspects of "stopping TB" – how to manage the estimated 630,000 patients who have multidrug-resistant TB (MDR-TB). Read more...
The Union to coordinate study of shortened MDR-TB regimen in francophone Africa

The Union has received a grant from France Expertise International / Initiative 5% to coordinate an operational research study on the effectiveness of a shortened MDR-TB regimen. The study will be conducted in 9 francophone African countries. The hope is that the results of the study will lead to a change in the current international guidelines.

FROM NEWS SOURCES

National

"A Mans Journey From Nepal To Texas Triggers Global TB Scramble" (HERE)


The Wall Street Journal is chronicling the world's imperfect response to the rise of drug-resistant tuberculosis, an ancient disease that modern medicine, until recently, could defeat. In its drug-resistant forms, TB can still be fatal, and the treatment may be painful, requiring up to two years or more of medication and potentially months of isolation. Costs are steep too; according to a recent CDC study, treatment on average in the U.S. was about $140,000 and ran as high as $700,000.

TIJUANA, Mexico—He was like many people in their early 20s, at least the type with spiky black hair and two lip rings. Four years ago, while living in this teeming border city, Gonzalo Garcia says he spent free time in the U.S., to shop, meet girls, and "hang out." He had no idea he was developing a potentially deadly form of tuberculosis. Exactly how long he had it will never be known. He says he started losing weight and becoming tired and tried to get help. But it took a year before a doctor finally figured out what was wrong: He had a drug-resistant strain of TB. "Many doctors said I was just fine," said Mr. Garcia, sitting in the clinic where he was cured.

The Tijuana General Hospital TB Clinic in Mexico is working to treat drug-resistant strains of tuberculosis. Many people with the deadly disease enter the U.S. from Mexico. WSJ's Betsy McKay reports. To this day, it isn't clear if he infected anyone on either side of the border while he was contagious. But his tale illustrates a nagging concern among health officials who say the 2,000-mile border between the U.S. and Mexico could become a breeding ground for one of the hardest forms of TB to treat. Already, both California and Texas, as well as some states on the Mexico side of the border, have unusually high rates of drug-resistant TB. "This is a very hot region" for drug-resistant TB, said Rafael Laniado-Laborin, chief of Tijuana General Hospital’s tuberculosis clinic and laboratory, who has had an influx of new patients recently—including one who recently returned from the U.S. and is in the middle of treatment. With tuberculosis of any form, people can get around until the disease is quite advanced. "You will go and work and move around," he said. "You will transmit the disease before you know you're sick."

To be sure, the actual number of cases in the U.S. and Mexico is still small and the rates of multidrug-resistant TB—or MDR—are nowhere near as severe as India, China, or Eastern Europe, where drug-resistant TB is at epidemic proportions. In 2011, the most recent year available, Mexico had 467 MDR-TB cases, the World Health Organization estimates, while the U.S. had 124, according to the Centers for Disease Control and
Prevention. Almost half of the U.S. cases came from California and Texas. Health officials say it is crucial to jump on prevention now, because the disease is transmitted airborne and can spread quickly.

"We're all connected by the air we breathe," said Thomas Frieden, Director of the CDC, and a TB expert who successfully battled a major outbreak of multidrug-resistant TB in New York City in the 1990s, then spearheaded India's TB-fighting program for the World Health Organization.


ATLANTA – A novel TB treatment regimen featuring once-a-week therapy produced results equivalent to those seen with the standard once-daily approach, a researcher said here. The finding, from a randomized trial, could have a "massive impact on adherence rates and cure rates," said Amina Jindani, MD, of England's St. George's University of London. The novel regimen would allow more intensive supervision of therapy in the so-called continuation phase of the 6-month TB treatment, Jindani reported here at the Conference on Retroviruses and Opportunistic Infections. The findings have "rekindled" hope for once-weekly TB therapy, commented Richard Chaisson, MD, of Johns Hopkins University, who moderated a press conference at which the study was presented. Chaisson noted that a U.S. trial, conducted a decade ago, did not show as good a result and -- although the FDA approved weekly treatment with rifapentine (Priftin) -- many clinicians were not convinced. "I think everyone had given up hope for a once-weekly regimen," he told MedPage Today. "The hope has been rekindled."

The current World Health Organization recommendations for TB treatment involve daily isoniazid (Nydrazid), rifampin (Rifadin), pyrazinamide, and ethambutol (Myambutol) for 2 months, followed by daily isoniazid and rifampin for another 4 months. During the early intensive phase, patients take their drugs under supervision – so-called directly observed therapy – but many falter in adherence during the continuation phase, when they take the medications without supervision.

