

# World TB Day, 2007

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Dissemination Service



Media Resource Desk

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## World TB Day, AFRICA: The days of TB complacency are over

Tuberculosis (TB) is back with a vengeance and it has a new face: the combination of the HIV epidemic with new strains of the disease that are resistant to the existing drugs has seen new TB cases and TB-related deaths skyrocket in the last decade.

Mycobacterium TB, the bacterium that causes the disease, is ancient. But powerful antibiotics brought it under control in the developed world, scientists largely abandoned efforts to develop new drugs or diagnostics, donors stopped funding TB programmes and the global health community shifted its attention elsewhere.

The world, and sub-Saharan Africa in particular, is now paying the price. Very few countries in Africa have the technology to test for drug-resistant TB. Without sophisticated laboratory facilities, TB patients co-infected with HIV also present a diagnostic challenge.

In countries like Lesotho and Mozambique, lack of access to health services in remote, rural areas adds to the likelihood that large numbers of TB infections are going undetected and untreated, including cases of multidrug-resistant (MDR) and extremely drug-resistant (XDR) TB.

In Kenya, where overcrowded slums like those in the capital city of Nairobi create the perfect breeding ground for MDR-TB, there is some capacity to diagnose drug-resistant strains, but no treatment is available from public health services. Only a handful of patients access the drugs, which cost about 300 times more than those for standard TB treatment, from an international relief organisation, Medecins San Frontieres (MSF).

South Africa, with superior resources and laboratory capacity, is better positioned than most African countries to detect and manage the new, more dangerous forms of TB.

But experts say the country's TB control programmes have failed to adapt to the new threats of drug-resistance and HIV co-infection. Some have blamed South Africa's dismal TB cure rates on poor implementation of the WHO-recommended Directly Observed Short-Course Treatment (DOTS) for TB; others have called for a new, more patient-centred approach drawing on the strategies used for AIDS treatment.

With the outbreak of virtually untreatable XDR-TB in

KwaZulu-Natal Province in 2006 the debate has widened to include the issue of infection control at health facilities, and the potential need for forced hospitalisation and treatment of infected individuals.

Talk of quarantine could add to the stigma that already prevents many people from seeking TB treatment: in the Johannesburg township of Soweto, the strong association between TB and HIV means that people suffering TB symptoms often prefer not to seek treatment rather than face the possibility of being HIV-infected.

TB has always affected the most marginalised groups of society, which may explain why the disease has fallen off the public agenda. A recent report by an international development nongovernmental organisation (NGO), Panos, says even when journalists do cover TB, they usually fail to explore the links between TB, poverty and other socioeconomic factors, or interview people affected by the disease.

Source:  
[www.plusnews.org/  
report.aspx?rtID=70871](http://www.plusnews.org/report.aspx?rtID=70871)

## Lesotho struggling to control TB, HIV/AIDS epidemics

Lesotho is "struggling to contain" the spread of tuberculosis in the face of its HIV/AIDS epidemic, IRIN News reports. In 2006, the country reported 12,000 new TB cases, but TB expert Peter Saranchuk of Medecins Sans Frontieres said the actual number of cases likely is much higher. In addition, Saranchuk estimates that there are "vast" numbers of undiagnosed TB cases because roughly 85% to 92% of HIV-positive people in the country also have TB. The capacity to perform culture testing to diagnose TB among HIV-positive people is limited in Lesotho, and sputum samples must be sent to South Africa. Results typically are not returned for six weeks. Although TB also can be diagnosed among HIV-positive people using X-rays and clinical assessments, the strategy is relatively new, and Lesotho's department of health and social development still is training health workers in how to manage the two diseases, according to IRIN News. Coordination between Lesotho's TB and HIV/AIDS programs has not been common until recently, IRIN News reports. TB and HIV treatments previously were available at different sites, and few health professionals working on the two diseases collaborated. To address the issue, the department of health and social development established a strategy to control the two diseases that includes training health workers and counselors in both diseases; routinely offering HIV testing to people with TB; screening HIV-positive people

for TB; and providing treatment for both diseases at the same site. Michael Sekokomala -- head of Lesotho's largest TB outpatient clinic at Botsabelo Hospital in the capital, Maseru -- said more work needs to be done to implement the strategy. There is a shortage of counselors at the clinic to provide HIV testing to all patients, and people who have both diseases are required to make separate appointments to receive antiretroviral drugs at a nearby HIV/AIDS clinic. In addition, different strategies are used to ensure that patients adhere to their TB and HIV/AIDS treatment regimens. The DOTS strategy is used for people with TB, while HIV-positive people receive adherence counselling to ensure that they understand the importance of following their daily treatment regimens on their own. Shoeshoe Matsoele, deputy manager of Lesotho's TB control program, said that the DOTS strategy can be adapted to cover adherence to antiretroviral drugs. Matsoele added that volunteers trained in DOTS also can be trained to monitor adherence to antiretrovirals.

