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1. NEWS: New Aidspan paper looks at cost per notified case in high burden TB countries

Brian Mwangi 29 October 2014

Since its inception, the Global Fund has played an increasingly significant role in providing funding for TB control programs in Fund- eligible countries. By 2012, this contribution made up 80% of all international spending on TB.

The impetus for the paper entitled *Expenditure reported by national TB programs in 22 high-burden countries between 2010-2012: what is the Global Fund's contribution?* now available on the Aidspan website was to guide current discussions about the value-for-money in tuberculosis planning and programming and to provide further data for developing strong investment cases.

National TB programs in the 22 high-burden countries spent $6.37 billion between 2010-2012. For

that money 14 million cases were notified by the NTPs to WHO. On average the costs per case notified are relatively modest given the scale of the burden.

For the 17 non-BRICS countries the total cost per notified case ranges from $30 per case in Myanmar to $416 in Thailand, with an average of $86 per case per year. For the BRICS countries, but excluding Russia because it reported more comprehensively on its full expenditure, the average spend per case was $118 per year. In terms of financial support that can be attributed to the Global Fund, the average is $31 per case per year.

Again, for the non-BRIC countries, the Global Fund grants money met between 9% and 76% of the total expenditure for these countries programs, with an average of 40%.

The analysis estimated the proportion of support from the Global Fund per notified case in HBC. Then it went deeper, to calculate whether there were significant cost-per-case differences between countries, and between the BRICS and non-BRICS within the HBCs.

These comparisons are likely to be useful at country level, and this model can be duplicated for regional comparisons. The risk of relying on a single donor is also highlighted.

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2. COMMENTARY: Changing the status quo: investing in communities to beat TB

Blessina Kumar 29 October 2014

The Global Fund mobilizes and invests some US$4 billion annually to support national responses to AIDS, TB and malaria in nearly 140 countries.

As a partnership between government, civil society, the private sector and people affected by the diseases, the Fund is helping to accelerate the end of the epidemics that have ravaged populations and undermined economic growth. In launching its new funding model (NFM), the Fund is building on its 12-year history and working to ensure high impact and better returns on investment.

But the NFM is also helping to promote inclusiveness in a heretofore unseen way, mandating that

people living with disease sit side-by-side with government officials, business leaders and technical partners. This provides scope for a fresh approach to the epidemic, to examine the barriers to access from the bottom up and increase demand for care using the networking power of the affected.

Countries have navigated the challenges of this newly mandated openness in different ways. Some have embraced inclusiveness and added more seats around decision-making tables without incident. I was happy to observe Cambodia's country dialogue as it began to design its concept note to access some $16 million for TB management from 2014-2017. Representatives from across the spectrum of key populations were invited from around the country to share their concerns and stories of how challenging it was to access services, and to join in the discussion of how to plot the way forward.

After the two days of meetings in the capital, Phnom Penh, I am confident that the stakeholders who participated left secure in the knowledge that their voices were not only heard but valued, which I think will make for a strong concept note with high-impact activities that are owned by Cambodia as it moves to eradicate TB.

Other countries, however, have not followed this path, instead trying to 'negotiate' their way to inclusiveness rather than cultivating the voices of community representatives in discussions. In these countries, they may be pulling up chairs to the discussion table but ultimately community representatives are being left to their own devices and provided with no additional resources. These community representatives are then all-but-silenced, only co-opted and presented to demonstrate that targets have been achieved.

I worry what this means for TB, which feels sometimes like the neglected disease in pantheon of global illnesses drawing international attention and resource. TB is an old disease that is well-situated within the medical establishment -- yet does not have the same sophisticated advocacy networks or community presence as malaria or HIV. Eradicating TB requires a groundswell of community support championing its intention. Not only do all the different players in the sector need to play their parts well but they need a hospitable environment in which they can play their parts together.

In failing to ensure an inclusive process, settling instead for a negotiated agreement that upholds the status quo, countries are not creating that necessary hospitable environment. Instead, they are making what appear to only be material changes to their national TB response, in diagnostics, treatment and supply chain management rather than doing as much as is needed to strengthen community systems, include women and girls and building the civil society network.

So how can we change the status quo?

One easy way is to improve the quality of experts being contracted to provide technical assistance to

countries during the planning process. These contractors can be drawn from a range of sectors to lend their expertise to the community system-strengthening issues raised by the TB community. We already have good epidemiologists, statisticians and clinicians; what we need now are community organizers, communications experts and strong campaigners to help ensure that key populations not only are seated around the table but are confidently able to use their voices to help in the decision-making process.

