GENERATING DEMANDS AND ACTIVISM FOR LTBI

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Photo: David Harrison for Treatment Action Campaign
Where is prevention?

Reach at least 90% of all people with TB and place all of them on appropriate therapy—first-line, second-line and preventive therapy as required.

As a part of this approach, reach at least (90)% of the key populations the most vulnerable, underserved, at-risk populations.

Achieve at least 90% treatment success for all people diagnosed with TB through affordable treatment services, adherence to complete and correct treatment, and social support.

Stop TB Partnership

UNAIDS

90%

90%

90%
INNOVATION IS A POWERFUL CATALYST FOR ACTIVISM
WE’RE SEEING THIS PLAY OUT IN HIV PREVENTION

- Advent of PrEP has inspired a resurgence in HIV *prevention* advocacy.
- This has included some controversy—or, affected communities having tough conversations about issues of Availability, Accessibility, *Acceptability*, and Quality of prevention options.
- At the same time, PrEP and TasP have mapped a way to side-step debates about treatment *versus* prevention.
INNOVATION IS ALSO INSPIRING ACTIVISM IN TB PREVENTION

- Approved by a stringent regulatory authority for TB infection (FDA, 2014)
- Listed on the Global Drug Facility catalogue (2016)
- Sold at an affordable price point in the U.S. (2014)
- Subject of ongoing research (e.g., FDC and pediatric formulation development)
SCIENTIFIC PROGRESS ALONE ISN’T ENOUGH. PEOPLE NEED ACCESS TO ITS BENEFITS.

The pieces for rifapentine uptake are falling into place—for some people, in some places. But more needs to be done:

1. Register rifapentine more widely.

2. Increase awareness, build demand, mobilize communities.

   Even in the U.S., not all clinicians have realized that rifapentine (Priftin) = 3HP = shorter LTBI treatment.

   TAG has received lots of requests for information on 3HP from communities (South Africa, Peru, U.S., Vietnam etc.)
WE NEED TO MOBILIZE COMMUNITIES AROUND TB PREVENTION
“LTBI” is what we’re trying to address. But the term “LTBI” is not a good tagline for a movement.

We need to start speaking to communities about **TB prevention**—in all its forms: preventive therapy, vaccination, infection control.

Communities should be mobilized to address:

1. Unmet prevention research needs (R&D advocacy)
2. Scale-up of existing interventions (access advocacy)

Or better yet, devise even more persuasive ways to talk about prevention—e.g., becoming **TB proof**.
LOOK FOR COMMUNITY PARTNERS OUTSIDE THE USUAL “SUSPECTS”

Form partnerships not just with TB or HIV community-based organizations, but also with NGOs working on issues related to:

- Immigration
- Homelessness
- Children and families
- Refugees/re-settlement
- Labor Unions
- Others?
3 ENSURE ETHICS & HUMAN RIGHTS GUIDE OUR THINKING
• Where we decide to intervene on the LTBI spectrum of risk will shape the number of (healthy) people asked to undergo testing and treatment.

• Tackling LTBI asks us to think about a whole new clinical category of people—the pre-symptomatically ill.

• We shouldn’t be surprised if we’re met with a lot of skepticism.
THIS SKEPTICISM IS NOT UNWARRANTED

• We should remember that in many places, a TB diagnosis carries a lot of stigma.

• There are still places where TB infection / disease / transmission are criminalized under the law.

• TB is a disease of families and close-knit communities.

• Can we get to the point where people diagnosed with active TB request contact-tracing and screening of family and friends?

• Can we get to the point where PLHIV demand preventive therapy as their right?
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