The spread of multi-drug resistant TB and extensively drug-resistant TB, which is resistant to the two most potent first-line treatments and some of the available second-line drugs, also is causing concern in Lesotho, IRIN News reports. The country has a very limited capacity to determine the extent of MDR-TB and address the disease because culture testing

is the only sure way to diagnose MDR-TB. "We don't know how many MDR cases we have," Sekokomala said, adding, "We just have MDR suspects, so XDR worries us very much, because if we can't even manage MDR, how can we manage XDR?" Sekokomala said that he believes there likely are XDR-TB cases in Lesotho because of the number of his patients who have died while undergoing treatment. There also is a lack of infection control measures in Lesotho's TB wards and clinics, according to IRIN News. Sekokomala said people thought to have MDR-TB are admitted to the TB ward at Queen Elizabeth II Hospital, the largest in the country. "There's only a corridor separating the TB ward from the children's ward, and children play in that corridor," he said. The Lesotho government is in the process of finalizing emergency guidelines for addressing MDR-TB and XDR-TB, and it recently entered into an agreement with Partners in Health to open a 40-bed isolation ward for MDR-TB cases at Botsabelo Hospital that is expected to open in May. Jennifer Furin, director of PIH in Lesotho, said she has been impressed with the government's swift response to the spread of drug-resistant TB but added that she is most concerned with the potentially high number of undetected MDR-TB cases.

**Source: IRIN News**

# Zambia: Still far from stopping TB

Violet Nakamba Mengo, Zambia  
An article from the HDN Key Correspondent Team  
9 March 2007

In a thatched mud hut deep in the heart of the Nabvutika Compound, a sprawling squatter township in Chipata, 40 year-old Daliso Tembo\* lies on a reed mat debilitated by the long battle against HIV and tuberculosis (TB).

In the corner of the one-roomed hut is a fireplace with remains of the wood that provided warmth overnight. The only ventilation is a tiny window covered by old pieces of cloth. Her husband was the first to get TB and has recovered, but Daliso did not escape the infection.

Daliso is one of a hundred dually infected TB/HIV patients the Tigwirizane Home-based Care Initiative is helping to cope, live through their illness, and die with dignity in a home setting surrounded by family.

According to Winfreda Banda, site coordinator of the Tigwirizane initiative, run by the Chipata Care, Prevention and Support Team (CCPT), relapsed TB cases are "rampant" in the compound due to poor housing, sanitation and overcrowding.

TB has become the leading cause of death among people living with HIV in Zambia. About three-quarters of people living with TB are co-infected with HIV.

One of the twenty Tigwirizane caregivers led us around the compound to see the conditions first-hand. Dressed in a blue volunteer tee shirt, Racheal Lungu\* limped along the tiny paths, winding through the overcrowded township from one critical patient to the next.

All ten patients she visited faced severe food shortages and extreme poverty beyond the realms of human decency.

With only meagre resources, Tigwirizane supports more than a hundred

households with food, painkillers, psychosocial counselling, household chores, nursing the sick and providing information on HIV and TB, including the need for early TB screening and treatment.

"Tigwirizane has been helping us with food and medicine for a long time," said Daliso with a voice deepened by TB, adding, "Before the organisation existed, most of our friends died due to lack of food, which most of us do not have. But the medicine we take gives us [an] appetite."

In another home, Mbunga Banda\* is dually-infected with HIV and TB, and refuses to take any medication. She could not speak, but her mother was at her bedside to explain what her daughter and she have gone through during the illness.

"I have lost all my children to AIDS. Only two are alive, but I know that very soon I will only have one," she said in a voice broken by emotions.

The realities of Nabvutika Compound beg the question whether we are fighting TB and HIV in the right ways in Zambia. Huge sums of money are spent on endless workshops, luxury vehicles, all in the name of fighting HIV and TB.

That money would create huge differences if it were channeled to community-based groups that work where the burden and needs are the greatest, and the clearest.