Most critically, we need support to train, equip and empower civil society leaders to form a movement that stretches both within and beyond national borders. Millions of dollars have been spent in India alone to develop a strong and enduring civil society movement to champion community-based approaches to TB, with little to show for it.

Civil society is virtually silent when there is a need for dialogue with government. And a disease-affected person attending, let alone participating, in those discussions, is as rare as a white Bengal tiger. There is not even a representative of the TB-affected population on India's country coordinating mechanism (CCM), making decisions on how to optimize the $233 million being invested by the Global Fund in the Indian TB response over the next three years.

So many decisions are being made that will decide the course of the response to the world's largest TB epidemic, and those who are most affected are not even part of the conversation.

There are so many opportunities to ensure an environment for inclusiveness is constructed, nurtured and sustained. We must work harder to achieve this, because we are working against the clock. Affected communities are still waiting (and dying patiently) and the responsibility to build this environment lies with those planning and implementing and with those who fund the process for inclusiveness. It is time we took the vow for inclusiveness again with a fresh energy and determination.

Blessina Kumar is the chair of the Global Coalition of TB Activists. All opinions contained in the above commentary are her own.

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3. COMMENTARY: Gender trouble for Tuberculosis

Ellen M.H. Mitchell 28 October 2014

The TB field prides itself on being painstakingly evidence-based and yet in one arena, acknowledged inequality has persisted for years without triggering much reflection or retooling. In fact the prevailing discourses continue to obscure gender inequality that is inconvenient and distract from efforts to fight TB where it lives.

To understand the dilemma we are in, it is necessary to look back at where we have come from. For years, the normative sex ratio for TB was measured as 1.7 men for every female patient diagnosed. It has been common knowledge that most TB patients are men and most deaths are male.[1-2] This gender orthodoxy is so fixed that the quality of TB surveillance systems is often judged by how consistently skewed the rates are over time.

The TB gender disparity has skulked in the background for years without serious attention beyond the occasional systematic review or qualitative study. While some attributed the gender disparity to barriers to care for women, others thought it was simply men's greater engagement in smoking, drinking, criminalized activities and deep pit mining that was tipping the scales. Some even explored the biological angle.

The absence of consensus on why the disparity exists has stymied efforts to address it. Every now and then an intrepid pragmatist would dare to propose doing something to address men's disproportionate burden of disease and disability, only to be quickly countered with stats from the Afghan surveillance system (M:F:0.62): the only place on earth where women's TB rates consistently exceed those of men.

The tuberculosis field only added a 'gender lens' recently, about the same time that donors stepped up demands for improved health access for women and girls. Once stirred to action, great efforts were made to dutifully highlight women's heightened risk. But even the development of a simple women's TB fact sheet was fraught with challenges because in many places women's use of TB services exceeds men's and the data to support women's extra TB burden were nowhere to be found.

On the contrary, ever stronger evidence for men's disproportionate vulnerability continues to pour in from the massive household surveys underway in high-burden countries. Reports from the multimillion-dollar, Global Fund-sponsored TB national prevalence surveys in Indonesia, Vietnam, Nigeria, Ethiopia, Rwanda and Tanzania are revealing a gender gap that is much wider chasm that previously acknowledged [2-6].

Across sub-Saharan Africa, from Kenya to Zimbabwe and Zambia and elsewhere, where the

feminization of HIV would be expected to drive the feminization of TB, well-designed surveys find no extra burden among women[7-9].

Even where women face formidable challenges, in countries such as Pakistan, there was no oft-cited undue toll on women [3].

These studies chip away at the notion that women's lower TB burden reflects a lack of access to health services. But this inconvenient gender inequality is not just about the disparate burden of TB in men; it is also what happens to men once they are diagnosed. Systematic literature reviews of gender and TB have found that:

1. Men tend to delay seeking care longer than women when they experience TB symptoms[10].
2. Male TB patients are more likely to abandon TB treatment and be lost to follow up.
3. Men are more likely die while on TB treatment

Even if the epidemiological justification for focusing on men was widely embraced, the awkward politics would not be.

Recasting men as a vulnerable group is risky business and extremely inconvenient because in addition to being counterintuitive, it simply does not appear to jive with the explicit preferences expressed by both the Global Fund and the US government for strategies that empower women and girls.

