TB EUROPE COALITION

BRINGING CIVIL SOCIETY TOGETHER
TO END THE TUBERCULOSIS EPIDEMIC

The second practical webinar in the series “The ABC for a TB Activist”.
The topic:
1/4/6x24 and supportive diagnostics: short TB treatment and prevention regimens.

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TB Europe Coalition
15 June 2023

1/4/6x24

A Campaign to Rally Energy, Political Will & Funding to End TB

& SUPPORTIVE DIAGNOSTICS

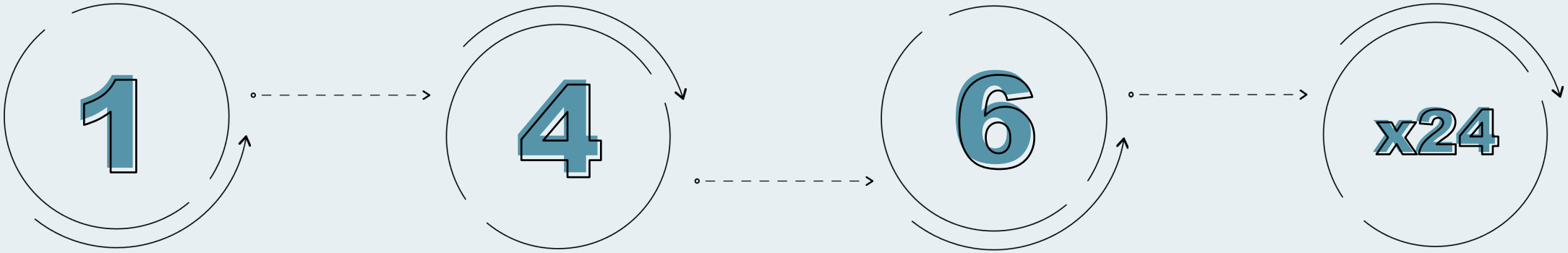
David Branigan, Treatment Action Group

TB Europe Coalition Webinar

15 June 2023

TAG
Treatment Action Group

WHAT DOES IT MEAN?



one-month or once weekly treatment regimens for TB prevention.

four-month treatment regimens for drug-sensitive TB.

six-month treatment regimens for drug-resistant TB.

by the end of 2024.

A deadline for having in place the "staff, stuff, space, systems, and support" needed for shorter TB regimens to be made accessible to everyone, everywhere as a human right.

& priority research to extend the benefits of short treatment and prevention regimens to any groups who cannot currently use them due to data gaps or research exclusions.

WHY DO WE NEED THIS CAMPAIGN?

The COVID-19 pandemic and other concurrent global health, economic, social, and political crises have rolled back and continue to threaten progress in the fight against TB.

We've already missed nearly all the treatment and prevention targets set during the United Nations High Level Meeting on TB in 2018.

To get back on track to ending TB by 2030, we need an infusion of energy, political will, and funding – the generation of which requires **something inspiring to rally around.**

After 20+ YEARS (!!) of research and development, we can finally treat TB infection in as little as one month and most forms of drug-sensitive and drug-resistant TB in four and six months.

Yet relatively few people have access to these shorter regimens – **the lack of access to these advances is a human rights issue that should inspire outrage.**

REMEBERING PAUL FARMER

(1959–2022)

“If everyone has a right ‘to share in scientific advancement and its benefits,’ where are our pragmatic efforts to improve the spread of these advances? … even as our biomedical interventions become more effective, our capacity to distribute them equitably is further eroded.”

— Pathologies of Power: Rethinking Health and Human Rights, AJPH 1999

The right of everyone to enjoy the benefits of scientific progress and its applications i.e., **the right to science**.

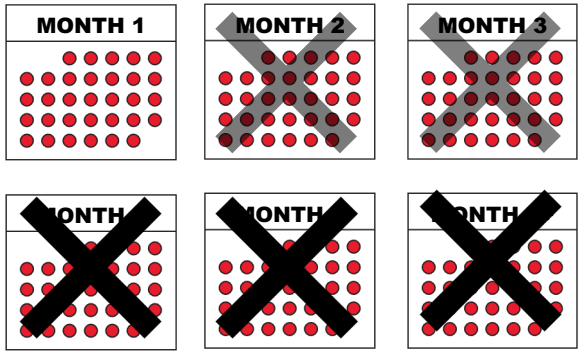
Governments have “a duty to make available and accessible to all persons, without discrimination, especially to the most vulnerable, all the best available applications of scientific progress necessary to enjoy the highest attainable standard of heath.”

— General Comment 25, Committee on Economic, Social and Cultural Rights

NOW AND THEN

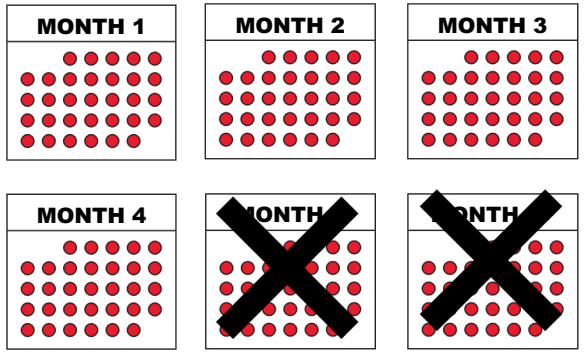
TB Prevention

6+ → 1 month



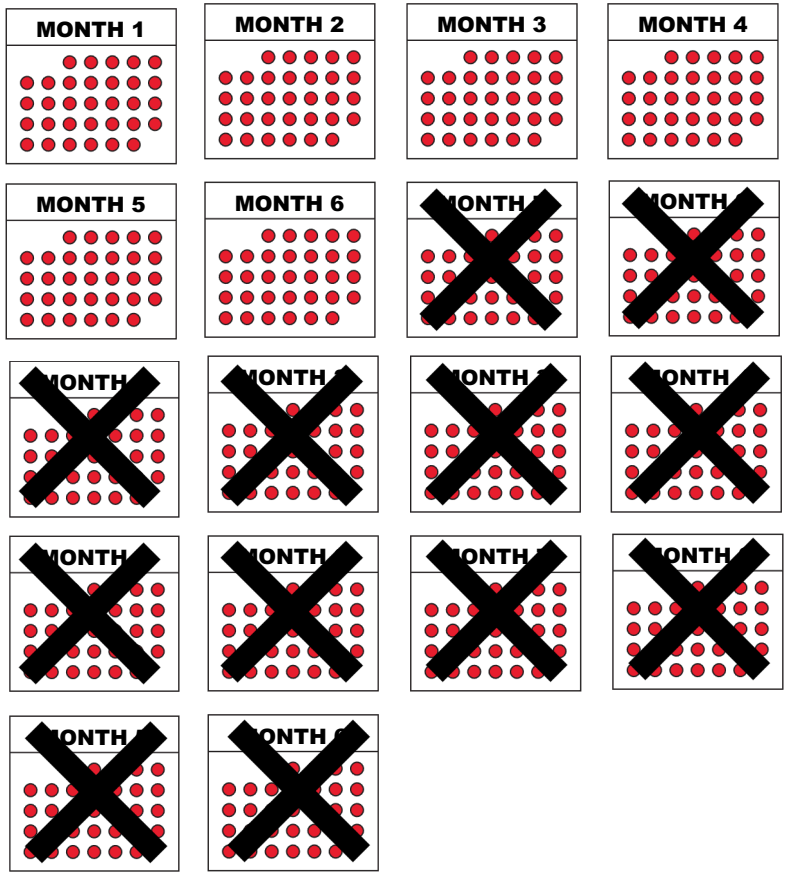
Treatment (DS-TB)