HIV and TB are devastating Zambian households. Poverty cripples the capacity of families and communities to respond to the epidemics, yet remains hidden from those with the power and resources to help.

Health Ministry spokesperson, Dr Canisius Banda, is aware of reports of drug resistant TB (MDR-TB) in all the nine provinces of Zambia. He said the ministry has worked round the clock to ensure that MDR-TB is seriously addressed through sensitization in all parts of the country.

"We can however, have a major impact on TB today, by rapidly identifying and curing patients with active disease," added Dr Banda. "This approach is at the heart of the internationally-recognized strategy for TB control, directly-observed treatment short course - or DOTS - which has proven remarkably effective in Zambia."

Though Zambia is implementing the DOTS strategy in all of its 72 districts, many people with TB have no access to this type of treatment. Such as the people in Nabvutika, who depend on home-based care services and are not aware of the government-led DOTS programme.

International and local partners carried out a national TB review two years ago, and the recommendations informed the 2006-2010 Zambia National TB Strategic Plan. The plan includes a focus on DOTS expansion and strengthening, as well as TB/HIV collaborative activities and community-DOTS strengthening.

In the last house we visited, Michael Phiri\* owes much to Tigwirizane for supporting him and his family. His relapsed TB means he has been bed-ridden for a long time and his family has endured critical food shortages.

"I have been unable to work in the fields due to this illness. My wife spends much of her time taking care of me, so only the children have been working. My son made it to grade eight but I was unable to raise the required fees because of my sickness."

Although Dr Banda believes the ministry's pace in addressing TB is adequate, the stories on the ground reflect a different reality: With the government seemingly focused more on political priorities, small projects such as Tigwirizane continue to fill the gaps and do so much to help TB patients and their families cope.

Note: Daliso Tembo, Racheal Lungu, Mbunga Banda, Michael Phiri are not real names.

Healthdev.org/eForums

# South Africa: XDR-TB in every province

March 11, 2007. Evidence indicates that a strong TB control programme can make a fundamental contribution to preventing and controlling MDR-TB and XDR-TB"

"Extreme drug-resistant tuberculosis has been found in every province, with KwaZulu-Natal the worst affected"

Extreme drug-resistant tuberculosis (XDR-TB) has been found across South Africa, says the Medical Research Council (MRC).

"The national health laboratory services have analysed the laboratory data for the past 18 months and have shown that these cases are present in every province," the MRC's Dr Karin Weyer told the SABC.

She said the extent of the spread of XDR-TB was not known as laboratory data was biased. The cases were first identified in KwaZulu-Natal. The SABC reported that KwaZulu-Natal remained the worst-affected province, with 270 cases reported so far.

Weyer was speaking after a workshop on TB in Pretoria attended by World Health Organisation officials and delegates from the Southern African Development Community.

Earlier, health department director-general Thami Mseleku said that without special efforts to test multi-drug resistant TB (MDR-TB) patients for resistance to other drugs, the government would be unaware of the presence of XDR-TB among TB patients.

Mseleku said the government had made diagnosis and treatment accessible to all communities and provided these services free, but "despite all these efforts, government is not winning the battle".

Mario Raviglione of the WHO highlighted the challenges of the Global Plan, an initiative of the WHO, to stop TB. He said communities were unaware and uninvolved, and that the connection between TB and HIV was not clearly known.

"To eradicate XDR-TB may take a number of years because it's not a pandemic, it comes and goes," Raviglione said.

Raviglione said the set goals of trying to curb TB included engaging all care providers, enabling and promoting research and addressing the relationship between TB/HIV.

Medical officer Ernesto Jaramillio, also part of WHO, said diagnostic capacity in XDR-TB was only present in few countries.

"Evidence indicates that a strong TB control programme can make a fundamental contribution to preventing and controlling MDR-TB and XDR-TB," Jaramillio said.

Official statistics show an increase in the number of TB cases detected in South Africa over the years, with a low cure rate of 50 percent and a high "defaulter rate" of 10 percent. These rates have resulted in a high proportion of MDR-TB patients.

Mseleku said lack of investment into research for TB drugs and new diagnostic tests had contributed to the country's poor TB position.

"We urge pharmaceutical and diagnostic companies to correct this gap with respect to new TB drugs and new diagnostic tests."

He said government needed to revise strategies to ensure early detection of resistant strains, and to have a surveillance system in place to monitor the resistance patterns.

Health Minister Manto Tshabalala-Msimang could not attend the workshop because she was ill.