In the novel regimen, treatment was still daily and directly observed in the intensive phase, but the antibiotic moxifloxacin (Avelox) was substituted for isoniazid. The big difference, Jindani said, came in the continuation phase, when 1,200 milligrams of rifapentine and moxifloxacin, taken weekly, were substituted for daily isoniazid and rifampin. The weekly dosing, she said, allowed directly observed therapy to be continued throughout the 6 months of treatment. In the study, Jindani and colleagues looked to see if the two regimens were within a 6-percentage point non-inferiority margin in terms of treatment failures 18 months after randomization. In the intent-to treat analysis, she reported, the proportions of failures were identical – 14% in each arm – and therefore the difference was within the non-inferiority margin. A shorter, 4-month regimen based on rifapentine and moxifloxacin was inferior to the standard treatment, she reported. The adverse event rates were also similar between the two successful regimens. There were 17 severe or life-threatening events – grades 3 and 4 – in each arm at any time during chemotherapy, Jindani reported. Jindani said earlier trials of rifapentine had unacceptably high relapse rates, which she and her colleagues attempted to overcome by giving a higher dose of the drug.

But Chaisson and other experts said changing clinical practice is going to take time because most TB therapy is conducted under strict guidelines by public health authorities, even in the U.S. Among other things, a change...
would require retraining thousands of nurses in the new protocol, commented Andreas Diacon, PhD, of Stellenbosch University in Tygerberg, South Africa, who was not part of the study. And, he told MedPage Today, public health authorities will probably want to have cost-effectiveness data before they make any changes. Jindani herself—a renowned TB researcher—said the only obstacle she sees is cost, because rifapentine, is much more expensive than rifampin. On the other hand, she told MedPage Today, "if there's uptake, the cost will very, very quickly come down." She added there are some people—those resistant to isoniazid, for instance—for whom the new regimen could be used immediately.

**International**

"Mozambique Turns to Technology in Battle Against Tuberculosis ", Lucy Lamble, Guardian, March 12, 2013

Support from the global health organization Unitaid will enable every province in Mozambique to have a GeneXpert machine, which provides automated testing that cuts the time required for TB diagnosis from two to three months to two hours. Health care workers collect a sputum sample in a testing cup, place the sample in a cartridge, and test the sample for TB bacteria in the GeneXpert machine. As a result, health care providers can diagnose TB and start a patient on drug therapy for multi-drug resistant TB in the same day.

Mavalan Hospital nurse Armanda Metens Novela stated that the delay required by current testing methods causes the hospital to lose track of approximately 20 percent of TB patients, requiring expensive follow-up tracing. Dr. Gael Ciaquin, World Health Organization national protection officer for TB, cautioned that the increase expected in new diagnoses will strain treatment resources. Mozambique currently diagnoses 50,000 new TB cases annually; incidence is probably closer to 100,000. Ciaquin stated that the GeneXpert machine will be helpful in diagnosing infections in children and cases linked to HIV, which is associated with hard-to-treat TB forms. The GeneXpert machine, originally developed for anthrax testing, is small and easy to transport to remote locations.

Brazil, Chile, France, Norway, and Britain formed Unitaid in 2006; since then, Unitaid has invested $40 million in healthcare in Mozambique. Funding for Unitaid comes from a "solidarity tax" of $1 for economy passengers and $40 for business and first-class airline passengers, levied by Cameroon, Congo-Brazzaville, Madagascar, Mali, Mauritius, and Niger. The solidarity tax has raised €1billion. United Kingdom funding comes from the Department for International Development. Support from the Bill and Melinda Gates Foundation, USAID, and PEPFAR reduced the cost of the cartridges used in the GeneXpert machine from $16 to $10 for 145 low-income countries.

"Steroids May Help Reduce Deaths from all Types of Tuberculosis ", Medical Xpress, March 12, 2013

A team led by researchers from St. George’s, University of London, reviewed results of 41 TB studies conducted between 1955 and 2012 and found there were 17 percent less deaths among patients taking anti-TB drugs and corticosteroids (steroids) in comparison to patients taking only anti-TB drugs. While most TB cases are the pulmonary form of TB, other forms of TB can attack almost any organ. The review included pulmonary, pericarditis, meningitis, peritonitis, and pleurisy TB studies. The team analyzed data from 41 major TB trials on the efficacy of corticosteroids, which are based on adrenal gland hormones, in combination with
anti-TB drugs. The study included 3,560 patients who had received both TB drugs and steroids, and 2,982 who had received only TB drugs. The participants’ treatment regimens varied in dosage and duration.

Prof. Julia A Critchley, DPhil, reports that, regardless of the TB form, adding steroids to anti-TB drugs lowered the risk of death for all patients. Until now, steroids have only been proved effective as a secondary treatment for meningitis and pericarditis forms of TB. Critchley cautioned that before recommending steroids for all TB patients, further studies should address the benefits of steroids in combination with current TB drugs and consider whether the benefits of steroids outweigh harmful side effects. The most effective current anti-TB drug, Rifampicin, was not available during the 19 trials conducted prior to 1983. Taking steroids makes patients more vulnerable to other infections. Research associate Fiona Young stated that the presence of drug-resistant forms of TB and the effects of HIV on TB treatment underscore the importance of understanding the benefits of steroid treatment.