6 → 4 months



Treatment (DR-TB)

18 → 6 months
(+no more hearing loss!)



SHORTER REGIMENS MEAN...

People and families affected by TB can get back to work, school, etc. and recover economically sooner.

People affected by TB find treatment more safe, tolerable and acceptable, leading to fewer interruptions that can generate resistance, higher rates of treatment completion, and better outcomes.

Human resources and other health program savings from shorter duration of prevention and treatment regimens can be repurposed to improve active screening and case finding, and psychosocial and other supportive services and programs.

STAFF, STUFF, SPACE, SYSTEMS, SUPPORT

STAFF

Staff being all care providers, including doctors, nurses, community health workers (e.g., public, private, informal, community-based, etc.)

STUFF

Stuff being diagnostic tests and corresponding consumables, imaging technologies, medications, other equipment

SPACE

Space being appropriate, dignified care facilities for patients within a clinic, hospital, or community care setting

SYSTEMS

Systems being policymaking and regulatory mechanisms, active case finding outreach programs, referral services

SUPPORT

Support being accompaniments for patients to get better, such as food, housing, counselling, and other psychosocial services. This approach requires a multi-sector and fully financed TB response.

DIAGNOSTICS SUPPORTIVE OF 1/4/6X24

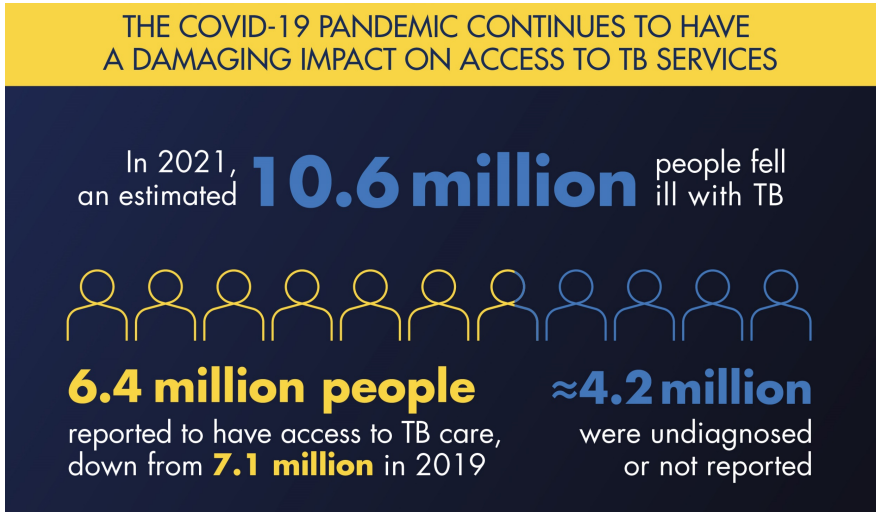
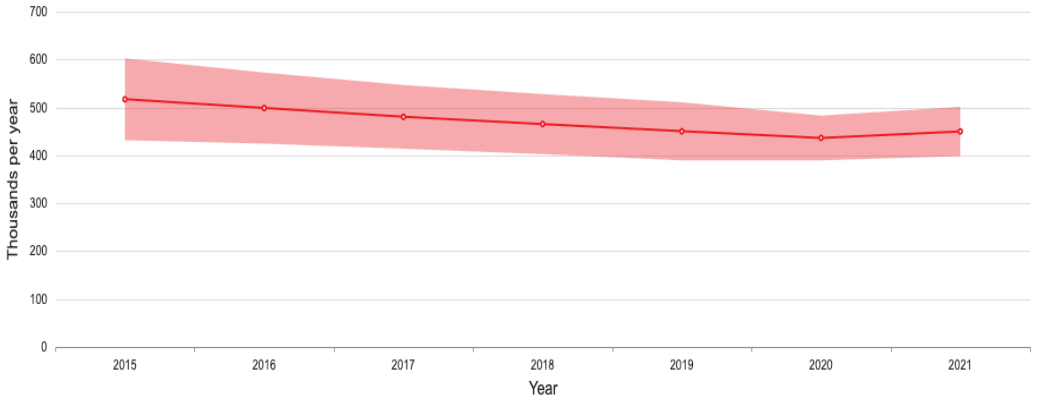


Fig. 2.3.1 Global trend in the estimated number of incident cases of MDR/RR-TB, 2015–2021
The shaded area represents the 95% uncertainty interval.

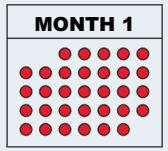


Source: WHO Global TB Report, 2022

- In 2021, 40% of the 10.6 million people who developed active TB were not diagnosed or notified to the health system.
- Most people with TB symptoms first seek care in primary health centers or in the private sector, where they are often not offered TB testing or are only tested using smear microscopy, an outdated diagnostic that is only about 50% sensitive and does not test for drug resistance.
- Even though several rapid molecular diagnostics have been endorsed by WHO, only 38% of all people diagnosed and notified with TB in 2021 received a WHO-recommended rapid diagnostic (WRD).
- Of the 450,000 people estimated to have developed RR/MDR-TB in 2021, just one in three was linked to DR-TB treatment.
- Testing for TB infection is not required to start TB preventive treatment (TPT) for people at higher risk of developing disease, but limited access to tests for TB infection makes it hard to scale TPT.

