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## Internationale Nachrichten

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### 1. Landmark in TB for public health

01 December 2015 - Cape Town, South Africa - Two back-to-back events yesterday saw the conclusion of a landmark day in public health for tuberculosis. The Stop TB Partnership's Global Plan to End TB 2016-2020: The Paradigm Shift was endorsed by global and national leaders ahead of the start of the 46th Union World Conference on Lung Health in Cape Town. The 2nd Global TB Summit ended with nearly 50 parliamentarians of the now 650-strong Global TB Caucus having met across three days to discuss what they can do collectively and individually to support the roll out and funding of the Global Plan to End TB 2016-2020 in order to end the TB epidemic.

The Global Plan high level endorsement press event in the morning was hosted by South Africa's Minister for Health Dr Aaron Motsoaledi, chair of the Stop TB Partnership Coordinating Board, and was joined by a strong leadership panel including Nick Herbert, MP from the UK and co-chair of the Global TB Caucus, Cheri Vincent representing the US Government, Eric Goosby, the UN Special Envoy for TB, José Luiz Castro, Executive Director of The Union, Lucica Ditiu, Executive Director of the Stop TB Partnership, and Solelwa Sifumba, a young medical student who has had MDR-TB who shared her compelling story.

On November 20, The Stop TB Partnership published the Global Plan to End TB, in which it delivered a very blunt message to the world - without an immediate and large increase in investment to fight TB, the global fight to eliminate the disease as a public health threat by 2035 (as spelt out in the World Health Organization's End TB Strategy) will be missed. And if the glacial global decrease in TB incidence of 1.5 per cent per year continues, the disease will remain a public health threat for another two centuries. The Global Plan aims to diagnose and treat at least 90 per cent of all people with TB (including reaching at least 90 per cent of people with TB among key affected populations) and ensure at least 90 per cent successfully complete treatment, including in drug resistant cases.

Endorsing the Plan, the Honorable Minister of Health of South Africa, Dr Motsoaledi said, "TB has been persistent through history because its roots are deeply intertwined with economic and social factors. The management of TB is therefore a litmus test for our commitment to social equality and health for all. Unfortunately, its longevity has created a sense of acceptance that the disease is here to stay and a sense of complacency."

South Africa is leading from the front with its own ambitious plans to hit the Stop TB's 90-(90)-90 target by 2020. This will target mining communities where TB rates are enormous, testing current and former miners and their families and friends, as well as 90 per cent of the prison population, where TB has always thrived, and also where the late Nelson Mandela became infected with TB in the 1980s.

"TB is the world's biggest infectious killer, yet it receives only a fraction of the resources and attention given to other major diseases", said Rt Hon Nick Herbert, MP and Co-chair of the Global TB



Caucus. "If we are to meet the newly agreed Sustainable Development Goals and eliminate TB by 2030 we need to take a new approach to tackling the pandemic. The Global Plan gives us that opportunity, but it needs global political commitment and proper resourcing. That is why I will be asking members of the Global TB Caucus to endorse the Plan and to press their governments to do the same."

"South Africa, which is showing tremendous leadership in its fight with TB, is the ideal location for parliamentarians and partners and should serve as a global example to meet and endorse the Stop TB Partnership's Global Plan to End TB," says Dr Lucica Ditiu, Executive Director of the Stop TB Partnership.

"It's time for a paradigm shift in the fight against TB," said José Luis Castro, Executive Director of The Union Against Tuberculosis and Lung Disease, who are convening this week's conference. "To be successful, countries need to read the plan and begin to implement it immediately, which will require new financing - and mobilizing new health workers on the front lines. We need to invest now in research that will bring us new, simple TB diagnostic tests, new medications and most importantly, a better vaccine."

Solelwa Sifumba, a young 25 year old medical student at the University of Cape Town who has now recovered from MDR-TB said, 'I contracted multidrug-resistant TB in 2012 while on the wards. The journey was terrible to say the least but I made it through. I returned to medical school this year after completing my full course of treatment and hit the ground running. I am proud to say that I've made it to my 5th year. This year, I have also managed to work with the student council at medical school to spread awareness of TB and the message that we need to protect ourselves, an attempt to go against the culture that as medical students and health professionals, we are somehow immune to TB.'