"Agencies warn of global TB "powder keg", funding gap", Kate Kelland and Stephanie Nebehay Reuters, March 18, 2013

LONDON/GENEVA (Reuters) - Deadly strains of tuberculosis that are resistant to multiple drugs are spreading around the world, and authorities urgently need another $1.6 billion a year to tackle them, global health officials said on Monday. Donors should step up with "significant funding" to help experts track down all existing cases and treat the most serious ones, the World Health Organization (WHO) and the Global Fund to Fight AIDS, TB and Malaria said in joint statement.

Margaret Chan, WHO director general, said nearly 4 percent of people newly infected with TB worldwide were resistant to multiple drugs from the start - signaling that resistant forms of the disease were being transmitted directly from person to person. In some countries, including regions of Russia, up to 35 percent of new cases are multi-drug resistant. "This gives you an idea of powder keg we are sitting on," Chan told a news briefing in Geneva, where both agencies are based.

TB is often seen as a disease of the past - but the emergence over the past decade of strains that cannot be treated with existing drugs has turned it into one of the world's most pressing health problems. Of all infectious diseases, only HIV - the human immunodeficiency virus that causes AIDS - kills more people. In 2011, 8.7 million people fell ill with TB and 1.4 million died of the disease. The WHO says as many as 2 million people may be infected with drug-resistant strains by 2015, up from the current estimate of 630,000.

Treating even typical TB is a long process. Patients need to take a cocktail of antibiotics for six months and many fail to complete the treatment. That, alongside overuse and misuse of antibiotics, has fuelled drug resistance. Multi-drug resistant TB withstands two standard drugs. And an even more severe form known as extensively drug-resistant TB - which can evade even the most highly effective drugs - was reported in at least 77 countries in 2011, according to the WHO. Doctors in India have also reported cases of totally resistant TB,
for which there are no effective drugs.

FUNDING GAP

The WHO and the Global Fund said they had found an anticipated gap of $1.6 billion in annual international support for the fight against TB in 118 low and middle income countries. If this gap were filled, it could mean 17 million patients with TB and multi drug-resistant TB could be fully treated, saving about 6 million lives between 2014 and 2016, they said. Mark Dybul, executive director of the Global Fund, said if donors did not act now, costs of dealing with drug-resistant TB could rocket. "It is invest now or pay forever," he said.

Russia, India, China and South Africa together account for nearly two-thirds all multi-drug resistant TB cases, said Mario Raviglione, director of the WHO's Stop TB department. "This is a global epidemic and one that we need to take seriously globally," Dybul said. The agencies said most of the extra money was needed to step up the accurate diagnosis of TB, and the process of establishing which drugs it may resist. Cash was also needed to improve access to effective medicines.

On top of the $1.6 billion funding gap, the WHO and its partner health agencies said another $1.3 billion a year was needed to boost research on TB and encourage the development of new drugs, diagnostic tests and vaccines. The vaccine known as Bacilli Calmette-Guerin, or BCG, is given routinely to babies in countries with high rates of TB to prevent severe disease. But its protection wears off in a few years and it does not protect against the most common form of TB that invades the lungs of adults and adolescents. Eagerly awaited results last month from trials of the first new TB vaccine for 90 years were disappointing, showing it offered no added benefit over BCG. Drug companies and research groups are working on other potential new vaccines but scientific progress is proving tricky and slow.


To assist India in its fight against TB, the nonprofit Clinton Health Access Initiative and a McGill University professor brokered a deal with several makers of diagnostic equipment to give private Indian laboratories the same discounts on equipment to detect multidrug-resistant TB as is offered to the government of India and other developing countries. The laboratories agreed to a price that is about half of the current market price in India. According to Madhukar Pai, an associate professor at McGill University in Canada and one of the world’s top TB experts, they were able to convince the manufacturers that if the diagnostic equipment were more affordable, a greater number of patients would use them, which would be good for the manufacturers and for TB control. The Indian Government, with the support of the World Health Organization (WHO), runs a national program that tests and treats patients for free. However, about half of India’s TB patients do not use the government program because they assume that they will receive substandard medical care in the public sector. Instead, they use private medical providers, who may offer cheap, inaccurate tests and inadequate treatments, hence increasing drug-resistant strains.

India’s Central TB Division has not endorsed the new initiative. As a result, it is difficult to determine its impact. It is important for New Delhi’s support of the initiative to persuade private physicians and patient to use the tests. Dr. Navin Dang, a New Delhi laboratory owner and an organizer of the initiative, said that WHO
has endorsed all of the discounted diagnostics, and they are widely used globally. Indian TB officials argue that they have not validated some of the tests and even after about a year of pilot tests, the TB division has not adopted GeneXpert, a rapid test to detect TB and drug resistance in two hours. Dr. Pai and Dr. Dang recently canceled plans to announce the initiative because of the TB Division’s refusal to participate. Pai noted that to get a huge uptake, government’s participation was needed to get the word to private-sector doctors and patients about the tests and the discounted prices. Even a personal visit by Dan and other organizers to the TB Division could not move the officials. The Joint Secretary of Health for India Anshu Prakash, who oversees TB, commented that he was not told why the TB Division did not endorse the initiative, but he suggested that it may have been because a written proposal was not submitted. Prakash also stated that he needed to review a proposal in writing before giving his endorsement.