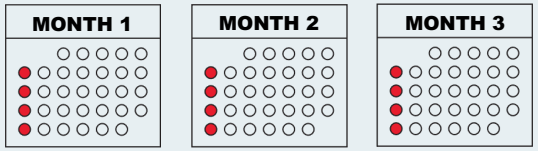
1 = TB Preventive Treatment (TPT)

1HP



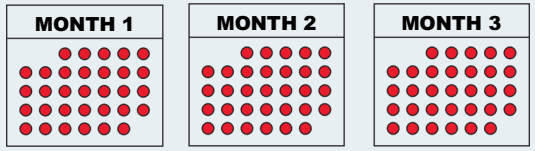
1 month of daily isoniazid (**H**) + rifapentine (**P**)

3HP



3 months of once-weekly isoniazid (**H**) + rifapentine (**P**)

3HR



3 months of daily isoniazid (**H**) + rifampicin (**R**)

Supportive Diagnostics	State of access
Tests for TB infection *(not required for people living with HIV or TB contacts under 5 years)* • Interferon-gamma release assays (IGRAs) • TB-specific skin tests (TBST)	Limited availability of IGRAs due to complexity and cost. TBST pending quality assurance by Global Fund ERP; no WHO Prequalification pathway yet for these products.
Screening tests to rule out active TB, prior to starting TPT • Chest X-ray +/- computer-aided detection (CAD) • C-reactive protein (CRP) tests for people living with HIV (PLHIV) • Rapid molecular tests for PLHIV	Limited scale-up of chest X-ray devices due to high cost of hardware. Scale up of CAD dependent on access to digital chest X-ray. CRP tests widely available. Limited scale-up of rapid molecular tests due to cost and placement.

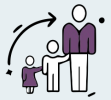
4 = DS-TB Treatment

S31/A5349

Adults and adolescents down to 12 years old are eligible for the **4-month rifapentine- and moxifloxacin-containing regimen** from TBTC Study 31 / ACTG A5349

4 H P M Z – four months of daily treatment with isoniazid, rifapentine, moxifloxacin + pyrazinamide for the first two months.

SHINE



Children 0-16 years old with "non-severe" TB are eligible for **the 4-month regimen from the SHINE trial**

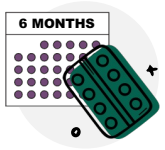
"Non-severe" TB is smear negative and limited to the lymph nodes or confined to one lobe of the lungs without cavitation (determined by x-ray).

4 H R Z [E] – four months of daily treatment with isoniazid and rifampicin + pyrazinamide (and ethambutol in certain situations) for the first two months.

These factors combined indicate a smaller amount of TB bacteria in the child's body necessitating a shorter duration of treatment.

Supportive Diagnostics	State of access
Screening tests for TB and to diagnose non-severe TB in children • Chest X-ray +/- CAD	Limited scale-up of chest X-ray devices due to high cost of hardware. Scale up of CAD dependent on access to digital chest X-ray; research gap of CAD performance among young children must be addressed.
Diagnostic tests for TB • Rapid molecular tests for TB (including use of stool and other non-invasive samples for children who cannot produce sputum) • Broader use of WHO-recommended clinical diagnostic algorithms • Urine LAM tests for PLHIV	Limited scale-up and decentralization of rapid molecular tests due to cost and infrastructure requirements. Need to implement standard operating procedures for testing non-sputum samples that are easy to obtain from children. Limited scale-up of urine LAM tests due to insufficient prioritization and action to update national algorithms.
Drug-susceptibility testing • Rapid and high-throughput molecular tests for RIF, INH and FQ resistance • Line probe assays for PZA and EMB resistance	Limited scale-up of molecular tests for RIF, INH and FQ resistance due to cost. Limited access to line probe assays due to centralized placement and cost.

6 = DR-TB Treatment



6 B Pa L [M] – six months of daily treatment with bedaquiline, pretomanid, linezolid, and moxifloxacin.

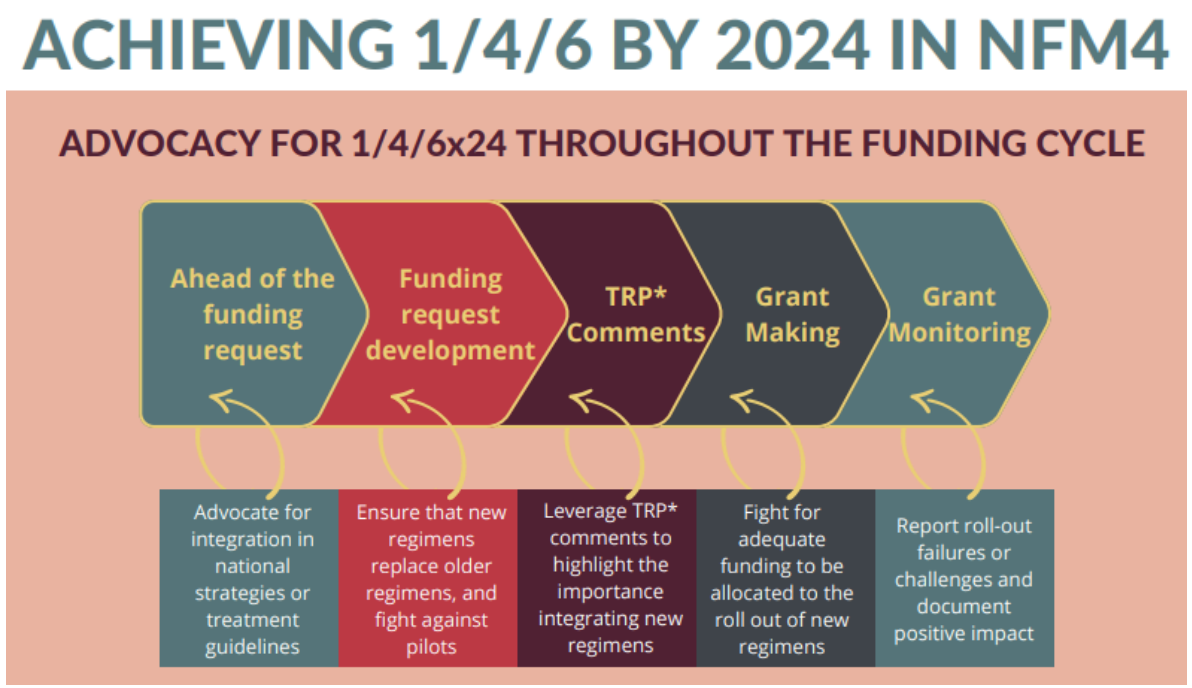
Linezolid is given at 600 mg daily, with further dose reduction as needed. The regimen can be given without moxifloxacin (6BPaL) if there is fluoroquinolone resistance (pre-XDR-TB).