Ms Cheri Vincent representing the US Government said "We welcome the launch of the Global Plan to End TB 2016-2020. This ambitious plan provides a blueprint to reach the Sustainable Development Goal of ending TB by 2030 and describes the actions and resources needed for success. By further scaling-up and integrating TB services into health systems, by reaching and curing everyone with TB in need of treatment, and by ensuring access to quality health interventions to all in need, we can reduce poverty and build healthy, resilient societies that are free from TB. We have the ability to rid the world of this curable disease. With concerted global action, investment, and innovation, we can end TB."

"There is no doubt that we are facing serious barriers in the fight against TB. The Global Plan provides a roadmap that builds on the End TB Strategy and tackles the challenges the barriers present," says Dr Eric Goosby, UN Special Envoy for TB. "It's a forward-looking, ambitious document that calls upon all parties to do their share in helping to reach the SDG 2030 goal."

"The Global Plan to end TB sets out ambitious but achievable goals and complements UNAIDS Fast-Track approach to break the AIDS epidemic over the next five years," said Michel Sidibé, Executive Director of UNAIDS. "Ending these twin epidemics as part of the Sustainable Development Goals will avert millions of new infections and lead to better health outcomes for people in the most affected areas of the world."

The Global TB Summit which ended in the afternoon was the biggest political event on TB in nearly 100 years and it brought together leading experts and civil society figures that briefed the delegates on the major issues facing TB elimination. The Summit was hosted by the co-chairperson of the Global TB Caucus, the Minister of South Africa, Dr Aaron Motsoaledi, in coalition with Nick Herbert, MP, the UK All Party Parliamentary Group on Global TB and José Luis Castro, the Executive Director of The Union.

The meeting ended with 50 parliamentarians from over 30 countries representing among others, the UK, South Africa, Canada, Kenya, India, Mozambique, Georgia, France endorsing the Global Plan and committing to concrete actions for its roll out as well as a fully replenished Global Fund. This event follows on last year's inaugural summit, which culminated in the Barcelona Declaration to End TB



now signed by over 650 political representatives from over 100 countries.

**Source:** Stop TB Partnership, <http://bit.ly/21IX5vm> (01.12.2015)

## 2. Chennai's new strategy to eliminate TB

Thanks to the Zero TB Cities project, if all goes well, Chennai may drastically reduce TB mortality, shrink the number of new cases annually and impact TB prevalence in the city in a matter of 3-5 years.

Chennai has been chosen as one of two cities in the world where the Zero TB Cities project will try to create an "island of elimination"; Lima in Peru is the other city. The project will be formally launched in Chennai in a few months' time.

The project will be implemented by the Municipal Corporation of Chennai with the Chennai-based REACH and the National Institute for Research in Tuberculosis (NIRT) assisting it.

"Our U.S.-based team partnered with the Clinton Health Access Initiative (CHAI) India, to do extensive scoping missions across major Indian cities starting in 2014. Over the course of several visits, Chennai came out as the strongest site to explore a Zero TB City approach in India," Tom Nicholson associate in research at the Duke Center for International Development (DCID), Durham, and who is heading the new project said in an email to *The Hindu*.

The very objective of the project is that other cities in India and elsewhere take the initiative in a similar way and tackle their own TB epidemics urgently. "When the municipal authorities in Lima or Chennai stand up and identify TB as a priority public health menace that needs to be tackled, other locations may follow suit, and build their own locally appropriate plans to more toward ultimate elimination of TB. If we can help, we will of course find a way to do so," Mr. Nicholson said.

"The goal is to help communities move to zero deaths from tuberculosis in their own way, and create "islands of elimination", which will hopefully reverse the overall tuberculosis epidemic," Pamela Das, Executive Editor and Richard Horton, Editor-in-Chief, note in an Editorial in *The Lancet*.