**JOURNAL ARTICLES (March 9 – March 22, 2013)**


Am J Respir Crit Care Med. 2013 Mar 7. [Epub ahead of print]


18-fluorodeoxyglucose positron emission tomography for tuberculosis diagnosis and management: a case series. Heysell SK, Thomas TA, Sifri CD, Rehm PK, Houpt ER.


Multidrug-resistant tuberculosis. Lemos AC, Matos ED.

Tuberculosis in Brazil: Last ten years analysis - 2001-2010. de Oliveira GP, Torrens AW, Bartholomay P, Barreira D.


A meta-analysis of self-administered versus directly observed therapy effect on microbiologic failure, relapse, and acquired drug resistance in tuberculosis patients. Pasipanodya JG, Gumbo T.
**Clin Vaccine Immunol.** 2013 Mar 13. [Epub ahead of print]


**Curr Drug Targets.** 2013 Mar 6. [Epub ahead of print]

Strategies for Developing Tuberculosis Vaccines: Emerging Approaches. Mollica A, Stefanucci A, Costante R.

**Infection.** 2013 Mar 7. [Epub ahead of print]

Primary inoculation tuberculosis after an accidental scalpel injury. Huang D, Yin H.

**Int J Tuberc Lung Dis.** 2013;17


Converging risk factors but no association between HIV infection and multidrug-resistant tuberculosis in Kazakhstan. VAN DEN HOF S, Tursynbayeva A, Abildaev T, Adenov M, et al.


Successful management of multidrug-resistant tuberculosis under programme conditions in the Dominican Republic, RODRIGUEZ M, Monedero I, Caminero JA, Encarnacion M, et al.


Performance of the GenoType(R) MTBDRplus assay directly on sputum specimens from Brazilian patients with tuberculosis treatment failure or relapse. Maschmann RD, Spies FS, Nunes LD, Ribeiro AW, Machado TR, Zaha A, Rossetti ML.


Assessing Adherence to Accepted National Guidelines for Immigrant and Refugee Screening and Vaccines in an Urban Primary Care Practice: A Retrospective Chart Review. Waldorf B, Gill C, Crosby SS.

Systemic immune activation and microbial translocation in dual HIV/TB infected subjects. Toossi Z, Funderburg
**NT, Sirdeshmuk S, Whalen CC, Nanteza MW, Johnson DF, Mayanja-Kizza H, Hirsch CS.**

*J Infect Dis.* 2013 Mar 8. [Epub ahead of print]


**J Infect Dis.** 2013 Mar 12. [Epub ahead of print]

*Tuberculosis Relapse in Vietnam Is Significantly Associated With Mycobacterium tuberculosis Beijing Genotype Infections.* *Huyen MN, Buu TN, Tiemersma E, Lan NT, Dung NH, Kremer K, Soolingen DV, Cobelens FG.*

**J Int Assoc Physicians AIDS Care (Chic).** 2013 Mar 12. [Epub ahead of print]

*The Performance of Quantiferon-TB Gold in-Tube (QFT-IT) Test Compared to Tuberculin Skin Test (TST) in Detecting Latent Tuberculosis Infection (LTBI) in the Presence of HIV Coinfection in a High TB-Burden Area with BCG-Vaccinated Population.* *James PM, Ganaie FA, Kadhahali RL.*

**J Nutr.** 2013 Mar 20. [Epub ahead of print]


**MMWR Morb Mortal Wkly Rep.** 2013 Mar 22

*Tuberculosis control activities before and after hurricane sandy - northeast and mid-atlantic States, 2012. Centers for Disease Control and Prevention (CDC).*

**Pediatr Infect Dis J.** 2013 Mar 6. [Epub ahead of print]

*Bronchoscopic Evaluation in Childhood Pulmonary Tuberculosis: Risk Factors of Airway Involvement and Contribution to the Bacteriologic Diagnosis.* *Cakir E, Kut A, Ozkaya E, Gedik AH, Midyat L, Nursoy M.*


*Control of (Multi)Drug Resistance and Tuberculosis Incidence over 23 Years in the Context of a Well-Supported Tuberculosis Programme in Rural Malawi.* *Mboma SM, Houben RM, Glynn JR, Sichali L, Drobniewski F, Mpunga J, Fine PE, French N, Crampin AC.*

*Tuberculosis incidence correlates with sunshine: an ecological 28-year time series study.* *Koh GC, Hawthorne G, Turner AM, Kunst H, Dedicoat M.*

*Transcription of Genes Involved in Sulfolipid and Polyacyltrehalose Biosynthesis of Mycobacterium tuberculosis in Experimental Latent Tuberculosis Infection.* *Rodríguez JE, Ramírez AS, Salas LP, Helguera-


Molecular typing of mycobacteria isolated from extrapulmonary tuberculosis patients at Debre Birhan Referral Hospital, central Ethiopia. Garedew L, Mihret A, Ameni G.