The gender focus advocated by TB's biggest donors has been almost exclusively geared toward framing women as a TB risk group. This emphasis is not lost on TB program managers. Indeed a recent technical meeting at WHO erupted in giggles and smirks at the very suggestion that adult men be considered as a vulnerable key population. Few TB stakeholders see significant resources flowing toward underserved men any time soon, regardless of what the data say.

Is it possible for donors to perceive the high incarceration rates of poor men as a form of institutional gender-based violence? Can a strong and persuasive voice in civil society help them view the commodification of men's bodies in the mines of Southern Africa as a gender issue and not only a human rights concern?

Is a focus on inequality a zero-sum game? Those who step up to champion the unmet needs of men will have to tread carefully, and resist implying that women are not felled by TB in unacceptable numbers. No one questions that women and girls deserve tailored TB strategies of their own.

Fortunately there are signs of a subtle shift that may portend something bigger. Initial discussions on

gender-responsive TB programming are rumored to be starting in Rwanda, Malawi and Nigeria.

The Global Fund called on 30 September for civil society groups to provide technical assistance to help ensure gender assessments occur as part of TB program reviews. The following week, USAID signalled an interest in bundling TB screening with voluntary medical male circumcision.

There is an inordinate amount of groundwork still needing to be done to better understand the cultural, biological and structural forces that make TB so dangerous for all of us. Having the blessing of the Global Fund and USAID to do that work may spur some sleeping giants and bring new insights and solutions to this old problem.

Ellen Mitchell is a Senior Epidemiologist at KNCV TB Foundation. All opinions in this commentary are her own.

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4. COMMENTARY: How to improve HIV/TB prevention, treatment and care in prisons

Heino Stoever 29 October 2014

At the global epicenter of the HIV epidemic, intravenous drug use and sharing of syringes, needles and drug use paraphernalia, unprotected sex, multiple sexual partners, and low and inconsistent condom use are among the drivers of the spread of the virus [1]. Equally, prisoners comprise a key vulnerable population contributing to the epidemic.

Because prison populations often consist of individuals with greater risk factors for contracting HIV than the general population, HIV and AIDS are significant health threats to the entirety of the prison

population -- both inmates and employees [2].

The TB notification rate in prisons ranges from 11 to 81 times higher than in the general population. The situation is worsened by the emergence and spread of drug-resistant TB, particularly multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB.

Risk factors for tuberculosis (TB), hepatitis A, B and C, and sexually transmitted infections (STIs) are also greater for incarcerated individuals than those in the general population [2]. These infections tend to exacerbate each other, as in the case of HIV/TB co-infected individuals: TB infection is the leading cause of death among HIV-infected individuals in sub-Saharan Africa [3].

These are among the considerations that contribute to the challenges to prison and government authorities in responding to the risk of HIV infection.

Prisoners and prison staff often come from communities with high prevalence of infectious diseases, including HIV/AIDS [2]. Risk behaviors for HIV and other infectious diseases that begin in the community often escalate during incarceration[2]. Evidence suggests that in Southern Africa unprotected sexual activity is the most prominent HIV risk behavior and responsible for the majority of infections, whereas sharing of razors, tattooing and piercing instruments and injection-drug use are less problematic [4, 5].

Rape and sexual aggression among prisoners as well as between prison staff and prisoners has received little attention in Southern Africa, although it is reported as a reality in prison. Few studies have documented the context in which sexual activity is occurring in prisons in Southern Africa.

Without this information, proposed HIV prevention interventions for Southern African prisons will be based on assumptions, which could lead to futile efforts in the face of an ongoing epidemic.

In Eastern Europe and Central Asia intravenous drug use is the key driver of the HIV epidemic [8].Overcrowding, poor ventilation, access to clean drinking water, and food are key problems in the prison settings in most of the countries at the epicenter of HIV and TB.

Overcrowding is an especially acute problem for many other infectious diseases. In the main prison in the Mozambican capital, Maputo, more than 2,000 men are incarcerated in a premises designed to hold a maximum 875 inmates. This situation is exacerbated by the near-total absence of means of protection like condoms, clean needles and syringes, ventilation, lighting, water and proper food. The high rate of deaths occurring in prisons in many prisons in Southern Africa is alarming: predominantly attributable to HIV co-infection with TB.

It will be critically important for global health advocates at the policymaking level to help define contextually relevant guidelines for how to manage TB/HIV among the incarcerated, that can be applied at the facility level. Current standards should be measured against international standards. Clear policies and guidelines are needed for guidance. Let HIV be the door-opener for further improvements of prison health.