The flicker of hope shines brightly amidst the gloomy and grim tuberculosis scenario in the country — 220,000 avoidable TB deaths in 2014 in people who were HIV negative and 2.2 million new TB cases, accounting for 23 per cent of the global total. The country today faces the world's greatest TB crisis despite halving TB prevalence and the mortality rate in the last 25 years.

"Business as usual can no longer be an option in the fight against tuberculosis" as the global decline in the number of new TB cases every year has been extremely slow in the last 25 years. At this rate, it will take another two centuries to eliminate the disease, *The Lancet* notes.

The Zero TB Cities project that began in 2014 and launched in active form last month has earnestly embraced the Zero TB Declaration in 2012 that calls for a "new global attitude" in the fight against TB.

"In India, there is evidence that transmission of TB is much higher in cities, and cities are often the source of infection for rural communities. So, getting to zero in cities will eliminate important reservoirs of TB," Dr. Suvanand Sahu, Deputy Executive Director of Stop TB Partnership, Geneva said in an email to *The Hindu*.

Making a marked departure from the current highly ineffectual methods used to tackle the disease, the project envisages a comprehensive tuberculosis elimination strategy at the community level by using all the currently available arsenals. The "island of elimination" strategy does not call for any breakthroughs but only requires a change of mindset and better use of methods and tools that already exist.

To cut the transmission cycle and reduce mortality, the project intends to fight the TB war in Chennai by actively searching for people with TB disease, providing preventive therapy to people infected with TB and belonging to high-risk groups, controlling TB transmission by routinely using efficient tools for early and accurate diagnosis and providing appropriate therapy immediately, and finally by making sure the right supportive programmes are in place to keep patients on therapy.



Fortunately, the Revised National Tuberculosis Control Programme (RNTCP) guidelines are very forward looking and already advocate most of the strategies to be adopted by the Zero TB Cities project.

Though how soon the initial objective will be reached will depend on how quickly and how well the programme is rolled out, Chennai already enjoys a head start. Together with other stakeholders — NGOs, private practitioners, pharmacies, deans of medical colleges and NIRT — the Corporation has already initiated some measures that will form the “key focus” of the project.

For instance, the gaps in fighting the disease have already been identified by the Chennai Corporation, and ruling out TB in HIV positive adults using an advanced tool (GeneXpert) has been going on since June this year. Actively tracing and testing people living in the same household as a recently diagnosed TB patient and therefore at high risk of contracting the disease is already being done. “From Stop TB we are already supporting a TB REACH project in Chennai which among other things is focussing on how to implement contact investigation better,” said Dr. Sahu.

“The city is planning to go beyond household contacts to look for hotspots of transmission in slums and poverty pockets, and to implement active case finding in such settings,” said Dr. Sahu.

Seamless integration between public and private sectors for TB care will be less challenging in Chennai as the Corporation and REACH already work closely with the private sector to make case notification more effective and to address the issue of availability of TB medicines to people approaching private practitioners. In a small way, REACH already has a public-care representative embedded in private hospitals to facilitate medicine availability to poor patients.

“We see “Zero TB” as a long term goal, a catch-all way of saying we are moving in an accelerated fashion toward the pre-elimination phase, which is seen in wealthy health systems where TB exists but is no longer an urgent public health problem,” Mr. Nicholson said. “Realistically we expect that any city can expect to reach pre-elimination phase with the comprehensive approach.” Only after the infrastructure is in place to search, treat and prevent will moving toward the more ambitious goals of zero deaths, zero transmission, and ultimately zero patients be even conceptually possible.

Despite the disease being airborne and presence of a large population infected with TB bacteria (latent TB) acting as a reservoir, Mr. Nicholson is confident that TB can be and has been controlled in thousands of settings in the past.

While referring to the problems posed by migration of people into the city from high-burden settings Mr. Nicholson said: “The Zero TB Cities approach needs to be part of a larger movement and cannot fully succeed in isolation in India in terms of getting to the final “zeros” in Chennai.”

The Project is a collaborative effort between Harvard’s Department of Global Health and Social Medicine, Duke University’s Sanford School of Public Policy and Duke Center for International Development. Stop TB Partnership provides the operational and strategic collaboration.