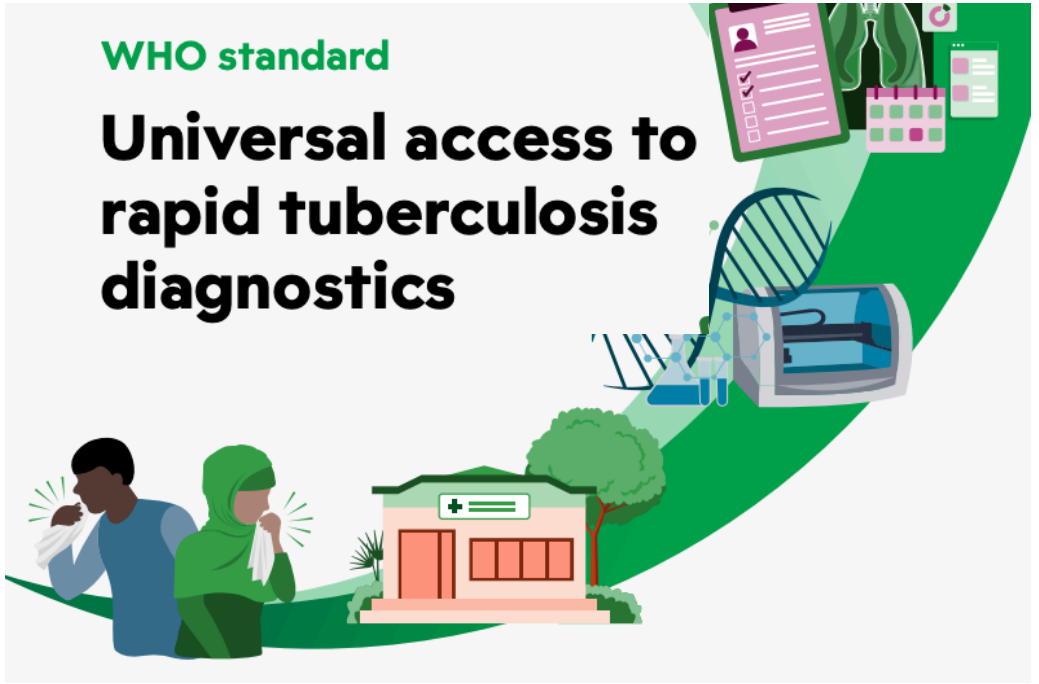
Treatment is extended to nine months if culture conversion (the amount of time it takes for TB cultures to turn negative, indicating TB bacteria are no longer replicating) is slow.

Supportive Diagnostics	State of access
Drug-susceptibility testing • Rapid or high-throughput molecular tests for RIF, INH, and FQ resistance • Mycobacterial culture for BDQ, PTD, and LZD susceptibility testing • Targeted next-generation sequencing (tNGS) susceptibility testing for all TB drugs	Limited scale-up of molecular tests for RIF, INH, and FQ resistance due to cost. Limited access to mycobacterial culture for BDQ, PTD, and LZD resistance due to centralized placement and long turnaround time to results (2-6 weeks); need for a WHO-recommended critical concentration for PTD phenotypic DST. tNGS pending WHO recommendation; likely high cost and initial placement in central labs requiring sample transport.

ADVOCACY TO ADVANCE ACCESS

Scaling up access to the shorter, safer 1/4/6 regimens and implementing the WHO standard for universal access to rapid diagnostics requires urgently expanding access to currently available tools for TB screening and diagnosis and increasing investments in TB diagnostics research and development, including children as a priority population. This will require increased donor and domestic funding for implementation and R&D, along with more affordable pricing and improved supply of drugs and diagnostics.





Program Essentials include 1/4/6 regimens

"Treatment and care services should be designed and delivered considering the needs and preference of people with TB rather than that of the health care system… Use of shorter, all-oral and patient-friendly treatment regimens recommended by WHO… are important elements to support a person with TB to access and complete their treatment successfully."

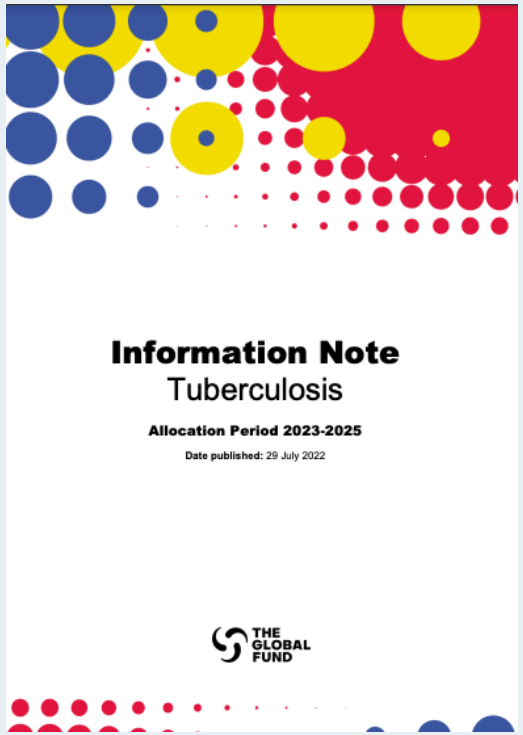


Table 4: Program Essentials for Global Fund Supported Services

2. TB treatment and care
2.1 Child-friendly formulations, all-oral regimens for DR-TB, and 4-month regimen for non-severe, DS-TB are used for TB treatment in children.
2.2 People with DR-TB receive shorter, all-oral regimens or individualized longer treatment regimens as recommended by WHO and people-centered support to complete their treatment.
3. TB prevention
3.1 TB preventive treatment (including shorter regimens) is available for all eligible people living with HIV (adults and children) and for all eligible household contacts of people with bacteriologically confirmed pulmonary TB.

Also: "The new, 4-month DS-TB regimen (2HPMZ/2HPM) for people aged ≥12 years may be considered when the needs justify the additional costs over the existing standard regimen."

https://www.theglobalfund.org/media/4762/core_tuberculosis_infonote_en.pdf

Program Essentials include supportive diagnostics

“To improve early TB diagnosis, applicants are encouraged to implement intensified case finding in health facilities, conduct active case finding and surge campaigns targeting key and vulnerable populations and high TB prevalence settings. The use of molecular WHO-recommended rapid diagnostics (mWRD), as the initial diagnostic test to replace sputum microscopy should be prioritized. Testing non-sputum-based samples of children, improving bacteriological confirmation of pulmonary TB, and universal rapid drug-susceptibility testing (DST) are other priorities.”

