

# WORLD TUBERCULOSIS DAY

APRIL 2008

## World TB Day Statement from UN Secretary-General Ban Ki-moon

**SAAIDS** Southern Africa  
HIV/AIDS Information  
Dissemination Service



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World TB Day is an occasion to urge action to stop tuberculosis, a disease which still kills an appalling 4,000 people every day. The man-made multi-drug resistant strain and its even more lethal form, extensively drug-resistant TB, are both spreading.

If we are to prevent a virtually untreatable tuberculosis epidemic, we must tackle the roots of the problem: poor services, poor supplies, poor prescribing and poor use of drugs.

That is why the theme of this year's Day is "I am Stopping TB".

This is a fight that can be won only with the collective commitment of millions of individuals – donors and researchers, doctors and health care workers, patients and family members. Thanks to a broad coalition of partners working to stop TB, the proportion of people who become ill with the disease is slowly falling.

But this progress is not keeping pace with population growth, so more and more people are becoming infected with tuberculosis.

The World Health Organization recently issued a report painting a grim picture of the spread of drug-resistant TB in a number of countries. And tuberculosis is all the more deadly when it intersects with the HIV epidemic.

We must intensify the global response in order to save lives. The United Nations will convene a Global Leaders' HIV/TB Forum this June in an effort to boost our collective capacity to drive down HIV-associated TB deaths.

In this effort, we can draw inspiration from a number of African countries which have shown that it is possible to scale-up services that reach out and screen TB patients for HIV, screen HIV-infected people for TB, and initiate care. Rwanda, for example, provides HIV screening for more than three quarters of all people in TB care settings. Kenya and

Malawi have also made major strides.

These impressive advances are the result of the efforts of individuals. "I am stopping TB" is not just the theme for this Day, but a pledge we must uphold as we battle the epidemic throughout the year and into the future.

<http://www.stoptb.org/>

### Global Realities

- \*Someone in the world is newly infected with TB every second
- \*A third of the world's population is currently infected with TB
- \*5-10% of people who are infected with TB become sick or infectious at some time during their life
- \*People with HIV and TB co-infection are much more likely to develop active TB
- \*Each person with active TB infects on average 10 to 15 people every year
- \*TB is a disease of poverty
- \*1.6 million people died of TB in 2005, equal to 4 400 every day
- \*Each year 424 000 people develop MDR TB

## WHO TB/HIV policy implementation still lacking

By Michael M. Gwaba

ZAMBIA - In 2004, several countries agreed to implement the WHO Interim Policy on Collaborative TB/HIV Activities, which aims to decrease the burden of tuberculosis (TB) and HIV in affected communities.

In 2007, a community research project was funded by the Open Society Institute (OSI) through Public Health Watch to see how the policy is being implemented in some African countries.

The findings of two organisations from Tanzania and three from Nigeria, Kenya and Zambia were presented at the 38th World Conference on Lung Health under the theme 'Community Monitoring of National TB and HIV Policies in Africa'.

The research projects were conducted by community organisations made up of people living with HIV who had battled TB, and journalism groups from the four countries. The research was conducted during a period of six months and prior to the project, members of the participating organisations were trained in how to use research tools and hold interviews.

Sources of information for the research included policy makers, nongovernmental organisation (NGO) staff, the media and community leaders and members. Each organisation identified the major issues of concern in their country and focused their research on those chal-

lenges.

Their findings were all similar – many people haven't seen or heard about the policy and there is no information being disseminated on TB nor any awareness programmes being implemented. They also found that stigma still causes most people to delay accessing treatment and that there are no programmes in place to address such barriers.

The research results from all four countries showed that there are low levels of commitment from politicians and governments and that communities are rarely engaged in TB and health-related activities.

During the research, the groups involved reported receiving little or no cooperation from the health service providers, who suspected they were being audited by a third party representing the WHO and appeared to consider the community groups inferior.

The lessons learnt from the research were also strikingly similar. Understanding the interim policy helped members of the community organisations integrate TB into their HIV activism and also provided journalists with a greater knowledge of the issues.