**Source:** The Hindu, <http://bit.ly/1kymfvd> (23.11.2015)

### **3. Intravenous rifampicin reintroduced in South Africa**

On October 5, 2015 GoundUp reported that South Africa was running out of an essential medicine – intravenous rifampicin – for treating very sick patients with tuberculosis and drug-resistant bacterial infections. The reason for that was the discontinuation of the medicine production by its sole supplier for the country – Sandoz.

In a response statement from October 7, 2015 Sandoz claimed to be working to identify an alternate supplier for South African patients in need.

On October 29, 2015 Sandoz informed Treatment Action Group that an alternate source of intravenous rifampicin had been identified for the South African market – Equity Pharmaceuticals, effective immediately, is able to supply South African patients with a sustainable supply of this intravenous treatment under Section 21 terms.

**Source:** TB Online, <http://bit.ly/1YTLS8Z> (30.10.2015)



## Forschung & Entwicklung

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### 1. Tuberculosis Elimination By 2035 In Peril After Research Funding Crashes

According to Treatment Action Group (TAG), the funding for tuberculosis research fell to USD \$674 million, \$1.3 billion short of the \$2 billion needed annually. The plan of eradicating the disease between 2030 and 2035 seems unlikely to happen with this event. Mark Harrington, executive director of TAG, issued in a statement, "Anything short of a massive and sustained infusion of money into TB research will jeopardize our chances of meeting global goals."

Tuberculosis's death rate has dropped to 47% since 1990. However, this widespread airborne infection kills 4,000 people every day worldwide. The progress in elimination of the disease is halted by drug-resistant strains as they outpace the development of new treatment. These drug-resistant strains are also difficult to diagnose and treat. In 2014, the drug-resistant tuberculosis strains had afflicted 480,000 people. The World Health Organization targeted 2035 as the year when the world is tuberculosis-free. This is also reaffirmed by the United Nations Sustainable Development Goals by putting out an earlier target of 2030 in September.

According to TAG, gains in tuberculosis research had been modest since 2005. In 2010, the entire movement had stagnated. Pharmaceutical companies are also dropping tuberculosis research since 2012, leaving the endeavor to philanthropic groups and public organizations. "We won't eliminate TB unless we accelerate research and development," Lucica Ditiu, executive director of the Stop TB Partnership, said. Ditiu also urged the countries, Brazil, Russia, India, China and South Africa in leading the financial campaign for research and development on new tuberculosis treatment. These countries have the 40% tuberculosis-related deaths in 2014 and are accounted for 46% of the world's new tuberculosis cases. (...)

**Source:** Science Times, <http://bit.ly/1InnQFf> (30.11.2015)

### 2. The Medicines Patent Pool Expands Mandate to Hepatitis C and Tuberculosis Treatment

The Medicines Patent Pool (MPP), the world's only voluntary licensing mechanism in public health, announced an expansion of its mandate today to hepatitis C and tuberculosis medicines. The UNITAID Executive Board, meeting November 4-5 in Geneva, approved the MPP's proposals to improve access to both life-saving direct acting antivirals (DAAs) to treat hepatitis C and new and re-purposed medicines for tuberculosis. UNITAID created the MPP in 2010 to provide better health options for people living with HIV. To date, MPP has signed agreements for twelve antiretrovirals (ARVs) for countries home to 87-93% of people living with HIV in the developing world.

"I greatly welcome the broadening of the Medicines Patent Pool's mandate to encompass hepatitis C and tuberculosis, giving MPP a vital opportunity to help secure lower prices for medicines to fight these two lethal diseases," said Philippe Douste-Blazy, Chair of the Executive Board at UNITAID.

"The MPP is a cornerstone of UNITAID's efforts to transform the HIV medicines market and rapidly scale up HIV treatment in low- and middle-income countries," said Lelio Marmora, UNITAID's Executive Director. "The MPP now joins us in helping to meet international targets to make curative hepatitis C and TB medicines accessible to those who need them."