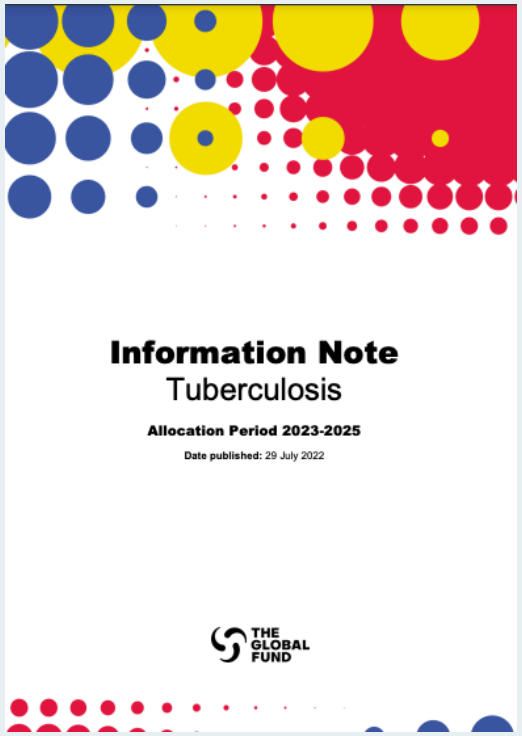


Table 4: Program Essentials for Global Fund Supported Services

1. TB screening and diagnosis
1.1 Systematic TB screening is provided for those at highest risk (key and vulnerable populations), including using Chest X-rays with or without computer-aided detection (currently recommended for people aged 15 years and older).
1.2 Multiyear plan to achieve universal use of rapid molecular assays as the initial test to diagnose TB for all people with presumptive TB, with implementation on track.
1.3 All people with bacteriologically confirmed TB are tested for at least rifampicin resistance and for those with RR-TB further tests are conducted to rule out resistance to other drugs.
1.4 TB diagnostic network operates efficiently to increase access to testing and includes specimen transportation, maintenance of equipment, connectivity solutions, biosafety, quality assurance and supply system.

https://www.theglobalfund.org/media/4762/core_tuberculosis_infonote_en.pdf

GFAN Advocacy Guides to 1/4/6x24

Global Fund funding request development, and the country dialogues that precede it, is a crucial time to ensure that the Global Fund invests in the latest advances in diagnostics and treatment in the next funding cycle.

ACHIEVING 1/4/6 BY 2024 IN NFM4

A guide to advocating for new and shorter TB regimens in Global Fund country dialogues

With the Global Fund's Seventh Replenishment Conference now behind us and a recently approved new allocation methodology for the 2023 – 2025 period, countries will soon begin to receive allocation letters from the Global Fund Secretariat prompting the development of national funding requests. Country Coordinating Mechanisms (CCMs), which are national committees that submit funding applications to the Global Fund and oversee grants on behalf of their countries, are starting to engage in country dialogues to give all stakeholders a voice in the development and agreement of key priorities for their national funding requests.

Now is the time for in-country TB advocates representing civil society and affected communities to prepare to engage in CCM led country dialogues. Evidencing a transparent and inclusive funding request development process is an eligibility requirement for Global Fund funding, and your voice is critical to identifying areas that require further prioritization to save lives and achieve maximum programmatic impact for national programs. In this briefing note, you will find information and key messages to support you to elevate rapid adoption and roll out of safer, shorter, and more effective novel TB treatment regimens throughout the country dialogue consultation process.

ADVOCACY FOR 1/4/6x24 THROUGHOUT THE FUNDING CYCLE

*The Technical Review Panel (TRP) independently reviews funding requests and issues recommendations

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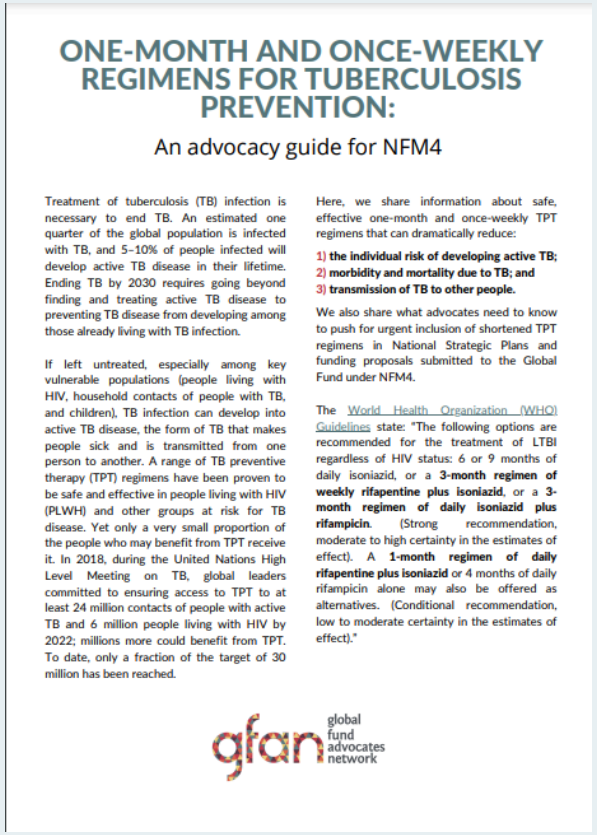

ONE-MONTH AND ONCE-WEEKLY REGIMENS FOR TUBERCULOSIS PREVENTION:

An advocacy guide for NFM4

Treatment of tuberculosis (TB) infection is necessary to end TB. An estimated one quarter of the global population is infected with TB, and 5–10% of people infected will develop active TB disease in their lifetime. Ending TB by 2030 requires going beyond finding and treating active TB disease to preventing TB disease from developing among those already living with TB infection.

If left untreated, especially among key vulnerable populations (people living with HIV, household contacts of people with TB, and children), TB infection can develop into active TB disease, the form of TB that makes people sick and is transmitted from one person to another. A range of TB preventive therapy (TPT) regimens have been proven to be safe and effective in people living with HIV (PLWH) and other groups at risk for TB disease. Yet only a very small proportion of the people who may benefit from TPT receive it. In 2018, during the United Nations High Level Meeting on TB, global leaders committed to ensuring access to TPT to at least 24 million contacts of people with active TB and 6 million people living with HIV by 2022; millions more could benefit from TPT. To date, only a fraction of the target of 30 million has been reached.

Here, we share information about safe, effective one-month and once-weekly TPT regimens that can dramatically reduce:

1) **the individual risk of developing active TB;**
2) **morbidity and mortality due to TB; and**
3) **transmission of TB to other people.**

We also share what advocates need to know to push for urgent inclusion of shortened TPT regimens in National Strategic Plans and funding proposals submitted to the Global Fund under NFM4.