Separate from the structural and population density problems are the challenges posed by poor hygiene standards and a shortage of harm reduction activities, leading to a gulf between most facilities and the international standard for prison care. There is an acute need for more qualified health care professionals to respond to the health needs in prison settings, as these are among the predominant barriers to access to services.

However, it is globally observed that government policies and legal implications regarding prevention modalities limit the scope of prevention activities (e.g. condom provision).

Many countries fail to link their programs in prisons to the national AIDS, tuberculosis or public health programs, leaving them isolated and without the ability to draw on existing national resources or even awareness campaign materials. Also many countries fail to provide adequate occupational health services to staff working in prisons.

To ensure best practice is observed by countries implementing Global Fund grants going forward, with a focus on this key population, the following recommendations have been made:

• Prompt detection of TB among prisoners should be ensured through a combination of screening methods
(screening on entry, mass screening at regular intervals, passive screening, contact screening) based on clinical questionnaires, chest X-rays, smear microscopy and self-referrals.

• Drug susceptibility testing (DST) should be performed on all patients with treatment adapted to the resistance pattern to help further amplification of resistance.

• Effectiveness is improved when treatment is administered under the direct observation of health care staff and in line with national TB program (NTP) guidelines.

• Adequate procurement, supply and management of quality medication and effective administration should
be in place. Airborne infection control, including protective measures for staff, should be ensured, and provider-initiated HIV counselling and testing to detect HIV and TB/HIV co-infected individuals should be

promoted to provide the necessary support and care.

• Continuity of care is imperative for released prisoners who are on treatment and for individuals who are on
treatment before entering the prison services.

• TB control is strengthened in prison-based programmes by raising awareness of TB among prisoners and prison
medical and non-medical staff through continuous educational activities.

• Operational research should be promoted to contribute to evidence-building for effectiveness.

From visits and assessments of prisons in Southern Africa and Eastern Europe it can be concluded that same-sex contacts are happening in various forms, as are risky behaviors with respect to intravenous drug use. Additionally, factors related to the prison infrastructure, prison management and the criminal justice system also contribute to vulnerability to HIV, TB and other health risks in prisons. These factors include violence, poor prison conditions, corruption, denial, stigma, lack of protection for vulnerable prisoners, lack of training for prison staff, and poor medical and social services [10].

Addressing HIV and TB in prisons effectively cannot be separated from broader questions of criminal justice and national policies. In particular, reducing the excessive use of pretrial detention and greatly increasing the use of non-custodial alternatives to imprisonment are essential components of any response to HIV/TB and other health issues in prisons.

UNODC/ILO/WHO/UNDP and UNAIDS developed a comprehensive package of interventions for "HIV prevention, treatment and care in prisons and other closed settings" [9]. The suggested interventions are evidence-based and have to be the basis for any funding in the prison setting. This package comprises of 15 key interventions, which should be reflected in any funding process:

1. Information, education and communication

2. Condom programs

3. Prevention of sexual violence

4. Drug dependence treatment, including opioid substitution therapy

5. Needle and syringe programs

6. Prevention of transmission through medical or dental services

7. Prevention of transmission through tattooing, piercing and other forms of skin penetration

8. Post-exposure prophylaxis

9. HIV testing and counselling

10. HIV treatment, care and support

11. Prevention, diagnosis and treatment of tuberculosis

12. Prevention of mother-to-child transmission of HIV

13. Prevention and treatment of sexually transmitted infections

14. Vaccination, diagnosis and treatment of viral hepatitis

15. Protecting staff from occupational hazards

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5. COMMENTARY: Is sustainable domestic financing of TB response a reality in EECA region?

Sveta McGill 29 October 2014

In 2014 the Global Fund to Fight AIDS, TB and Malaria started implementing its new funding model (NFM). The NFM aims to re-allocate its resources away from middle-income countries towards those with the highest burdens of disease and the least ability to pay. For the countries of Eastern Europe and Central Asia (EECA) - the single most-affected region in the world by the spread of multi-drug resistant TB (MDR-TB) – a loss of eligibility for Global Fund funding is bad news.

Since its founding in 2002, the Fund has been a key donor and supporter of HIV and TB programs in EECA. Global Fund investments have supported countries in their development of enabling environments and have helped strengthen their health and community systems allowing the region to show progress against HIV and TB. In particular, the Fund has been very supportive, both administratively and financially, of civil society in EECA where civil society organizations implement Fund-resourced programs.

As a result, TB advocates and CSOs are now very aware that it is mostly the work they are doing within vulnerable communities that will be most affected by the eventual withdrawal by the Fund from the region -- and, most worryingly, how this will affect the spread of disease.