The World Health Organization estimates that hepatitis C (HCV) affects between 130 and 150 million people worldwide. The vast majority lives in low- and middle-income countries. New direct acting antivirals that are effective across all major HCV strains could cure millions. Building on its HIV model, the MPP will seek to license for generic manufacture new and pipeline hepatitis C medicines that can eliminate the virus in a short course of oral therapy.

"The recent approval of new treatments with greater efficacy and low side effects represents an incredible opportunity to move closer to eradication, but only if these drugs are affordable and accessible," said Raquel Peck, CEO for the World Hepatitis Alliance, an umbrella organisation



representing 400 million patients. "We have urged for the Medicines Patent Pool's participation in the HCV response and are thrilled with the UNITAID board decision."

Tuberculosis is the leading cause of death for people living with HIV and killed 1.5 million people globally in 2014 alone. TB treatment has become more complex, particularly with the emergence of multidrug-resistant (MDR) strains of *Mycobacterium tuberculosis*. The MPP will work to ensure access to new treatments for multi-resistant and drug-susceptible TB.

"The TB Alliance welcomes the MPP's entry into the TB field," said Mel Spigelman, President & CEO of the Global Alliance for TB Drug Development, the world's leading product development partnership (PDP) for the development of TB medicines. "We are looking forward to working with the MPP on a range of projects, from access-oriented licensing for new drugs and regimens, to the development of appropriate formulations for children."

"We thank UNITAID for its confidence in the MPP," said Greg Perry, MPP's Executive Director. "MPP believes that its unique approach to negotiating licences for HIV is working and we look forward to applying our model to tackling access and innovation challenges in HCV and TB."

New numbers released today confirm that the MPP has saved the international community \$119.6 million from the procurement of low-cost HIV medicines, and its generic partners have distributed 7.26 million patient-years of treatments. The organisation is working on more than 50 development projects to bring MPP-licensed HIV antiretrovirals to market. These antiretrovirals include new promising treatments as well as WHO-recommended HIV medicines for first and second-line treatment for adults and children of all age groups.

**Source:** Medicines Patents Pool, <http://bit.ly/1kymfvd> (07.11.2015)

### 3. Tuberculosis: Daily antibiotics recommended to prevent resistant strains

A computer model of tuberculosis has shown that approved treatments prescribing antibiotic doses once or twice a week are more likely to lead to drug resistant strains than are daily antibiotic regimens. The finding, from a University of Michigan study, could help inform the treatment of the roughly 10 million people worldwide who fall ill with tuberculosis each year.

"We wanted to address open questions regarding treatment for tuberculosis," said Elsje Pienaar, a U-M postdoctoral scholar in chemical engineering and first author on the new study. "First, can we use the antibiotics that we have in a better way? And if we can change the ones that we have in some way, what modifications would be best?"

Active tuberculosis is notoriously difficult to treat, and the spread of antibiotic-resistant TB is increasing. Current drug regimens start with four different antibiotics for the first two months, dropping to two antibiotics for four more months of treatment. Because the temptation is so strong to stop taking the antibiotics once symptoms ease, the World Health Organization recommends that TB patients should receive their doses from a health care professional, or at least have someone designated to make sure they take their antibiotics on schedule. Even with these precautions, the WHO estimates that 480,000 people developed multi-antibiotic-resistant TB in 2014.

"This high-level resistance to multiple different antibiotics was able to emerge when we were supposed to have a good handle on TB treatment," she said. "I wondered if this was a 'man-made' monster that we inadvertently created because we do not fully understand the complex dynamics involved in TB treatment and control." (...) "Experimentalists can't test thousands and thousands of antibiotic regimens, but we can," said Jennifer Linderman, U-M professor of chemical engineering and biomedical engineering. Experiments with animals are expensive and time-consuming, and present ethical dilemmas, so the team is developing a reliable computer model of tuberculosis that can test many drug combinations and treatment regimens quickly. They can even identify the shortcomings of current antibiotics and what changes would best improve the cure rate for patients.



