Drug resistance in malaria, tuberculosis, and HIV in South East Asia: biology, programme, and policy considerations

Malaria, tuberculosis, and HIV present unique challenges in the control of antimicrobial resistance, and require targeted policies, say Samiran Panda and colleagues.

The World Health Organization South East Asia region, home to a third of the world’s population, has half the global incident cases of tuberculosis (TB), and a tenth of the estimated burden of malaria and HIV. The risk of disease transmission from travel and migration of people from and within the region highlights the importance of tackling this large disease burden. Failure to control or eliminate these diseases could negatively affect health and development worldwide. The increasing resistance to the drugs used to treat malaria, TB, and HIV (fig 1), and its ability to move across national borders, are challenges to controlling these diseases. Furthermore, drug resistance in malaria, TB, and HIV, and the effect of individual, socio-cultural, environmental, and political factors differ between countries, which make containment even harder.

Methods
We conducted an integrative review of the current status of malaria, TB, and HIV in the WHO South East Asia region with a focus on drug resistance and the commonalities and variations between countries. Our aim was to provide public health insight to facilitate policy discussion and inform programme planning at regional and national levels. We searched global and regional WHO reports, articles, and reviews published in peer reviewed journals, monographs, and unpublished grey literature. Our search focused on the biology of, and programmes and policies on, malaria, TB, and HIV. We identified the existing problems in the region and opportunities for solutions, including examples of good practices for disease prevention and control.

Mechanisms of resistance
Drug resistance (box 1) in malaria, TB, and HIV occurs either through the emergence of new resistant microorganisms or as a response to treatment (selection) pressure. Examples of response to treatment include the organism pumping a drug out of its active site (as happens with chloroquine in drug resistant Plasmodium falciparum malaria) and altering the site where a drug binds (as seen with the streptomycin binding site of Mycobacterium tuberculosis). These adaptations add to the intrinsic properties of some organisms that confer survival benefit—for example, the M tuberculosis cell wall contains high levels of mycolic acid, which reduces its permeability to antibiotics and other chemotherapeutic agents. Antiretroviral drugs target HIV replication in the cells through three virally encoded enzymes, reverse transcriptase, protease, and integrase. With the exception of the chemokine receptor antagonists that bind to a host protein involved in viral entry, antiretroviral drugs target virally encoded structures. Mutations in the viral genome at the time of HIV replication confer resistance by interfering with drug binding.

An additional challenge is that re-infection and resistance can occur months or years after the first infection. In malaria, re-infection is common as previous infection does not provide complete immunity and relapse after years of treatment is possible with Plasmodium vivax.
and *P. ovale* stemming from dormant liver forms. *M. tuberculosis* has a long generation time and can be dormant with low metabolic activity which makes it a difficult target for drugs. In addition, *M. tuberculosis* can be located in pulmonary cavities or caseous material, which are difficult for antibiotics to reach, or where low pH inhibits the activity of most antibiotics. Recent evidence suggests that HIV can continue to replicate and replenish its reservoir in the face of antiretroviral therapy.

Social and structural factors also play a role in drug resistance, which is seen in the evolution of drug resistance in malaria in Southeast Asia. These include the interrupted supply of quinine during Japanese occupation in the second world war of regions where cinchona was grown, and the recent appearance of resistance to artemisinin in several areas in the region following reversal of the policy on its restricted use, and the subsequent widespread administration as the first line treatment for falciparum malaria. Administration of chloroquine in salt to migrant workers from surrounding countries in the mining industry in Pailin Province, Cambodia, (where mining shafts allowed the collection of water from seepage, and rain, and provided a breeding site for mosquitoes) contributed to increased drug resistance because the concentration of chloroquine in blood was not curative. The need to tackle the socioeconomic determinants of health and reach out to where the vulnerability and risk are greatest, with the active participation of the local community and committed resources for universal health coverage, have been recognised as essential for the effective containment of malaria, TB, and HIV.

**Difficulties with drug treatment**

The development of drugs against malaria has been very slow and the progress made against drug resistant TB has been limited. In contrast, the development of drugs against HIV has been faster and more than 25 drugs of 6 classes are available. Although serious adverse effects are rare, malaria drugs are more toxic than antibacterial drugs, which can affect patients’ adherence to treatment. Similarly, the first line combination drugs, which are highly effective against drug sensitive pulmonary TB, have important limitations, including: compromised efficacy in people receiving treatment outside the public health system where standard guidelines are not necessarily adhered to; toxicity of the medicines, which can affect adherence; and drug interactions such as with antiretroviral drugs. Reports of fake drugs in the region and self-medication further compound these problems and draw attention to the need to improve the performance of existing regulatory mechanisms.

**Tracking resistance**

Three types of tools are used to monitor treatment efficacy and the development of resistance to malaria, TB, and HIV drugs: clinical response after administration of quality assured drugs at recommended doses for sufficient duration; laboratory tests indicating clearance or suppression of the organisms; and high throughput molecular techniques that identify genetic mutations known to confer resistance. Only through the standardised use of these tools will it be possible to compare and interpret results over time within or between countries in the region. Currently countries in South East Asia use such tools in isolation and no best practice example of the judicious combination of these tools has yet emerged. Sentinel surveillance for drug resistance monitoring over time and geographical space to allow trend analysis is also lacking for malaria, TB, and HIV in most of the countries in South East Asia. A recent example of a molecular investigation informing a public health decision is the discovery of a new marker of artemisinin resistant falciparum malaria; a mutation at the propeller domain of the Kelch protein K13 has been associated with increased parasite survival. This has led to a new working definition of artemisinin resistance. On the other hand, monitoring early warning indicators of HIV drug resistance provides a record of clinic and programme performance—for example, patient adherence to anti-HIV drugs, drug supply continuity, and retention of patients on treatment—which helps give context to HIV drug resistance data obtained from national surveillance laboratories. However, a balance is needed between improvement of a comprehensive tracking system for antimicrobial resistance and drug resistance surveillance in vertical disease programmes.