The World Health Organization (WHO) Guidelines state: "The following options are recommended for the treatment of LTBI regardless of HIV status: 6 or 9 months of daily isoniazid, or a **3-month regimen of weekly rifapentine plus isoniazid**, or a **3-month regimen of daily isoniazid plus rifampicin**. (Strong recommendation, moderate to high certainty in the estimates of effect). A **1-month regimen of daily rifapentine plus isoniazid** or 4 months of daily rifampicin alone may also be offered as alternatives. (Conditional recommendation, low to moderate certainty in the estimates of effect)."

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FOUR-MONTH TREATMENTS FOR DRUG-SENSISTIVE TUBERCULOSIS

An advocacy guide for NFM4

After decades of waiting, there are finally 4-month regimens for the treatment of drug-sensitive tuberculosis (DS-TB) supported by evidence from randomized controlled trials and endorsed by the World Health Organization (WHO). One regimen is for children with non-severe forms of TB (most children have this type of TB). The other regimen is for adults and adolescents and its implementation is not limited by disease severity. Here, we consider both 4-month regimens for DS-TB and what advocates need to know to push for their urgent inclusion in National Strategic Plans and funding proposals submitted to the Global Fund under NFM4.

Four-Month "SHINE" Regimen for children with non-severe forms of DS-TB

The WHO Guidelines state that in "children and adolescents between 3 months and 16 years of age with non-severe TB (without suspicion or evidence of MDR/RR-TB), a 4-month treatment regimen (2HRZ(E)/2HR) should be used." This is a strong recommendation based on moderate certainty of evidence. The evidence supporting this recommendation comes from the innovative and pragmatic SHINE trial, one of the only trials specifically carried out for children with clinically diagnosed TB—which is how most children are diagnosed in real-world settings. The SHINE regimen utilizes child-friendly formulations that countries are already using in the standard six-month regimen - dispersible, fixed-dose combinations of isoniazid, rifampicin with and without pyrazinamide (HRZ/HR), sometimes given with a standalone dispersible tablet of ethambutol (E). The SHINE study randomized 1,204 children from sites in Uganda, Zambia, South Africa, and India whose TB met the definition of "non-severe disease" to receive either the standard 6-month TB regimen or a 4-month version of it, with 2 months cut off of the continuation phase. The 4-month SHINE regimen was found to be non-inferior to the 6-month regimen with a 97% success rate. Non-severe disease in the study was identified using smear microscopy and chest X-ray. Ethambutol was included in the first 2 months of treatment for all children with HIV and if it was a standard part of DS-TB treatment for children in the country.

These exciting results should lead to the rapid uptake of this 4-month regimen for children, especially since no new drugs or combination tablets are required. The key, however, will be ensuring that there is a strategy to diagnose children with non-severe disease (see strategies in key arguments below). Country Programs should develop this approach and record the distribution of disease severity in children to support planning and forecasting for implementing the 4-month SHINE regimen for children with non-severe DS-TB in the future.

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SIX-MONTH TREATMENTS FOR DRUG-RESISTANT TUBERCULOSIS

An advocacy guide for NFM4

The May 2022 World Health Organization (WHO) rapid communication on forthcoming drug-resistant tuberculosis (DR-TB) treatment guidelines, which will recommend all oral, six-month BPaL/M (bedaquiline, pretomanid, linezolid + moxifloxacin) regimens for treating DR-TB states that:

> The 6-month BPaLM regimen, comprising bedaquiline, pretomanid, linezolid (600 mg) and moxifloxacin, may be used programmatically in place of 9-month or longer (>18 month) regimens, in patients (aged ⩾15 years) with MDR/RR-TB who have not had previous exposure to bedaquiline, pretomanid and linezolid (defined as >1 month exposure). This regimen may be used without moxifloxacin (BPaL) in the case of documented resistance to fluoroquinolones (in patients with pre-XDR-TB). Drug susceptibility testing (DST) to fluoroquinolones is strongly encouraged, but DST should not delay treatment initiation.

This means that countries around the world can start making shorter, safer, and more effective regimens available to people living with DR-TB, which will be a tremendous lifesaving advance in TB treatment and care. Before the development of the BPaL/M regimens, the global treatment success rate for DR-TB was less than 60% with 9-18+ month treatment standards comprising a heavy pill burden per day (as high as 23 pills a day) and often injections. Now, DR-TB can be treated using six-month, all-oral, three- or four-drug regimens (BPaL/M) with reported success rates of approximately 90% in clinical trials.

Currently, no country in the world with a high burden of TB is routinely using BPaL/M regimens programmatically, although South Africa has committed to doing so by the end of 2022. However, as of October 2022, 22 regulatory authorities covering 49 countries have reviewed and approved BPaL/M, and an additional 11 countries have regulatory review in process. To date, at least 14 countries have administered the regimen through operational research or similar programs, with South Africa, Ukraine and Kyrgyzstan implementing BPaL nationally. Forty-one countries and counting have started to procure the regimen, with a cumulative total of ~5,000 treatment courses being shipped worldwide so far. Global Fund resources for the procurement and effective roll-out of BPaL/M regimens could dramatically accelerate and broaden uptake of these new DR-TB treatments.

New BPaL/M regimens are not only life saving, but also cost saving. A 2021 BPaL costing study found the cost per person completing treatment dropped by 50-80% in three diverse countries compared with older treatment regimens. As the usage of BPaL/M regimens expands in response to updated WHO guidelines, economies of scale are expected to make the regimen even more affordable.

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https://www.globalfundadvocatesnetwork.org/resource/advocacy-guides-to-1-4-6x24-shorter-regimens-for-tb/

KEY OPPORTUNITIES & NEXT STEPS

1. Take stock of where your national government is with respect to introducing and implementing the short-course 1/4/6 prevention and treatment regimens and what the barriers are – what are they not doing yet, and why?

2. Elevate the campaign to the attention of the Minister of Health and other duty bearers – what advocacy, communications, and other strategies can be used to generate political commitments and to address known barriers?

3. National Strategic Plan (NSP) Development – what is the timeframe, who is involved, and how can you influence its contents or get directly involved in the development process?

4. National Health & Research Budget Appropriations – what is the calendar / process for developing and passing annual appropriations bill(s)? Are there any legislators that can champion domestic funding increases for TB programs and research (e.g., to ensure a fully funded NSP)?

5. Global Fund Portfolio Optimization/Catalytic Investments and NFM4 – what is the timeframe, who is involved in the country coordinating mechanism (CCM), how can you influence the TB priorities or get directly involved in these discussions and decisions?