Their study proving the concept demonstrates how treatments with the standard antibiotics isoniazid and rifampin fare when taken according to different regimens approved by the U.S. Center for Disease Control. These include larger doses a few times per week and smaller daily doses. The computer simulations showed that daily treatment with both antibiotics is the best way to go, but even then, the drugs have a hard time killing off all of the TB bacteria. Part of the problem is that bacteria can hide out in tumor-like lesions called granulomas.

"The drugs actually have to penetrate into the core of this granuloma," said Denise Kirschner, U-M professor of microbiology and immunology. Even then, Kirschner says the bacteria can protect themselves further by going into a passive state, in which they stop trying to reproduce. "If it's just sitting there, the drug is not going to have as strong an effect on it, which is why you have to treat for six months," she said. "You need to catch those bacteria in the few moments when they divide." Looking for a way to kill these holdouts, the team investigated whether increasing the number of doses would help raise the antibiotic concentrations inside the granulomas. They found that upping the doses to nine per week, perhaps with patients taking morning and evening doses twice per week, they were able to cut the time until the bacteria were wiped out by about 10 days, on average. (...) A paper on this research is published in the journal BMC Systems Biology, titled "In silico evaluation and exploration of antibiotic tuberculosis treatment regimens."

**Source:** University of Michigan, <http://bit.ly/1WVvKkL> (24.11.2015)

## Reportage

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### 1. Undercover tuberculosis: How SA's top killer slips in under the radar

Lindiwe Mkwanzazi (32) looks past her left leg that's resting on a low table in the direction of the small box-style TV. Sitting in the one-seater maroon couch, her body is as still as the building she spends almost all of her time in – a run-down block of flats in Mayville, an increasingly industrialised suburb just a few kilometres from Durban's central business district. She lives in the tiny second-floor flat with her parents and her 10-year-old daughter Amanda who, dressed in a bright pink tracksuit, stands at the door looking cautiously inside.

Mkwanzazi's face is expressionless, motionless. But her mother, Sipiwe Khumalo, a large woman in her 50s, remembers Mkwanzazi very differently. From the opposite side of the small lounge, Khumalo says five years ago one would have met an active young mother who supported her three young children with a steady job as a security guard. "When her knee got really painful she went to the clinic but they gave her Panado," Khumalo says. "I can't even remember how many times she went, again and again, and only when she could hardly walk they sent her to hospital [in April 2014]." Within five years she had dropped from a size 42 to a size 28.

Doctors performed a biopsy on Mkwanzazi's knee, removing a small piece of tissue to test for disease. After searching since 2010 she finally found out what was wrong when the biopsy results came back: she had tuberculosis (TB) in her knee joint. She began taking treatment but, Khumalo says, once her daughter is cured she does not think the damage will be entirely reversed.

"I think if more people knew that TB can go anywhere in the body people like in Lindiwe's case, they could get help earlier," she says.

Johan Davis, head of the orthopaedic spinal service at Tygerberg Academic Hospital in the Western Cape, says many people aren't aware of extrapulmonary tuberculosis – that the bacterial infection can occur in places other than the lungs. "It is certainly most common in the lungs and this is also the route the disease is spread, which is probably why it gets so much focus," he says.

In 2011, an estimated 15% of tuberculosis cases in South Africa were diagnosed in places outside the lungs and were more costly to treat and had worse outcomes than tuberculosis of the lungs,



according to the World Health Organisation (WHO). This is higher than China, one of the WHO's other high-burden countries, where fewer than one in 10 cases are found outside the lungs. Davis says South Africa's higher rate is related to the country's HIV infection rates, which are exponentially higher than China's. "The risk of TB outside the lungs rises incredibly when a patient is also HIV-infected – up to 60% of people with both conditions will have musculoskeletal tuberculosis, compared to 3% in the HIV-negative group," he says. This is because the body's immune system is less able to combat the tuberculosis bacteria when it enters the lungs, making it "easier to travel".