If the document were to be made available to everyone, they would better know what to expect in terms of treatment from service providers.

The research also helped raise awareness among community groups of the dangers of co-infection and raised concerns over the need for more information, education and communication materials to be developed on co-infection.

It also increased awareness of the need for people living with the disease to be represented on the joint collaborative body so that they could take part in the decision-making process.

The research conducted by the journalists highlighted the fact that there were low TB and HIV awareness levels among civil society groups. They also discovered a lack of government commitment on the release of funding for TB activities.

Health service workers, though recognizing this gap in funding, are not willing to speak about it for fear of being victimized by government officials.

Journalists should talk and write more about TB and should also help with the translation of scientific information into language that is simple enough for community members to understand.

Because radio is the most accessible medium for many in developing countries, programmes should be designed that will inform communities about the diseases and encourage people to go back to health centres for treatment

## Why Tuberculosis matters to women's health

By Masimba Biriwasha

Tuberculosis (TB) has a major impact on women's sexual reproductive health and that of their children.

For pregnant women living in areas with high TB infection rates, there are increased chances of transmission of TB to a child before, during delivery or after birth.

The disease, especially if associated with HIV, also accounts for a high incidence of maternal and infant mortality.

Unfortunately, there is little to no attention about women's vulnerability in the current discussion and media blitz of a resurgent TB internationally, and in particular, sub-Saharan Africa.

In sub-Saharan Africa, TB is threatening to unravel public health developments gains around increased HIV awareness yet the solutions are not easy, particularly where they concern the well-being of women.

There is need for huge financial, human, research and technological investments to fight the problem, but such investments will work only if they radically put women's health needs at the core.

More importantly is the need to align TB services and sexual reproductive health services, so that men and women know about the implications of the disease to their sexual lives and households.

In sub-Saharan Africa, however, there are pervasive systemic factors driving TB and drug resistance which cannot be ignored in the search of an effective solution to the problem.

A myriad of social and economic factors, as well as weaknesses in the health care system, inadequate laboratories combined with high HIV infection rates are fuelling the resur-

gence of the TB in the region. Food insecurity, poor sanitation and overcrowding also contribute to the easy spread of the disease.

According to WHO, although Africa has only 11% of the world's population, it accounts for more than a quarter of the global TB burden with an estimated 2.4 million TB cases and 540,000 TB deaths annually.

Governments in the region are grappling with inadequate infrastructure and the increasing threat of drug-resistant strains and co-infection with HIV.

HIV infection increases the likelihood of active TB more than 50-fold. An estimated one-third of the 24.5 million people living with HIV (PLHIV) in sub-Saharan Africa also have TB.

For women in the region, the prospect of a growing TB epidemic is harrowing, but discussion about the disease rarely sheds light nor seeks to address women's specific needs.

Given the high rates of HIV infection among women in the region - the majority of people living with HIV in sub-Saharan Africa (61% or 13.1 million) are women - it is clear that they are the largest group at threat to develop active TB, and more likely drug resistance.

Even with the availability of TB drugs women's socio-economic status and gender roles including child-bearing and caring puts them at high risk of both HIV and TB infection.

For many women in the region, the costs required to access health care centers for TB treatment are usually out of reach due to poverty and undetermined socio-economic positions.

The social stigma associated with a TB diagnosis and its association with HIV forces both men and women to delay going to get tested

for the disease. In some cases, when men in marital relationships test positive for TB, they are likely to withhold the information, thereby increasing the likelihood to spread the disease to both their partner and children.

Moreover, women in the region are largely responsible for the upkeep of the family, including looking after children, which may also affect consistent uptake of TB drugs. When a woman is infected with TB, the likelihood of spreading the disease to young children is very high.

An additional concern for women is that the uptake of TB drugs interferes with contraceptive use, pregnancy, and fertility.

According to researchers, Rifampicin, a key component of TB treatment can reduce the effectiveness of oral contraceptive pills and possibly other hormonal methods, such as implants, injectables and emergency contraception.