Research recently completed by RESULTS UK (http://www.results.org.uk) and Global Health Advocates France (http://www.ghadvocates.eu) on behalf of the TB Europe Coalition (http://www.tbcoalition.eu/) shows that views on the ground are less than optimistic on whether domestic funding for TB will be enough to fill the gap once the Fund leaves the region:

"For our country, the exit of the Global Fund is impossible, because the government will not be able to cover the needs of TB services that are now funded by Global Fund" (respondent from Kyrgyzstan)

While respondents acknowledge how important it is for all stakeholders to prepare for the phasing-out of Fund support, there are significant obstacles to making this path an easy one. The majority of people interviewed, who represented a broad spectrum of TB stakeholders and CSOs in EECA, responded negatively to the question on whether governments were likely to increase domestic TB funding. Most frequently, it is suggested that government TB spending will likely be constrained by budget restrictions and other priorities of state funding.

As to the outcomes of the donor phasing-out, the CSO-based work with hard-to-access populations was believed to be the area of work most severely affected:

"Patients (especially the ones with MDR-TB and XDR-TB) will not be able to access necessary TB treatment, without referral and motivation services currently provided by CSOs. As a result, their treatment adherence will be low, the number of newly registered TB cases will decrease, as the CSOs will not be able to continue their work as before when they were funded by the GF"(respondent from Kyrgyzstan)

Transition to government funding may also unfavorably affect most of the programs previously supported by the Global Fund, such as harm reduction, work with sex workers, men having sex with men (MSM) and some aspects of prison-based work. According to the research, these activities,

typically implemented by CSOs, are unlikely to be funded by national governments.

Phasing-out of Global Fund funding may also lead to increased TB and HIV prevalence rates with recipient countries being 'punished for their success':

"If you have been investing in a country, have managed to keep HIV and TB prevalence relatively low, and you take that funding away, the loss of funding may also result in rates going above 5% of the population. You are wasting the previous investments. Countries who had already registered some success, are being punished for doing that." (an independent expert)

Some participants believed that transition into TB funding may affect the quality of TB drugs:

"In Uzbekistan, there is one state organization that is responsible for centralized procurement of all drugs. The donor exit and increasing the role of the state may lead to a re-distribution of spheres of influence in TB drug procurement. The state will try to save money and procure more quantities of cheaper TB drugs of worse quality. The state procurement will also be hard to be controlled for international quality standards. Weakening of quality controls and exit of international donors may lead to creating new non-transparent procurement schemes in the country"(respondent from Uzbekistan)

There is a clear need to support countries in conducting the gap analysis of TB funding, and to systematically assist countries to develop their TB funding transition plan before the Global Fund phase-out. While the prospect of transition into domestic funding was always on the agenda, the real transition mechanisms are not in existence in most countries. The country dialogue should now become more active, more robustly supported by donors, and involve groups implementing Global Fund programs at country level and a wide range of country stakeholders. Donors' assistance in planning the TB funding transition is crucial in making this process effective.

Participants also believed that the EU institutions may have a bigger role to play in influencing and mitigating the consequences of the donor phase-out. While the role of the EU was generally acknowledged as 'not clear' in the EECA region, consistent policies and a sustainable step-by-step approach needs to be demonstrated by EU institutions to become more effective regional players influencing the policy making processes. Control over directing the EU spending in EECA needs to be reinforced:

"EU does have a role, but it is not completely clear. EU does not do enough. There is a lot of rhetoric coming out of EU, but they do not do a lot. They should play a stronger role and use their political leverage and financial instruments to ensure the transition of funding to national governments'

responsibility." (an independent expert)

At the governance level, a multi-disciplinary approach and involvement of communities with the disease in decision-making should remain a priority for both domestic and international support for TB response. Funding should be made available for institutional support of TB advocacy networks and other regional coalitions that would represent the interests of patients and communities affected by the TB epidemic.

Interestingly, the findings of the RESULTS, GHA and TBEC study resonate with the views expressed by Michel D. Kazatchkine, the former Global Fund executive director, and now a UN Secretary General's Special Envoy on HIV/AIDS in Eastern Europe and Central Asia, expressed in his recent Huffington Post blog:

"Although new technologies are now available to diagnose TB and test for TB drug susceptibility / resistance, the reality is that less than 50 per cent of the estimated new cases of MDR-TB are diagnosed across the region. And only half or less of those patients in need of treatment are actually treated and cured. Those who are not treated remain contagious and they also die. This nothing short of a crisis, one we have to stop neglecting."