Tuberculosis (Edinb). 2013 Mar 6. [Epub ahead of print]

Evaluation of antimycobacterial activity of a sulphonamide derivative. Agertt VA, Marques LL, Bonez PC, Dalmolin TV, Manzoni de Oliveira GN, de Campos MM.


New sputum metabolite markers implicating adaptations of the host to Mycobacterium tuberculosis, and vice versa. du Preez I, Loots DT.

Subpopulations of helper T lymphocytes in tuberculous pleurisy. Tong ZH, Shi HZ.


Vet Q. 2013 Mar 12. [Epub ahead of print]


COURSES

FROM THE RTMCCs:

The Southeast National TB Center (SNTC)

Arresting TB: Best Practices for Controlling TB in Corrections Date: 4/25/2013 Location: Louisville, Kentucky

This course highlights best practices for recognizing and controlling tuberculosis (TB) in correctional settings and is designed to enhance communication and collaboration between the local health department and correctional facility staff, both medical and custody. Attendees join in group discussion and actively participate
in exercises designed to foster skills for managing TB in correctional settings. Additional information can be found at: http://sntc.medicine.ufl.edu/Training.aspx

**Tuberculosis & Transplantation - Diagnosis & Management of Donor-Derived Infection** Date: 3/18/2013 Location: Archived webinar now available

This presentation, provided by Dr. Michele Morris, includes an overview of the organ procurement process and the current donor screening techniques. It outlines the current status of tuberculosis in transplantation and review the historical experience with donor-derived tuberculosis. Diagnosis and management of donor-derived tuberculosis is discussed. Additional information can be found at: http://sntc.medicine.ufl.edu/Webinars.aspx

**The New Jersey Medical School Global TB Institute**

**Medical Update: TB Technical Instructions for Civil Surgeons - Implications for Health Departments** Date: April 3, 2013 Location: Web-based

This webinar will provide an overview of the TB Technical Instructions for US civil surgeons and discuss their implications for health department providers. Case presentations will be used to explore strategies for collaboration as well as appropriate referral and follow-up of adjustment of status applicants. Additional information can be found at: http://www.umdnj.edu/globaltb/training/trainingcalendar.html

**TB Intensive Workshop** Date: April 23-26, 2013 Location: Newark, NJ

This workshop for clinicians provides comprehensive information on the principles and application of TB diagnosis and treatment, as well as the management of TB in special populations. Topics will include transmission and pathogenesis, diagnosis and treatment, drug resistance, TB-HIV co-infection, TB in children and adolescents, and key aspects of patient management. Lectures, interactive discussions, small group work and case studies will be used to enhance TB knowledge and clinical practice. Additional information can be found at: http://www.umdnj.edu/globaltb/training/trainingcalendar.html

**The Heartland TB Center**

Course Schedule Click Here for Class Information

**TB Nurse Case Management** Apr 9-11, 2013
Download: PDF Brochure (444 KB) »apply »

**Tuberculin Skin Test (TST) Practicum** Apr 11, 2013
Download: PDF Brochure (424 KB) »apply »

**Curry International Tuberculosis Center**

The Curry International Tuberculosis Center is pleased to announce that our 2013 Training Schedule is now
available, please visit: http://www.currytbcenter.ucsf.edu/training/schedule_2013.cfm.

**Tuberculosis Contact Investigation Interviewing Skills Intensive** April 30 – May 3, 2013 Oakland, California

The Curry International Tuberculosis Center will be conducting a 4-day Tuberculosis Contact Investigation Interviewing Skills Intensive. This training is designed for health professionals responsible for conducting tuberculosis contact investigation interviews. This training will include didactic lectures and small group activities focused on skill building for improved tuberculosis interviewing skills. Individuals must participate in all four days of the training. This training is approved for up to 26.25 nursing continuing education contact hours. No prorated credits are available.

**Perspectives on Partnerships in TB Control (in association with CTCA)** May 31, 2013 San Jose, CA

One-day training on topics geared to TB providers in California. More Information

**Tuberculosis Clinical Intensive** June 19-20, Seattle, WA

Two-day intensive for physicians and other licensed medical professionals who diagnose and treat tuberculosis. Details will be available soon

**Tuberculosis Nursing Workshop** June 21, Seattle, WA

One-day workshop for nurses, communicable disease investigators, and other licensed medical care providers who work with tuberculosis patients. Details will be available soon

**Treatment of HIV, STDs, TB, Hepatitis C and Substance Abuse on the Border: Focus on Reproductive Health Concerns** June 28-29, 2013 San Diego, CA


For a complete training description and application information, please visit: http://www.currytbcenter.ucsf.edu/training/tbciii.cfm

You can submit your application online by using the following website: http://www.currytbcenter.ucsf.edu/training/tbciii_app.cfm

PLEASE NOTE: The Curry International Tuberculosis Center prioritizes learners from the western region of the United States. Please visit our website for a list of the western region jurisdictions.