TB in pregnant women not only increases the rate of maternal mortality, but is also a major factor contributing to the risk of mother-to-child transmission of the disease.

A study conducted in South Africa revealed mother-to-child transmission of TB in 15% of infants born to a study cohort of pregnant women in which 77% were HIV-infected. Maternal HIV/TB coinfection also increases the risk of mother-to-child transmission of HIV.

Screening and treatment for TB in pregnant women at antenatal clinics must therefore be a major public health priority in the region. Information about TB needs to be an integral component of sexual reproductive health services.

To be precise, women infected with TB need to be empowered so that they can take control of their own care and lives.

## Prison-like hospitals for drug-resistant TB

25 March, 2008 - Another hospital breakout in South Africa by drug-resistant tuberculosis (TB) patients desperate to spend the holidays with their families has some public health experts questioning whether forced isolation is either the most effective or humane way to treat such patients.

On Thursday, 25 patients with multi drug-resistant (MDR) TB and eight with extensively drug-resistant (XDR) TB pushed their way past guards at Jose Pearson TB Hospital in Port Elizabeth, in the Eastern Cape. By Monday, 21 of them had returned, most of them voluntarily, four as a result of court orders.

MDR-TB is resistant to the two most powerful anti-TB drugs, while XDR-TB is resistant to these and at least two others. Whereas non-drug resistant TB is treated on an out-patient basis with a six-month course of drugs, South Africa's policy is to treat drug-resistant TB patients as in-patients until they are no longer infectious. XDR-TB patients, who are the most difficult to treat and pose the greatest public health risk, are required to spend up to two years in hospital, isolated from their families and facing the very real possibility that they will die before being released.

The average mortality rate for XDR-TB patients is just over 50 percent, but is closer to 85 percent for patients co-infected with HIV, according to South Africa's Medical Research Council.

Patients have described the isolation wards where they are quarantined as prison-like. While a number of the hospitals have in-

stalled pool tables, televisions and gym equipment to help patients combat boredom and depression, they have also boosted security by hiring more guards and building higher fences.

Despite such measures, patients regularly escape and have to be tracked down by health authorities fearful that the air-borne disease could be spread to families and communities.

South Africa is battling a dual epidemic of TB and HIV/AIDS. In 2006, it had both the highest TB prevalence rate in the world and the highest number of TB-related deaths, according to the Global TB Report, released by the World Health Organisation this month. People living with HIV are 50 times more likely to develop an active TB infection, but in 2006, only one third of TB patients in South Africa were tested for HIV.

Ensuring that TB patients complete their six-month course of drugs is vital to containing the spread of drug-resistant TB. South Africa has a cure rate of just 58 percent, the third worst in the world after Uganda and Russia according to the WHO report, which suggests that many patients are defaulting on treatment.

Arnaud Trebucq, who provides technical assistance to the TB division of the International Union Against Tuberculosis and Lung Disease, an organisation formed to help lower-income countries combat TB and lung disease, suggested that improving South Africa's TB cure rates would do much more to reduce the spread of MDR and XDR-TB than isolating patients who are already in-

fected.

Drug-resistant TB patients pose the greatest threat to their families and communities during the often lengthy period before they are diagnosed, pointed out Trebucq. "If the patient reacts to the drugs, he'll be infectious for a very short time; so, controlling infection by isolating patients - it's not obvious that it will do a lot," he told IRIN/PlusNews.

The main reason to keep MDR and XDR-TB patients hospitalised, he added, was to better supervise complex and toxic drug regimens. "Usually, you give a lot of different drugs; if you keep them in the hospital, you have a better insurance they take all the drugs under directly-observed treatment," he said. "But you have to discuss with the patient how long they can stay so it's an agreement."

The WHO recommends forced confinement of TB patients only as a last resort. "There is definitely a case for isolating MDR and XDR patients within health facilities, especially when they're infectious," commented Dr Paul Nunn, head of the WHO's XDR-TB unit. "It's less clear cut when it comes to isolating them by force."

