

# Addressing TB and HIV more effectively in southern Africa

2008



POLICY BRIEF



**SABIDS**

Southern Africa  
HIV and AIDS Information  
Dissemination Service



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## EXECUTIVE SUMMARY

TB, once thought to be a disease of the past or at the very least a disease restricted to poor countries, has re-emerged as the greatest threat to people living with HIV (PLHIV). It now threatens to reverse the huge gains made in the HIV and AIDS arena over the past 25 years. The HIV epidemic is reviving an old problem in well-resourced countries and greatly worsening an existing problem in resource-poor countries. One of the greatest challenges confronting service providers is that the best available treatments are of limited efficacy and are reaching only a small fraction of people who need them. Universal access to effective TB treatment is unachievable with current tools.

Countries need to take broader steps to redress the devastating collaboration between TB and HIV through adopting and implementing the Stop TB Strategy which is the WHO recommended approach to reduce the TB burden in line with global targets. Isoniazid Preventative Therapy for TB has been scientifically proven to decrease the risk of developing active TB and should be part of the package available for People Living with HIV (PLHIV).

## CONTEXT

Stakeholders in southern Africa are failing to address the challenges posed by TB and HIV, thus missing many opportunities to collaborate, build partnerships and improve access to TB and HIV prevention, diagnostic and treatment services. 80 percent of the 14 million people living with both TB and HIV are in southern Africa (WHO, 2006). TB is the chief cause of morbidity and mortality in individuals with HIV infection in sub-Saharan Africa. In 2001 South Africa recorded 37 917 deaths (age group 15 to 49 years) attributed to tuberculosis alone (Stats SA). TB is registering itself as the biggest killer of women of child bearing age, and is the most common opportunistic infection in southern Africa. Two million people die each year from preventable and treatable TB globally. The extensive TB epidemic in the southern Africa region is not being treated with urgency despite the evidence that if untreated, TB in people living with HIV leads to deaths within weeks.

## EVIDENCE

In Africa and Asia, TB is a major cause of illness and death. In 2006, the world recorded 9.2 million new cases of tuberculosis according to WHO and 0.7 of these cases were co-infected with HIV as well. An estimated 1.5 million deaths were recorded in HIV negative people and 0.2 million TB/HIV co-infected people died in 2006 alone. Half a million cases of multi-drug resistant TB (MDR-TB) were recorded during the period under review.

Four regions in the world are on track in terms of achieving the Millennium Development Goal 6 (to have halted and begun to reverse the incidence of TB), but Africa and Asia are not on track to achieve this target, (WHO,2008). If drastic measures are not taken by governments in this region to adopt and implement the Stop TB Strategy, the rest of the world will be unable to achieve the 2015 target.

## CURRENT INTERVENTIONS

### **The Stop TB Strategy**

The Stop TB Strategy is the World Health Organization's recommended approach to reducing the burden of TB in line with global targets. The Global Plan of the Stop TB Partnership details the scale at which the six components of the strategy should be implemented if global targets are to be achieved. The six components are:

- DOTS expansion and enhancement
- Addressing TB/HIV,MDR-TB and other challenges
- Contributing to health systems strengthening
- Engaging all care providers
- Empowering patients, and communities
- Enabling and promoting research.

Since 2004, WHO has been promoting greater collaboration between national TB and HIV/AIDS programs, through the development of a Policy on Collaborative TB/HIV activities. The TB/HIV Policy calls upon governments to establish mechanisms for collaborative planning, and to implement activities to decrease the burden of TB among people with HIV/AIDS, and the burden of HIV among people living with TB. The TB/HIV policy also recognizes the importance of community involvement in accelerating and improving TB/HIV services ([www.who/hivtb/tbhiv/en/](http://www.who/hivtb/tbhiv/en/)).

## GAPS

Despite the existence of the WHO recommended Stop TB Strategy, and other policies, governments in southern Africa continue to implement parallel TB and HIV programs, resulting in poor service delivery, particularly in terms of accessibility and availability of Isoniazid Preventative Therapy, and preventing and treating drug resistant TB. Coordinated TB/HIV services will result in improved quality and accessibility of services to community members. There is lack of concrete strategies, at regional level, to enforce governments to adopt and implement the WHO policy on collaborative HIV/TB activities in particular and the Stop TB Strategy in general. In addition, governments across the region have failed to critically engage communities affected by both TB and HIV in developing, implementing and evaluation of collaborative TB/HIV policies. A comprehensive and multi-sectional approach to managing and freeing funding for TB research, testing and care also remains prerequisite on the policy agenda of most countries in the region.