**Public health achievements and challenges**

**Malaria**

The confirmed cases of malaria in the WHO South East Asia region decreased from 2.8 million to 1.5 million between 2000 and 2015. Three countries accounted for over 95% of the cases in 2015—India (89%), Indonesia (9%), and Myanmar (2%). However, drug resistance is a concern, and treatment failure with artemisinin based combination therapies has been recorded in the Greater Mekong subregion.

**Tuberculosis**

Examples of good practice in the region for TB include: embedding operational research in the national disease control programme, and using research findings to guide decisions and development of national tuberculosis control programmes. Public health interventions and measures have led to a fall in the number of new TB cases since 2000. In 2015, three countries accounted for over 50% of the cases in the region—India (37%), Indonesia (18%), and China (17%). However, drug resistance is a concern, and treatment failure with artemisinin based combination therapies has been recorded in the Greater Mekong subregion. However, the region has 35% of the global burden of multidrug resistant tuberculosis (MDR-TB). Therefore, although MDR-TB occurs in fewer than 3% of new cases, and 18% of retreatment cases, the high TB incidence makes these lower percentages translate into large numbers. An estimated one third of people with TB goes undetected or are treated outside the national programmes. They have poor outcomes, contribute to disease transmission, and are at greater risk of death. The reported prevalence of MDR-TB in 2005 was seven times higher in Burmese migrants on the Thai side of the Thai-Myanmar border than the national average for Thailand, highlighting the vulnerability to MDR-TB in the region from migration.

**HIV disease**

The emergence of HIV drug resistance, with its negative implication for individuals, society, and ongoing prevention efforts is a concern when scaling up antiretroviral therapy. However, the current evidence shows that HIV drug resistance in South East Asian countries has not yet reached a high level. A recent systematic review of studies in the region published during 2000-11 found that most studies reported low levels of HIV drug resistance.

**Good practices and opportunities for cross country learning**

**Malaria**

Two countries in the region, the Maldives and Sri Lanka, are free of malaria; the Maldives since 1984 and Sri Lanka since 2012. Their experiences and ability to remain malaria-free offer several public health lessons. These include (1) elimination of the parasites rather than the vector mosquitoes through adaptation of appropriate treatment guidelines, (2) risk reduction through the careful use of insecticides, (3) larvicidal measures, including insecticide rotation to prevent the development of resistance in mosquitoes, (4) ongoing training of healthcare workers, (5) active community engagement, (6) prompt identification of and interventions for imported cases, and (7) ensuring concerted vigilance, of politicians, public health doctors, general clinicians, tribal chiefs, community leaders, and community members. Population based surveillance at the household level, and surveillance in military camps and difficult geographical terrain, were crucial for all these interventions to work together.

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to inform evidence based policy making; the introduction of a rapid diagnostic test kit in Indonesia which led to a considerable increase in the detection and treatment of resistant TB cases; and the establishment of a web based case notification system in India. The Indian system of notification, under the revised national TB control programme, also included private health providers (http://nikshay.gov.in/AboutNikshay.htm). Ministers of health of all the 11 member countries of the WHO South East Asia region also called upon leaders, policy makers, partners, civil society, and the public in the region and around the world actively to support their call for action to end TB (harmo, TB, and HIV) and to create an enabling environment for the whole of society to stop TB and HIV.

In conclusion, vector control, or behavioural risk reduction measures alone are not enough for disease prevention, and combination treatment should be used at the same time. However, other determinants of health, such as poverty, undertreatment, and stigma, if not also tackled, will continue to leave some population groups vulnerable to disease. We think therefore that the following elements are important for the effective control or elimination of malaria, TB, and HIV: commitment and ownership at the country level; combination approach in prevention and treatment; community engagement, including participation of vulnerable groups (people who inject drugs, mobile and migrant populations, residents of labour settlements); care of patients with quality assured, effective medicines, and necessary regulatory measures; and decentralised surveillance systems to detect community spread of infections early.

Contributors and sources: SP, SS, CAH, EM, RNP, TYA, PS, ABT, and SKS conceived the idea. SP, ANS, SP, SS, KAH, EMC, RNP, TYA, PS, ABT, and SKS managed the manuscript. All authors have read and approved the manuscript.

Competing interest: We have read and understood BMJ's journal-specific policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned; externally peer reviewed.

This article is one of a series commissioned by The BMJ based on an idea from WHO SEARO. The BMJ retained full editorial control over external peer review, editing, and publication. Open access fees are funded by the WHO SEARO.

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BMJ: first published as 10.1136/bmj.j3545 on 5 September 2017. Downloaded from http://www.bmj.com on 30 October 2022 by guest. Protected by copyright.

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Cite this as: BMJ 2017;358:j3545
http://dx.doi.org/10.1136/bmj.j3545

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