Davis, who also lectures and conducts research at Stellenbosch University, says that, in his experience, about half of South Africa's musculoskeletal tuberculosis cases are found in the spine and the other half is divided between the other joints and bones. Mkwanzazi's tuberculosis-infected knee is therefore "a relatively rare case in the context of rare cases", says Davis, who has treated this form of the disease as an orthopaedic surgeon.

There is no specific prevalence data for joint-related tuberculosis in the country. But a 1995 paper published in the *Journal of Bone & Joint Surgery* carried a study on all knee-tuberculosis cases in children at Maitland Cottage Hospital in Cape Town from 1979 to 1991. A total of 33 cases were found and, although diagnosis and treatment has changed since then, the authors noted that "early diagnosis is essential to preserve the mobility" of patients. Three children, whose illness was at an advanced stage when they started treatment, were considered disabled because their knee joints could only rotate between 20 and 80 degrees.

Davis says four years is a long time for an active tuberculosis infection to remain undiagnosed. "I do not know this patient but, in my experience, by then the expected destruction of the cartilage in the knee could be so profound she likely won't really recover in terms of mobility and function."

Extrapulmonary tuberculosis is more difficult to diagnose than tuberculosis of the lungs and often requires specialists, says Davis. "In spinal TB, for example, we will surgically remove fluid or tissue from the area for a diagnosis and if the disease is severe the patient may need reconstructive surgery along with the conventional drug treatment." He says most extrapulmonary sites are hard to reach and need a certain level of expertise "just to get the tissue" for diagnostic purposes.

Additional scans and X-rays may also be required, which are often extremely expensive. "It's incredibly resource-intensive compared to TB of the lungs where getting a diagnostic specimen can be as simple as a patient providing a sputum sample at a clinic."

The national department of health's 2014 tuberculosis guidelines state that suspected extrapulmonary tuberculosis cases should be referred to tertiary centres. "But there is a chronic shortage of specialists in the country, which makes the problem even harder to tackle," says Davis. The biggest problem is diagnosis: the typical symptoms, widely known and associated with tuberculosis, "particularly coughing up blood", don't necessarily appear in cases where the infection is not in the lungs.

"TB is also a great mimicker – it can look like other pathologies. In other parts of the body, especially the musculoskeletal system, it can be confused with forms of arthritis and cancer."

Often a surgical procedure, in the form of a biopsy, is needed to confirm the diagnosis. Davis says there are very few public-sector specialists in the Western Cape capable of doing this in the case of spinal tuberculosis. "I'm not sure about the rest of the country, but my guess is that other provinces are even less resourced."

For Mkwanzazi, Davis says a knee replacement is likely her only option, but because she is young, even this is not ideal. "A knee replacement has a lifespan of about 10-15 years, and once worn out it might need replacing," he says. At home Mkwanzazi's eyes move from the TV and in a lucid moment they connect with Amanda. She closes her eyes and looks away as tears fall slowly down her cheek. Amanda brings a walker from the bedroom at her mother's request. "I can't do anything anymore. I can't even go outside, never mind make money for my family. I sit here all day but when my child





comes home from school I don't have any food ready for her," she says.

Mkwanazi uses the walker's frame to raise herself. Once up she lifts her head and looks at her audience. "I suffer most because I can see my mother suffering. She is old, but she is working. Cleaning. Cooking. Looking after me when I should be looking after her. She is the mother to Amanda instead of her grandmother."

**Source:** Mail & Guardian, <http://bit.ly/1OPxGJk> (27.11.2015)

## PRESSEMITTEILUNG STOP-TB FORUM

### **Tuberkulosebekämpfung und die medizinische Versorgung von Flüchtlingen in Deutschland: Gesundheitssysteme stärken, Vorurteile entkräften**

*Berlin, 26. November 2015. Die momentane medizinische Versorgung von Flüchtlingen in Deutschland zeigt die Notwendigkeit einer schnellen Stärkung des Öffentlichen Gesundheitsdienstes (ÖGDs) -- insbesondere die Sicherung einer adäquaten Diagnose und Behandlung von TuberkulosepatientInnen. Die Art der Berichterstattung zu Verdachtsfällen bei Flüchtlingen zeigt zudem, dass eine bessere Aufklärung der Öffentlichkeit notwendig ist, um eine Stigmatisierung von Betroffenen zu vermeiden. Wie das Robert Koch Institut hervorhebt, stellen Flüchtlinge eine gefährdete Gruppe dar und nicht eine, von der eine Gefahr ausgeht.*