Tuberculosis is at a crisis point in EECA and it is a crisis that can no longer be ignored. Kazatchkine's post ends with the hope that the issue begins to receive the attention it deserves at international forums such as at the 45th Union World Conference on Lung Health in Barcelona.

Sveta McGill is a Health Advocacy Officer at Results UK. All opinions in this commentary are her own.

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6. NEWS: Georgia signals willingness to pay -- and to change -- in its TB management

Tinatin Zardiashvili 30 October 2014

New national strategic plan to address adherence challenge that is at root of MDR-TB problem

Georgia is committing both financial and human resources to an overhaul of its national TB program to address the growing problem of MDR-TB in the country, signalling its willingness to pay -- and to change -- as it develops its TB concept note for the Global Fund.

Failed reforms of the health system over the last two decades have contributed to the mounting toll that multi-drug resistant TB is taking on the country, which has placed Georgia 27th on the list of countries worldwide in terms of disease burden, with an incidence of 88 per 100,000 according to 2011 WHO figures.

The privatization of health facilities has, with hindsight, been seen as one of the major inhibitors of success in TB management. Because primary health facilities were not always equipped with the right equipment, or staff, to address the problems posed by tuberculosis among the general population, treatment adherence plummetted, driving the current problem.

Active coordination at the ministry level with Georgia's international partners including the Global Fund and the US Agency for International Development (USAID) has not translated to an integrated or holistic approach to TB at the community level, Aidspan understands. Considerable investment in modern diagnostic and treatment laboratory equipment has not been matched with a comparable investment in treatment; while 63% of MDR-TB cases are thought to have been identified, some 30% of those patients have failed to access treatment.

According to the national strategic plan, " once MDR-TB is detected, Georgia has succeeded in providing access to appropriate treatment, but the country has not yet achieved treatment success goals. Over one third of the MDR-TB patients who start treatment are later lost to follow up, and can also serve as sources of infection for others."

In the post-Soviet era, civil society, too, has been slow to engage with TB, which despite its wide presence, remains a disease that carries with it considerable stigma.

A commitment to overcoming these barriers is likely be the focus of the next NSP (2016-2018). Government has also committed to increasing state funding for the TB response, with an eye towards the gradual drawing-down of international support for TB programming, currently assessed at some 54% of the NTP budget.

One innovative approach that has earned modest success is underwritten partially by Global Fund grants. To encourage treatment adherence and overcome the sizable default rate, Georgia is providing

a cash incentive for patients, to pay for the transport to and from medical facilities in order to be seen by health professionals. From 2015, this program is likely to see a commitment from the Georgian government to assume that financial outlay.

Country dialogue for Georgia's TB concept note is currently underway. It is anticipated that existing programs funded by the Global Fund -- medicines, including second-generation MDR/XDR TB drugs, diagnostics and lab equipment -- will be maintained, with some funding set aside to support community system strengthening to improve adherence and bolster civil society's ability to participate in the TB response.

“Georgia is developing its concept note for TB under the new funding model (NFM)," Dr Tamar Gabunia, the head of the USAID TB program in Georgia and deputy chair of the country coordinating mechanism (CCM), told Aidspan. "The joint program review mission will be conducted in November 2014 by WHO, GDF and GLC experts to identify strengths and weaknesses of the national TB response. This review along with the financial gaps analysis will inform the new TB strategy and the investment proposals for domestic and donor funding for the next 3-5 years.”

Also likely to receive some financial support through the Global Fund allocation under the NFM are programs specifically targeting key populations. Co-morbidity of TB and HIV is estimated at 2% of all HIV-positive Georgians, and a TB component has since early 2014 been incorporated in the harm services provided by the Global Fund-supported Georgian Harm Reduction Network (GHRN).

People who inject drugs who are at high risk of TB are screened during GHRN outreach work, and then referred to TB centers for diagnostics, support and counseling.

Georgia is also having success with addressing the TB problem in its prisons. Since 2012, the number of active TB cases has declined fto 47 from 533, and the number of cases of MDR-TB from 68 to 8. This can be attributed to a series of reforms to the health services being offered in the country's prisons, ensuring that "pretrial prisoners receive the same standard of TB services at a TB center as convicted inmates do," according to the Ministry of Corrections.

Also part of these reforms was the establishment of opioid substitution therapy and drug-rehabilitation services for prisoners, as well as HIV, TB and Hepatitis C prevention interventions.

[This article was first posted on GFO Live on 30 October 2014.]

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