## KEY RECOMMENDATIONS

Southern Africa is the epicenter of the global HIV and AIDS epidemic, and has the highest TB incidence rate per capita in the world. It is important therefore that governments in the region adopt a comprehensive strategy in addressing both diseases. By adopting a collaborative HIV/TB strategy, governments in the region will save resources and at the same time have an impact on communities affected by both diseases resulting in improvements in quantity and quality of life among a large section of their populations.

## 1. Scaling up accessibility and availability of Isoniazid Preventative Therapy for TB

TB preventative therapy with isoniazid, (INH) also known as isoniazid preventative therapy (IPT), when given for 6-12 months to people living with HIV, reduces the risk of TB by 40 percent. In addition when given for 12 months in people living with HIV who have completed TB treatment successfully, IPT reduces the risk of TB re-curing by 50-80 percent. Whilst there are clear benefits for IPT, governments in the region have not developed and implemented national policies for providing IPT for people living with HIV as part of a broader national TB prevention policy and practice. Governments and civil society organisations should embark on massive IPT educational campaigns targeting people living with HIV, health workers and community members. Governments and the international community should support efforts currently underway to further research the preventative benefits of IPT.

## 2. Preventing and treating Drug Resistant TB

In southern Africa the advent of anti-retroviral therapy (ART) has significantly improved mortality rates in co-infected individuals. However, the emergence of multi-drug resistant tuberculosis (MDR-TB; resistant to two or more 'first-line' antibiotic drugs) and extreme drug resistant tuberculosis (XDR-TB; resistant to three or more 'second-line' antibiotic drugs) strains, has seen TB repositioning itself as the leading cause of death for PLHIV. The outbreak of MDR- and XDR-TB in the region may be a result of inadequate TB control. To combat MDR and XDR-TB governments in the region should address the following areas:

- **Prevention through better HIV and TB Services**

Poor adherence to TB treatment is the main cause of drug resistance. Governments should put concerted effort towards strengthening community education programmes in order to combat ignorance, fear and stigma with knowledge of how to diagnose, prevent and treat MDR and XDR-TB. Governments should invest in facilities, human and other resources to properly isolate and treat MDR- and XDR TB clients. In addition there is need to ensure adequate infection control in health facilities.

- **Diagnosis of MDR and XDR**

Although it is clear that the southern Africa region is in danger of MDR-and XDR-TB, the magnitude of the problem is not yet known. This is so because most health systems do not have the ability to diagnose XDR-TB due to lack of availability, complexity and cost of TB culture and drug sensitivity testing. The problem is compounded by poor laboratory infrastructure in most countries. In order to combat MDR- and XDR-TB in the region, governments need to expand access to TB culture and drug sensitivity testing, through use of a reference laboratory network.

- **Availability and Protection of Second line TB Drugs**

MDR-TB can be treated successfully but South Africa is the only country in the southern Africa region where MDR-TB treatment is available. Lesotho has a few small pilot sites as well. Elsewhere in the region people with MDR-TB are left undiagnosed and, and ultimately left to die. Governments need to take steps to avoid development of resistance to TB drugs.

Client-centred approaches have proven effective in AIDS management and offer important lessons for TB treatment and care, improving adherence to medication and enhanced disease management. Research shows that often, the reason for treatment defaulting in TB clients is because the health system for TB care fails to make TB treatment patient-centred. Current debate about quarantining TB clients bears testimony to a health worker-driven approach that has left clients feeling like despised 'prisoners'. Empowered clients would understand and support isolation for their own management, and adopt a sense of responsibility in protecting others for a public health perspective.

### 3. Increase fund flow for TB Research, Testing, and Care

A 2006 analysis by the New York based Treatment Action Group (TAG) revealed huge funding gaps for TB, despite global consensus on the urgent need to invest in research for the development of new and more efficient diagnostics and treatment for TB. According to TAG, at the current pace of resource allocation, only US\$2 billion will be available in the next ten years compared to a projection of \$9 billion dollars quoted in the Global Plan to Stop TB. Resource allocation for research and development should not rely solely on international partners, instead governments in the region should honour their commitments by applying strong political leadership in the development of new TB treatment systems and facilities, as well as relevant monitoring and surveillance systems. Stakeholders should capitalise on, and employ, the effective HIV and AIDS advocacy approaches that resulted in improved funding levels over the past 25 years. The unity of purpose among scientists and activists contributed significantly to the improved funding in the HIV and AIDS sector. Funding for TB and HIV interventions need to be aligned so parallel exclusive programs do not occur and there is increased integration between TB and HIV services provision.

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