**FROM NATIONAL JEWISH MEDICAL AND RESEARCH CENTER:**

**The 50th Annual Denver TB Course**

April 10-13, 2013 and October 9-12, 2013 Denver, Colorado

The purpose of this course is to present this body of knowledge to general internists, public health workers, infectious diseases and chest specialists, registered nurses, and other health care providers who will be responsible for the management and care of patients with tuberculosis. For more information and to register,
FROM THE UNION:

The Union’s International Management Development Programme 2013 Courses: To register for any of these courses, visit www.union-imdp.org or email imdp@theunion.org to receive more information. Course fee for all courses includes lodging, breakfast, lunch, coffee and tea breaks, and course materials.

Influencing, Networking and Partnership 23 – 27 September, 2013 Chicago

Creating partnerships and networks is an important element to the success of a TB program. Participants in this course will learn how relationship building and developing strong partnerships can boost health program results. Key topics the course addresses: Developing useful networks among health organizations; Creating partnerships to expand a project’s reach; Building group consensus to achieve greater results Balancing relationships to create high-performing teams

TB infection control in the era of HIV: another step in supporting TB control
The risks associated with TB infection transmission have increased significantly with the HIV epidemic, and TB is a leading cause of death among people with HIV/AIDS. To help address this issue, The Union has developed a new three-day intensive course on TB infection control that is available in English, Spanish and Portuguese. The first two offerings were recently held in Ecuador. Read more...
to predict which TB genotype clusters are likely to become outbreaks (Althomsons et al, 2012). In order to
determine whether it is feasible to develop a national program for intervening with these high-risk clusters
and preventing outbreaks, a clear process must be developed for: applying the algorithm using real-world
data; performing a comprehensive investigation to identify all persons involved in the cluster; and intervening
in the cluster to maximize the number of infected persons that complete treatment. CDC and the awardee of
the Cooperative Agreement will collaborate through this feasibility project to develop a process for
intervening with small TB clusters that have a high likelihood of becoming outbreaks, thereby preventing
outbreaks from occurring. The outcomes of the project will include a report of tools, strategies, and processes
that can be used to detect, investigate, and intervene with clusters at high risk of becoming outbreaks
(outbreak prevention investigation and intervention process report/protocol) and a written summary of the
amount of monetary and personnel resources used to investigate and intervene with the cluster. The four
phases (or program strategies) of this feasibility project include cluster detection, cluster investigation,
intervention, and documentation/process development; candidate clusters will be included in all phases. A
minimum of one and maximum of three candidate clusters will be included. Cluster detection will start at the
onset of the project period based on the algorithm published by Althomsons et al (2012); however, the cluster
investigation and intervention phases can only start once a candidate cluster has been identified. Therefore,
the timelines in this project will be presented in reference to the date of cluster detection rather than the start
of the cooperative agreement. The awardee may start with the initial list of specific strategies/activities in the
"toolboxes" developed by CDC, but are expected to add to these throughout the course of the project based
on own experience and published evidence from the peer-reviewed literature. The awardee is expected to
actively work with CDC throughout the process and in development of the products.

2) Fund Number: 4616 - Research In Latent Tuberculosis Infection (LTBI) in the Setting of HIV C o-Infection
(R01)

The purpose of this FOA is to stimulate research about the role of microbiologic adaptive mechanisms, host
immunologic factors, and their interactions in the development, maintenance, and re-activation of latent
tuberculosis infections (LTBI) with a focus on HIV co-infection. Mechanisms of TB latency are poorly
understood. LTBI occurs when Mycobacterium tuberculosis (MTB) persists in the host without signs of active
disease, yet maintains the potential to cause active tuberculosis.
Application Due Date: 07/25/2013

MEETINGS, CONFERENCES AND EVENTS

EVENTS:

NATIONAL PUBLIC HEALTH WEEK : April 1st, 2013

From coast to coast, events are being scheduled daily to support this year’s campaign. Through the theme
"Public Health is ROI: Save Lives, Save Money," APHA is engaging both the public and private sectors to
participate in activities supporting the week, which runs from April 1-7. These include:

the NPHW Twitter chat on April 3 at 2 p.m. EDT, via #NPHWchat, will focus on topics such as workplace wellness, chronic disease prevention, public health research and more;

the Walk for Health and health fair to support World Health Day and the 2013 theme, high blood pressure, with sponsors including APHA and the Pan American Health Organization; and

the NPHW message board, which features APHA members and partners who finish thought bubbles, "Public health is ..." and "Life without public health would be ... ."