## TB Bigger Public Health Problem in Botswana

Mmegi/The Reporter  
By Thato Chwaane

April 2, 2007 - Although Tuberculosis (TB) has been documented as a major health problem in Botswana since the 1950s, it reached its lowest by 1989 with notification rate of 202 per 100 000, a Ministry of Health's national TB programme officer has revealed.

Speaking at a one-day seminar organised by BOTUSA and Botswana Media Women Associa-

tion (BOMWA) in Gaborone recently, Oaitse Motsamai said from 1989, there was an annual increase of 10 to 15 percent.

Motsamai said the TB notification rate increased to 623 per 100,000, the highest ever experienced and one of the highest globally.

"TB is now a bigger public health problem than 30 years ago," she said.

She stated that HIV is the driving

force behind the high notification rates, adding that HIV positive patients are more likely to die from TB when diagnosed late. Motsamai also said TB causes faster HIV progression to AIDS.

Motsamai said that the contributing factors to TB are poor living conditions, exposure to a TB patient especially if they are coughing, HIV infection and being under weight. She said its transmission is mostly through coughing, when TB germs are spread.

The signs and symptoms include loss of appetite, weight loss and high temperatures. TB of the lungs is the most common, and it is advisable to visit health facilities if one has been coughing for over two weeks, has chest pains, greenish blood-stained sputum, night sweats and difficulty in breathing.

She said that TB is curable even if one has HIV. The treatment is for six months or more on a daily

observed treatment (DOT) at a health facility or it can be given by trained community volunteers at home under the Community TB Care initiative.

World Health Organisation (WHO) national programme officer Boingotlo Gasennelwe said patients are encouraged to adhere to treatment until it finishes, because incomplete treatment can make TB germs resistant to drugs. "Completing treatment will

finally reduce TB transmission," she said.

This year's World TB Day theme is: "TB anywhere is TB everywhere".

Source: <http://allafrica.com/stories/printable/200704021723.html>

## TB Africa's Silent Challenge

Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), Although Tuberculosis (TB) was discovered centuries ago, its impact and spread remains unprecedented. Approximately 2 billion people (one-third of the world's population) are infected with Mycobacterium tuberculosis, the cause of TB (CDC, 2007). As a disease that is spread from person-to-person through the air, TB is particularly dangerous for people infected with HIV. Worldwide, TB is the leading cause of death among people infected with HIV (UNAIDS, 2007). Another growing concern is the development of drug-resistant strains. These strains can be created by inconsistent and inadequate treatment practices that encourage bacteria to become tougher. The multidrug-resistant strains are much more difficult and costly to treat and multidrug-resistant TB (MDR-TB) is often fatal. Mortality rates of multi drug resistant TB are comparable with those for TB in the days before the development of antibiotics. MDR-TB is present in virtually all of the 109 countries (UNAIDS, 2007).

Almost half a million MDR-TB cases are estimated to have occurred in 2003, or about 5% of all TB cases (WHO 2004). Recent surveys suggest that multidrug-resistant TB is increasing in some African countries. Not surprisingly, there are gender dimensions to TB as well. TB causes more deaths among women than all causes of maternal mortality combined, and more than 900 million women are infected with TB worldwide (UNAIDS, 2007). Once infected with TB, women of reproductive age are more susceptible to developing active TB than men of the same age. It is thus apparent that stopping the spread of TB becomes everyone's priority. As the theme for 2007 says, TB anywhere is TB everywhere. New and innovative ways of combating the disease should be developed and there needs to be global galvanization for urgency and action on the matter. Interestingly, the best way to stop TB is not to fight it in isolation to the fight against HIV. In fact, we need to stop thinking of the two diseases in separate bodies, because a third of the 40 million people living with HIV today are also co-infected with TB (France 2006)

### Intersection between TB and HIV

TB kills up to half of all AIDS patients worldwide. People who are HIV-positive and infected with TB are up to 50 times more likely to develop active TB in their lifetime than people who are HIV-negative (UNAIDS, 2007). In addition, HIV infection is the most potent risk factor for converting latent TB into active TB, while TB bacteria accelerate the progress of AIDS infection in the patient. Many people living with HIV in developing countries develop TB as the first manifestation of AIDS. The two diseases represent a deadly combination, since they are more destructive together than either disease alone:

TB is harder to diagnose in people who are HIV-positive. This is because HIV weakens the cells in the immune systems that are needed to fight TB. HIV promotes both the progression of latent TB infection to active disease and relapse of the disease in previously treated patients.