6. Are there other important stakeholders and/or funding mechanisms to engage with in your national context?

CAMPAIGN ASKS & ACTORS:
NATIONAL GOVERNMENTS

Expedite uptake of new innovations through 1) rapid updates of national guidelines, strategic plans, and essential medicines lists; and 2) healthcare worker trainings on short course TB prevention and treatment regimens.

Increase domestic and international investments in TB programming.

Leverage legal and other strategies that can help improve access to TB medicines and diagnostic technologies.

Develop patient-centered models of treatment and prevention that deliver care through differentiated, community-based systems, including for post-TB support.

CAMPAIGN ASKS & ACTORS:
DONORS / FUNDING MECHANISMS

Increase investments in TB programs, to support higher medicines costs and increased health systems, human resources, and laboratory infrastructure and diagnostic technology needs.

Establish new, and expand existing, sources of funding for civil society and community organizations to work on national 1/4/6x24 campaigns and accountability initiatives.

Expand resources and capacity to accelerate research to fill data gaps and shorten treatment even further.

CAMPAIGN ASKS & ACTORS:
PHARMA & DIAGNOSTICS COMPANIES

Develop fit-for-purpose formulations for short-course prevention and treatment regimens, including fixed-dose combinations and formulations appropriate for children.

Develop fit-for-purpose diagnostic technologies, including rapid molecular tests that can detect TB and resistance to key medicines (rifampicin, isoniazid, fluoroquinolones, bedaquiline) at the point of care.

Commit to rapid registration with stringent regulatory authorities and other national regulatory authorities as needed and early submission to the World Health Organization Pre-Qualification Program.

Commit to transparent, evidence-based pricing determined by the cost-of-goods-sold (COGS) plus a reasonable profit margin or to patent non-enforcement.

Commit to addressing outstanding research priorities (see next slide).

CAMPAIGN ASKS & ACTORS:
RESEARCH NETWORKS / INSTITUTIONS

Design and implement studies that address remaining research and data gaps

Evaluate risk factors or populations that would benefit from treatment extensions

Advance fit-for-purpose quantitative and qualitative research to support the introduction and scale up of the shorter regimens and supportive technologies.

Evaluate preferences and needs of the target populations to see what they want and will use

Ensure regimens are safe and dose optimized for PLHIV, younger adolescents, children, and pregnant people.

Invest in developing better point of care TB diagnostics and new TB vaccines

CAMPAIGN ASKS & ACTORS:
ALL HEALTHCARE PROVIDERS

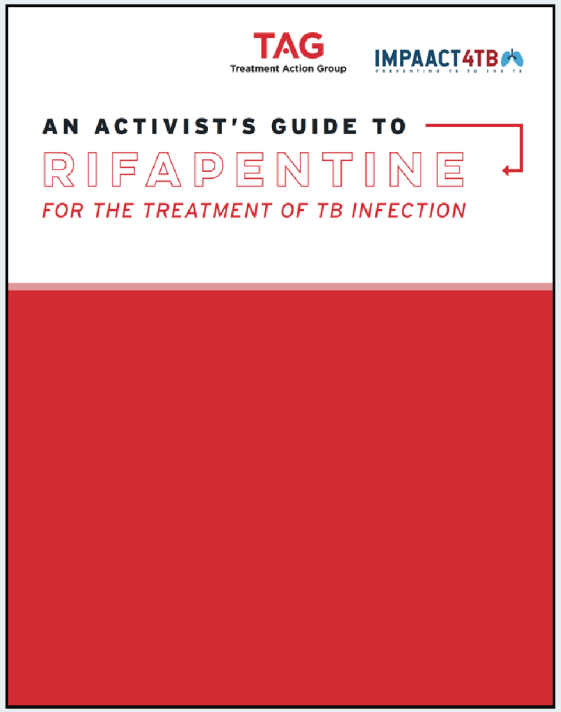
Demand access to new innovations through rapid updates of national guidelines, strategic plans, and essential medicines lists. Expedite uptake of new innovations through healthcare worker trainings on short course TB prevention and treatment regimens.

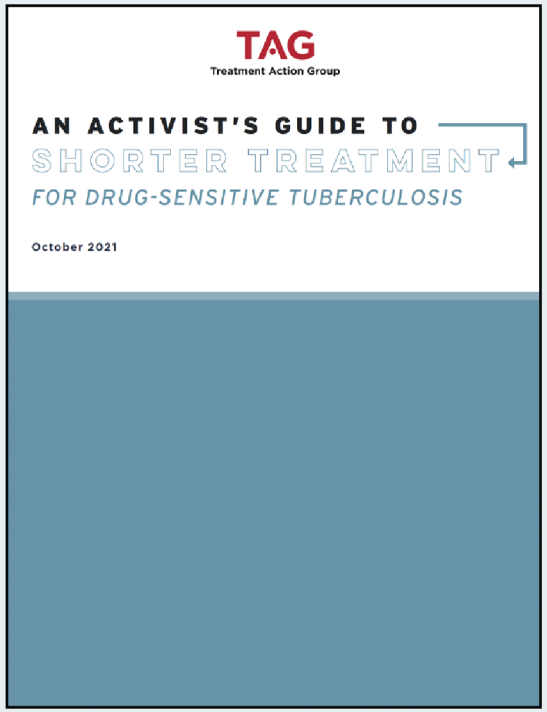
Mobilize through healthcare professional associations to network, inform, learn and build commitment to implementing 1/4/6 by the end of 2024.

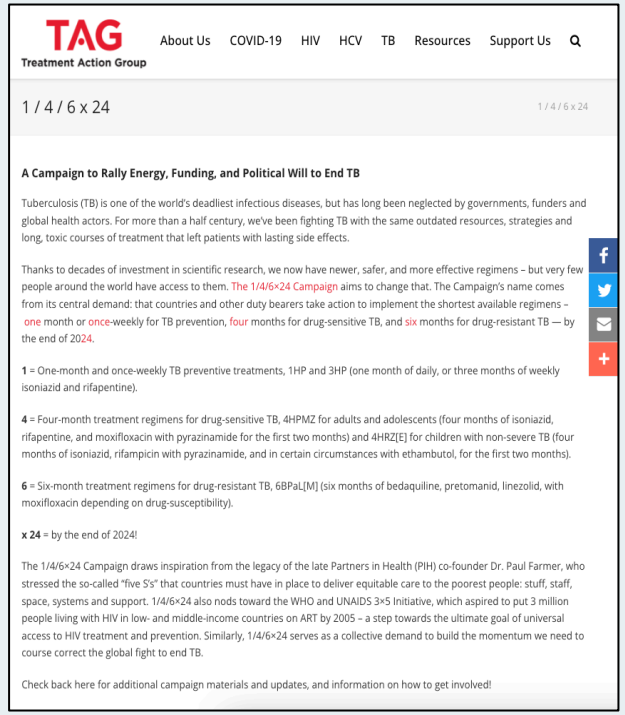
Demand legal and policy frameworks that can help improve access to TB medicines and diagnostic technologies.