MEETINGS/CONFERENCES (Alphabetically listed by sponsoring organization)

AMERICAN COLLEGE HEALTH ASSOCIATION (CHA):

ACHA 2013 Annual Meeting: May 28 - June 1, 2013, Boston, Ma

Five days of networking, collaboration, and continuing education! This year we honor the spirit of service and compassion that college health professionals have shown in their dedication to serving college students and their campus communities

AMERICAN EVALUATION ASSOCIATION:

Evaluators from around the world are invited to share their knowledge and expertise at Evaluation 2013. This year's 27th annual conference October 16-19 will be in Washington, DC. Professional development workshops will be held October 14-16 and 20. AEA welcomes proposals on topics that span the breadth and depth of the field and in particular on those focusing on the conference theme of Evaluation Practice in the Early 21st Century.

AMERICAN PUBLIC HEALTH ASSOCIATION (APHA):

141st APHA Annual Meeting: November 2 - November 6, 2013,Boston, Ma

The APHA Annual Meeting & Exposition is the oldest and largest gathering of public health professionals in the world, attracting more than 13,000 national and international physicians, administrators, nurses, educators, researchers, epidemiologists, and related health specialists. APHA's meeting program addresses current and emerging health science, policy, and practice issues in an effort to prevent disease and promote health. APHA has a world of public health in store for you. Review the Program-at-a-Glance (PDF) to get a quick visual image of the APHA 2013 Annual Meeting Schedule. The theme of the meeting is: Think Global, Act Local: Best Practices Around the World. For more information about each session type visit www.apha.org/meetings/sessions/.

AMERICAN THORACIC SOCIETY (ATS):


The 2013 International Conference of the American Thoracic Society (ATS) will be held in Philadelphia,
Pennsylvania May 17-22, 2013. For general information regarding the conference, please refer to the following website: http://conference.thoracic.org/2013/ This conference provides that will offer the latest information on clinical, basic and translational science in pulmonary, critical care and sleep medicine. With more than 500 sessions, 800 speakers, and 5,300 original research abstracts and case reports, ATS 2013 invites attendees to learn about an exciting array of topics in adult and pediatric pulmonary, critical care, and sleep medicine, or to concentrate on a specific clinical or scientific interest.

Full ATS 2013 program information and registration for Postgraduate Courses, Sunrise and Meet the Professor seminars, the Thematic Seminar Series, and workshops is available at conference.thoracic.org/2013 . If you experience a technical problem while registering, please call 866-635-3585 or email thoracic@xpressreg.net.

As in past years, the ATS 2013 conference will feature a public health poster session with focus on topics of special interest to tuberculosis (TB) control: Call for Abstracts for the TB Public Health Poster Forum at the ATS meeting

Sponsored by: U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION & STOP TB USA

As in past years, the conference features a CDC/Stop TB USA- sponsored Public Health Poster Forum on Sunday, May 19th from 7 p.m. to 9 p.m. The poster session will focus on innovative techniques that help meet the challenges of TB prevention, control, and elimination in the United States. This two-hour public health poster forum will focus on innovative techniques which are helping to meet the challenges of TB control, prevention, and elimination in the United States. Specific topics include: targeted TB testing and treatment of latent TB infection (LTBI); conducting/expanding contact investigations; performing outbreak investigations; improving treatment adherence; addressing multidrug-resistant TB; managing HIV/AIDS associated TB; providing TB education; and building TB-related coalitions.

Chairing: S. Mase, MD, Atlanta, GA, C. Ho MD, Atlanta, GA, S. Etkind, R.N., MS, Washington DC

Target Audience: National, State and Local TB Program Staff, Public Health Professionals (nurses, physicians, epidemiologists), Pulmonary specialists, Infectious Disease specialists, TB & HIV Clinicians, Epidemiologists, TB consultants, Laboratory scientists, Microbiologists.

Please consider developing an abstract for poster presentation on a significant or innovative aspect of your TB control program for this 2013 poster forum. Topics include: 1) Updated policies/procedures and successful activities for conducting TB-related contact investigations, including successful treatment completion in contacts identified with LTBI; 2) The use of programmatic and epidemiologic data to develop and update policies and procedures; 3) Successful activities for the evaluation and treatment of immigrants and refugees; 4) Reports of TB outbreaks, including surveillance and program activities related to detection and control of outbreaks, MDR TB outbreaks, and the development and use of outbreak response plans; 5) Successful activities or interventions to prevent and eliminate TB in high-risk populations, such as African-American communities, foreign-born persons, homeless persons, or populations along the U.S./Mexico border; 6) Innovative and successful interventions to increase adherence and completion of treatment for TB disease and LTBI; 7) Successful activities or interventions to prevent and eliminate TB in persons with HIV-infection; 8)
Successful activities or interventions to prevent and eliminate TB in persons incarcerated in correctional facilities; 9) Successful training and education materials, courses, or sessions for TB program staff, public and private healthcare providers, or successful educational efforts developed for patients with LTBI or disease; 10) Successful efforts to comprehensively evaluate and improve TB prevention and control programs; and 11) Successful implementation of the use of new diagnostic tests for LTBI or TB disease.