„Gesundheit ist ein Menschenrecht. Deutschland kann und muss für eine angemessene medizinische Versorgung von Flüchtlingen einstehen. Der Kampf gegen die Tuberkulose, eine der ältesten bekannten Krankheiten der Menschheit, zeigt exemplarisch, dass dies Ressourcen statt Ressentiments erfordert. Gerade Deutschland, die Heimat des Tuberkulose-Forschungspioniers Robert Koch, sollte hier eine Vorbildrolle einnehmen“, bringt es Burkhard Kömm, Geschäftsführer der Stop-TB Forum-Mitgliedsorganisation DAHW Deutsche Lepra- und Tuberkulosehilfe, auf den Punkt.

Das Stop TB Forum, ein Zusammenschluss humanitärer und entwicklungspolitischer Nichtregierungsorganisationen aus Deutschland, mit dem Ziel der weltweiten TB-Bekämpfung, sieht dafür die deutsche Politik national und international in der Pflicht. Für eine nachhaltige TB-Kontrolle fordert das Netzwerk daher:

#### 1. Stärkung der nationalen Versorgungsstrukturen in Form des ÖGDs

Der ÖGD befindet sich seit einigen Monaten unter verstärkter Beanspruchung. „Exemplarisch dafür steht das Ringen um die Gewährleistung einer angemessenen Diagnostik und Behandlung von Tuberkuloseinfektionen. Beides sind wichtige Gradmesser für die Leistungsfähigkeit des ÖGDs und für den politischen Willen, diese zu sichern,“ so Dr. Martin Priwitzer, Arzt im öffentlichen Gesundheitsdienst und Präsidiumsmitglied des DZK. „Neben der medizinischen Untersuchung und Behandlung von Flüchtlingen bildet die angemessene Unterbringung im Fall der TB Schlüssel zur erfolgreichen Vorsorge. In diesem Zusammenhang ist die besondere Rolle des ÖGDs für die aktive Fallsuche hervorzuheben. Wir brauchen aber eine schnelle Aufstockung finanzieller und personeller Ressourcen, um diese Funktion weiterhin effektiv wahrnehmen zu können.“

#### 2. Umfangreicheres internationales Engagements Deutschlands gegen die Tuberkulose

Die deutsche Politik hat zuletzt im Rahmen der G7-Präsidentschaft mehrfach bekräftigt, dass die Stärkung von Gesundheitssystemen eines ihrer zentralen Anliegen darstellt. Dieses Versprechen ist nicht nur national, sondern vor allem auch international einzulösen. „Ursachenbekämpfung wird hierfür unerlässlich sein“, stellt Max Klein, Koordinator des Stop-TB Forums, fest „ein nachhaltiger Ausbau von Gesundheitssystemen sowie die Verbesserung von Lebensbedingungen sind elementar, insbesondere in Ländern mit höherem TB-Vorkommen. In diesem Zusammenhang kommt auch der



angemessenen Finanzierung des Globalen Fonds zur Bekämpfung von Aids, Tuberkulose und Malaria (GFATM) von deutscher Seite eine zentrale Rolle zu.“

### 3. Vorgehen gegen die dramatischen Forschungslücken bei Tuberkulose

„Entsprechende Maßnahmen müssen zudem flankiert werden durch größeres Engagement im Bereich Forschung und Entwicklung. Weiterhin wird die Bekämpfung der Krankheit international und auch in Deutschland durch massive Forschungslücken erschwert“, so Hedwig Diekwisch von der BUKO Pharma-Kampagne. „Nach wie vor existiert keine adäquate Impfung gegen Tuberkulose. Zudem bedeutet die Behandlung resistenter TB aufgrund veralteter Antibiotika mehrjährige Strapazen für PatientInnen.“

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