Actively demand patient-centered models of treatment and prevention and link up with programs that deliver care through differentiated, community-based systems, including for post-TB support.

CAMPAIGN RESOURCES (1/3)
ACTIVIST GUIDES







An Activist's Guide to Rifapentine for TB Infection:

https://www.treatmentactiongroup.org/publication/an-activists-guide-to-rifapentine-for-the-treatment-of-tb-infection/

An Activist's Guide to Shorter Treatment for Drug-Sensitive Tuberculosis:

https://www.treatmentactiongroup.org/publication/an-activists-guide-to-shorter-treatment-for-drug-sensitive-tuberculosis/

GFAN Advocacy Briefs:

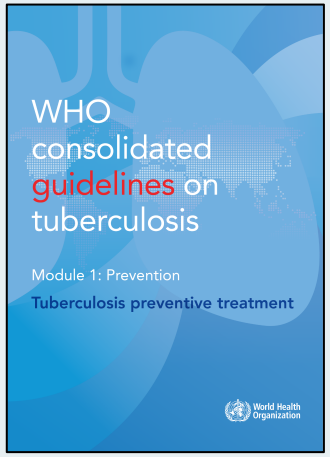
https://www.globalfundadvocatesnetwork.org/resource/advocacy-guides-to-1-4-6x24-shorter-regimens-for-tb/

More Campaign Resources:

https://www.treatmentactiongroup.org/1-4-6-x-24/

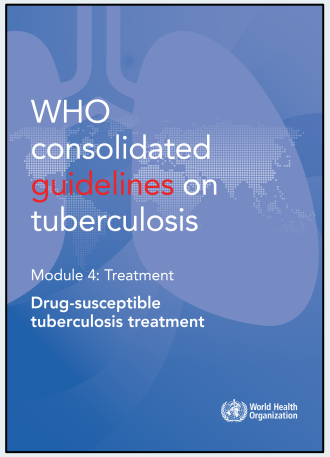
CAMPAIGN RESOURCES (2/3)

WORLD HEALTH ORGANIZATION GUIDELINES+



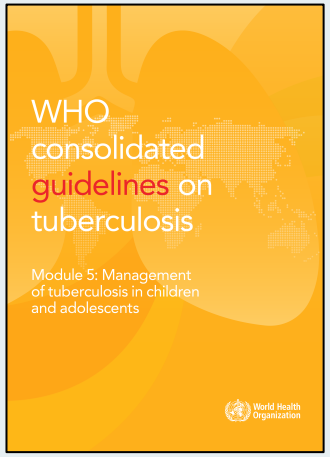
WHO consolidated guidelines on tuberculosis, Module 1: Prevention: Tuberculosis preventive treatment:

https://www.who.int/publications/i/item/9789240001503



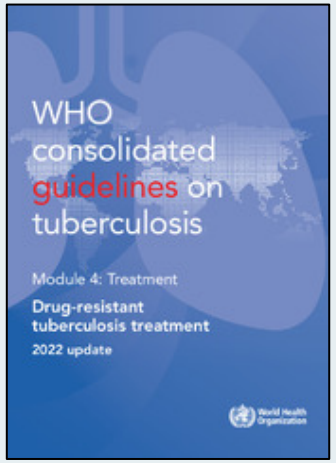
WHO consolidated guidelines on tuberculosis, Module 4: Treatment: Drug-susceptible tuberculosis treatment:

https://www.who.int/publications/i/item/9789240048126



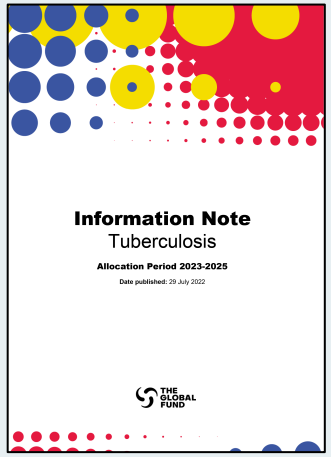
WHO consolidated guidelines on tuberculosis, Module 5: Management of tuberculosis in children and adolescents:

https://www.who.int/publications/i/item/9789240046764



WHO consolidated guidelines on tuberculosis, Module 4: Treatment of drug-resistant tuberculosis:

https://www.who.int/publications/i/item/9789240063129



Global Fund Tuberculosis Information Note, Allocation Period 2023–2025:

https://www.theglobalfund.org/media/4762/core_tuberculosis_infonote_en.pdf

CAMPAIGN RESOURCES (3/3)
LANDMARK STUDIES

Swindells S, Ramchandani R, Gupta A, et al. **One Month of Rifapentine plus Isoniazid to Prevent HIV-Related Tuberculosis.** N Engl J Med. 2019 Mar 14;380(11):1001-1011. doi: 10.1056/NEJMoa1806808.

Sterling TR, Villarino ME, Borisov AS, et al. **Three months of rifapentine and isoniazid for latent tuberculosis infection.** N Engl J Med. 2011 Dec 8;365(23):2155-66. Doi: 10.1056/NEJMoa1104875.

Dorman SE, Nahid P, Kurbatova EV, et al. **Four-Month Rifapentine Regimens with or without Moxifloxacin for Tuberculosis.** N Engl J Med. 2021 May 6;384(18):1705-1718. doi: 10.1056/NEJMoa2033400.

Turkova A, Wills GH, Wobudeya E, et al. **Shorter Treatment for Nonsevere Tuberculosis in African and Indian Children.** N Engl J Med. 2022 Mar 10;386(10):911-922. doi: 10.1056/NEJMoa2104535.

Conradie F, Bagdasaryan TR, Borisov S, et al. **Bedaquiline-Pretomanid-Linezolid Regimens for Drug-Resistant Tuberculosis.** N Engl J Med. 2022 Sep 1;387(9):810-823. doi: 10.1056/NEJMoa2119430.

Nyang'wa BT, Berry C, Kazounis E, et al. **A 24-Week, All-Oral Regimen for Rifampin-Resistant Tuberculosis**. 2022 December 22. N Engl J Med;387:2331-2343. doi: 10.1056/NEJMoa2117166.

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