This year we are again asking for electronic submission of the poster abstracts. Since this session is sponsored by CDC, rather than the ATS, these abstracts will not be published in the ATS conference book. However, all abstracts will be printed and handed out at the session. Instructions for abstract submission, related forms, and a sample abstract are Found Here. Please use the attached electronic form to describe your proposed poster. Abstracts should be submitted to Dr. Sundari Mase at fyy0@cdc.gov or Dr. Christine Ho at gtb9@cdc.gov. The deadline for receipt of abstracts is April 5, 2013. We will make notifications regarding acceptance of abstracts by April 19, 2013. We will make notifications regarding acceptance of abstracts by April 1, 2013.

ASSOCIATION OF PRACTITIONERS IN INFECTION CONTROL (APIC):

40th Advancing infection prevention education Annual conference  
June 7-10, 2013 Fort Lauderdale, Florida

ASSOCIATION OF PUBLIC HEALTH LABORATORIES (APHL):

APHL 8th National Conference on Laboratory Aspects of Tuberculosis: August 19 - 21, 2013, San Diego, CA  
www.aphl.org/conferences/pages/default.aspx

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS (ASTHO):

ASTHO Annual Meeting:September 18-20, 2013, Orlando, FL  
http://astho.org/t/event.aspx?eventid=7905

CALIFORNIA TB CONTROLLERS ASSOCIATION (CTCA):

2013 CTCA Conference; May 29-31, 2013, San Jose, California

Our 47 th CTCA Educational Conference, Blazing New Trails in TB Control: Combatting Drug Resistance and Putting Molecular Diagnostics into Practice will be held at the DoubleTree by Hilton in San Jose. A Curry International Tuberculosis Resource Center Training will follow on May 31st. Registration will open soon on ctca.org.

NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICERS (NACCHO):

NACCHO Annual 2013, July 1-12th 2013, Dallas, TX.  
Download Individual Registration Form

NATIONAL TB CONTROLLERS ASSOCIATION (NTCA):

2013 National TB Conference: "TB at the Crossroads: Reasons for Optimism"  
June 11-13, 2013 (Pre-meetings June 10, 2013, Post-meetings June 13 & 14), Atlanta, GA
Conference agenda and hotel information will be released in early March. For questions regarding the conference, please contact: Donna Wegener, NTCA Executive Director at dhwegener@tbcontrollers.org or Eva Forest eforest@tbcontrollers.org 678 503-0503 or Sherry Brown sbrown@tbcontrollers.org

A "Call for Abstracts" and abstract instructions can be Found Here: Call for Abstracts, Instructions. The deadline for receipt of abstracts is Monday, April 15, 2013.

RESULTS:

International Conference 2013: July 20-23, 2013, Crystal City, Arlington, Virginia
Professor Muhammad Yunus to be Keynote Speaker  REGISTRATION FOR THE 2013 RESULTS INTERNATIONAL CONFERENCE IS OPEN! Learn more on our websiteREGISTER FOR THE RESULTS INTERNATIONAL CONFERENCE 2013

THE UNION:

44th World Conference on Lung Health: October 30 - November 3, 2013,Paris, France

The Union welcomes all authors to submit their abstracts. The 2013 theme is “Shared air, safe air?” Paris 2013 - Download Brochure The 44th Union World Conference on Lung Health is a 5 day conference covering the latest developments, opportunities and challenges in tuberculosis, HIV, tobacco control, lung health and non-communicable diseases.

Go to the website for details. The deadline is 25 April 2013. www.worldlunghealth.org

VIROLOGY EDUCATION

6th International workshop on Clinical Pharmacology of TB Drugs 9 September 2013, Denver CO, USA

The aim of this abstract driven workshop is to make a significant contribution to the optimization of TB treatment by bringing experts together to present and discuss the latest important scientific findings in the TB clinical Pharmacology field. Ample time is reserved to discuss and translate scientific and regulatory issues to further optimize TB treatment. The format will be a one-day workshop with invited lectures, abstract presentations and sufficient Q&A time to guarantee an intimate and highly interactive event.

We encourage you to submit your data for an oral or poster presentation on the following topics: Pharmacokinetics and Pharmacodynamics of Approved TB Drugs; Pharmacokinetics and Pharmacodynamics of New TB Drugs; Pharmacokinetic- & Pharmacodynamics modeling; Drug-drug and drug-disease state interactions; TB treatment in special populations; New Drug Development MethodS

The Workshop Materials from the edition of this workshop are available on our website.

StopTBUSA was formerly known as the U.S. National Coalition for Elimination of Tuberculosis (NCET). Please pass this information on to your colleagues who are interested in TB elimination.