TB progresses faster in people who are HIV-positive;

TB in people who are HIV-positive is almost certain to be rap-

- pidly fatal if undiagnosed or left untreated;

Many HIV-positive people in developing countries develop TB as the first sign of the later stages of the disease

The risk of developing TB disease is much greater for those infected with HIV and living with AIDS as compared to those who are not infected.

### **People infected with HIV and living with AIDS are at greater risk for developing MDR TB**

As earlier stated, AIDS is dramatically fuelling the TB epidemic in sub-Saharan Africa, where up to 80% of TB patients are co-infected with HIV in some countries (WHO, 2004). For many years efforts to tackle TB and HIV have been largely separate, despite the overlapping epidemiology. Improved collaboration between TB and HIV programmes will lead to more effective control of TB among people who are infected with HIV and to significant public health gains. The strengthening of these activities requires reorganization of health systems at the central, intermediate and peripheral level as well as the training of health professionals and the organization of supplies and equipment among other many things.

### **Collaborative HIV/TB Programme activities**

There is need for the setting up of a coordinating body for TB/HIV activities at all levels. HIV/AIDS and tuberculosis programmes should create a joint national tuberculosis and HIV coordinating body, working at regional, district and local levels (sensitive to country-specific factors), with equal or reasonable representation of the two programmes and including tuberculosis and HIV patient sup-

port groups (WHO, 2004). Areas of collaboration would include capacity-building and training, ensuring coherence of communications about TB/HIV, ensuring the participation of the community in joint TB/HIV overseeing the preparation of the evidence base and governance and mobilization of resources for TB/HIV. There has been talk on doing this but few countries have programmes reflective of this inter-relationship.:

### **Other programmes to consider at the health or hospital level;**

Offering HIV testing and counseling to all TB patients;

Providing cotrimoxazole and anti-retroviral treatment (ART) to TB patients found to be infected with HIV;

Screening people living with HIV for TB disease and provision of TB preventivetherapy once active disease is ruled out. Appropriate TB treatment should be provided if disease diagnosed.

Expediting the diagnosis and treatment of TB in people living with HIV by using the revised diagnostic algorithms recommended by WHO in resource constrained settings. (UNAIDS, 2007)

### **At the Home care level**

Include TB case detection and care in training of HIV/AIDS caregivers (family members, volunteers, and health care workers).

Prevent new cases of TB among PLWHA and their families with isoniazid preventive treatment when appropriate.

Establish referral mechanisms between HIV/AIDS home care programmes and TB clinics.

### **Community care**

Provide information and education on TB and HIV to increase community awareness of both in-

fections and their inter-relationship. The messages concerning these diseases should always go hand in hand.

Intensify tuberculosis case finding in areas of high HIV prevalence, where there are effective local TB programmes achieving good rates of successful treatment.

Community-based organizations, such as those providing HIV/AIDS home-based care, may also be involved in identifying people with signs and symptoms of tuberculosis, and ensuring directly observed treatment for tuberculosis. Isoniazid preventive therapy can be provided to close contacts of HIV-positive people with infectious tuberculosis. This can be done at little additional cost by existing organizations.

In a nutshell, there is need for the operationalisation of joint programmes that are reflective of the nexus between TB and HIV. Moreso; there is need for community capacity building and mobilisation to stop the twin epidemics. Nothing will succeed without HIV/TB mainstreaming at all the levels of society.

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Sent by: SAfAIDS  
([www.saf aids.org.zw](http://www.saf aids.org.zw))

## TB Anywhere is TB Everywhere: Statement by SAfAIDS Executive Director, Lois Chingandu, World TB Day 2007

This Saturday - 24 March - we will once again commemorate World TB Day - this year under the international theme, "TB Anywhere is TB Everywhere".

Tuberculosis (TB), an ancient disease dating back to the era of the Egyptian pharaohs, is today a global health problem affecting over 2 billion people. Despite over 40 years of TB treatment, the US Centers for Disease Control (CDC) reports that the disease records an estimated 2 million annual deaths, while UNAIDS in 2007 cites TB as the leading cause of death among all of the world's known curable infectious diseases. Up to 1980, successful interventions had reduced TB to a manageable infectious disease. However, increased poverty, flagging health systems and the growth of the HIV epidemic have allowed for the silent yet lethal re-emergence of the TB epidemic.

The persistence of TB, even though we know how to manage it, is a reflection of the general complacency that now exists in fighting the disease. And we must accept that we will never be able to control TB, until we address the issue of poverty, especially in southern Africa, which has 11 of the 15 nations with the highest estimated per capita TB incidence rates. Despite the increase in the global economy over the years, most of the world's population, particularly in sub-Saharan Africa, has remained poor and without access to

basic necessities such as food, water, sanitation and medical facilities. TB and its main infection ally, HIV, are not only rampant in such areas, but also their treatment is more difficult as both conditions require a patient to have healthy nutritious meals with their medication - something which is impossible for the many who cannot even afford one decent daily meal.

It is therefore impossible and impractical for us to believe that we can eradicate, or even halve TB infections by 2015 - as current global targets spell out - unless we begin to implement global and national strategies to contribute to meaningful and worthwhile poverty reduction programmes in Africa. If we do not, then we will continue to observe the growth of the phenomenon of drug-resistant strains of TB, which currently account for 10% of all new TB infections, and cost far much more to treat. The recent emergence of multi-drug resistant (MDR) and extremely drug-resistant (XDR) strains of TB, in the East and South Africa's Kwazulu Natal province respectively, serve to remind us that current tools used in controlling and monitoring TB and its co-infection process with HIV are inadequate to address the severity of the epidemics.

What we need is scientific progress in the field of this research, and not mere knowledge acquisition. Progress needs to come through testing interventions that will help in diagnosing and treating this drug resistance - something that is not possible with the TB smear tests that currently exist. We further demand progress in carrying out large scale and extensive research into TB drug resistance throughout the world, as has been conducted by the World Health Organization (WHO) and the United States Centers for Disease Control (CDC). Subsequent studies have been conducted in KwaZulu Natal, South Africa.

While studies into TB drug resistance have been conducted in Lesotho, Swaziland, Botswana and Zambia, the sample sizes were relatively small due in part to the lack of laboratory capacity in these resource-limited areas. Before we can hope to roll out treatment in the region, we must first gauge its nations' capacity to diagnose those in need of it. We must therefore produce assessment reports to support TB programmes, just as we have done to assess the capacity of laboratories in the region to support the scaling up towards universal access to HIV and AIDS prevention, treatment, care and support services. And we must continue with our advocacy calls for TB vaccine research and trials, while developing treatment that will work harmoniously with anti-retroviral drugs (ARVs) in light of the linkages between TB and HIV infection.

While there is good understanding among policy makers of these linkages, there is still limited integration of the two services, and

weakened coordination between HIV and TB responses at operational level. The service providers, who have the responsibility to make the integration possible, either lack the knowledge about the linkages, or have insufficient training in dealing with TB and HIV co-infection. On this important day, we call upon policy makers to invest in extensive training of service providers, to operationalise the integration of services, and strengthen the coordination of TB and HIV and AIDS responses at all levels. For the future, we envisage a one-stop service for integrated TB and HIV testing, which would further cut on spending of already limited resources for the many who are co-infected with TB and HIV.

SAfAIDS commits itself to step up its information dissemination role through the roll out of an extensive programme to increase knowledge on HIV and TB co-infection, and to address the double stigma and discrimination suffered by people living with the two conditions. We also understand that drug resistance is in part being driven by a lack of awareness, among patients, about how to take TB treatment correctly and consistently for the usual 6-8 month period in which it is necessary, and that only through a community-based approach to the problem can we address such issues to do with drug adherence and compliance. We commit to continuing to inform not only individuals, but also their communities about TB and HIV diagnostic and treatment services. The importance of treatment supporters to assist in reminding patients to take their drugs on time is an intervention whose importance we have previously highlighted in our training package for community-based volunteers, which we devised last year in collaboration with the World Health Organization (WHO) and the International Federation of Red Cross and Red Crescent Societies (IFRC).

As SAfAIDS, we further add to this year's theme by declaring "TB anywhere is TB everywhere - Everyone has a role to play!" We say this because we believe that now is not the time to be passive about this disease. For if we are, we will relegate more people, particularly those co-infected with TB and HIV who number 13 million of the 40 million people living with HIV and AIDS worldwide, to unnecessary death. As such, we urge the Global Fund to fight HIV, TB and Malaria to increase funding for integrated programming for HIV and TB, while we encourage the Stop TB partnership to intensify its leadership role to support implementation of a comprehensive TB strategy which includes research into HIV and TB, in all its strains, and to provide financial support to smaller groups, as well as civil society for funding advocacy and social mobilisation activities at the grass roots level.

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