Apart from the human rights issues surrounding forced isolation, a number of recent studies have suggested that hospitals themselves can be breeding grounds for drug-resistant TB. Research conducted at the Church of Scotland Hospital in Tugela Ferry, KwaZulu-Natal Province, where an outbreak of XDR-TB claimed 50 lives in 2006, found that most cases of drug-resistant TB were

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# Challenges of responding to drug-resistant TB

By Tayson Mudarikiri

ZIMBABWE—A young woman in Malawi has a cough. She will probably ignore it, hoping that it will go away. But she is wrong. Soon, the cough will get worse and she will have to go to a distant clinic for help.

Upon arriving at the clinic, she will be wrongly diagnosed with bronchitis or malaria and will be given the wrong treatment as her cough gets worse.

At some point, a health worker might decide to give her a sputum test for tuberculosis (TB). The young woman will then have to wait a few weeks before for the positive results and treatment.

If she is infected with a drug resistant strain of TB, or if she is living with HIV, she will possibly die before the results of the test reach her.

This picture of the challenges that people with TB in developing nations face was painted by Doctor Peter Small during a presentation at the 38<sup>th</sup> Union World Conference on Lung Health in Cape Town .

Small's presentation, titled 'Strengthening Laboratory Services for Today and Tomorrow', focused on the need for new technologies to tackle the TB epidemic. He also outlined the need for technologies to fight multi-drug resistant (MDR) TB, extensively drug-resistant (XDR) TB and HIV co-infection.

His presentation highlighted the 'Pandora's box' of challenges that developing nations face when dealing with drug-resistant

TB. "The situation I painted above is not only synonymous with Malawi," said Small. "It can happen in any resource-limited country."

## Diagnosis

Drug-resistant TB poses a challenge to diagnostics in developing nations. In countries such as Zimbabwe, there are no means of testing patients for MDR-TB. The director of a Zimbabwean community-based care organization for people affected by HIV called The Centre has been quoted as saying, "We are sure that we are seeing multi-drug resistant TB, but because there is no laboratory that can do the culture or sensitivity tests we don't have the evidence to prove it."

According to Small, "The root cause of the TB epidemic is failure of diagnostics."

Although efforts have recently been made by organizations like the Foundation for Innovative New Diagnostics (FIND) to speed up the effectiveness of TB diagnosis in developing countries, diagnostics remain a big problem for high TB burdened countries.

"Less than 5% of MDR-TB is being diagnosed. And much fewer of these cases are treated," said Catharina Boeline from FIND during a symposium on the development of alternative tools for the detection of MDR-TB in resource-limited settings.

## Cost

The cost of responding to MDR-TB cases is high per patient and the second line treatment drugs

that are used to treat MDR-TB are very expensive. Dr Helen Cox of the Burnet Institute of Medical Research and Public Health in Australia said that the reason few MDR-TB cases were diagnosed and even fewer treated was because of the costs involved.

She said MDR-TB treatment could cost anything from US\$ 2381 in Peru to US\$ 89,594 in the United States. A South African delegate at the conference said the country was spending US\$ 5000 on treating a single case.

The delegate argued that this was largely because South Africa admitted MDR-TB patients to hospital for about 4 to 6 months. The cost of this same process in Peru is reduced by community involvement, which involves patients being treated at home.

For now, developing countries can only escape a health crisis and manage these costs by avoiding MDR-TB cases. Drug-sensitive TB is much cheaper to treat, costing less than US\$ 10 per patient.

## Stigma and fear

MDR-TB has gained the reputation of a killer disease. Media headlines in South Africa have referred to MDR-TB patients as "Deadly TB patients" and the strain as "Killer TB."

As a result of these images, the number of people with MDR-TB that seek treatment may remain extremely low.

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## Prison-like hospitals for drug-resistant TB patients

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attributable to airborne infections, often contracted within the hospital, not the failure of patients to complete TB treatment.

Even at a TB hospital like Port Elizabeth's Jose Pearson, where XDR-TB patients stay on a different ward from MDR-TB patients, a report in the New York Times this week quoted a nurse saying that MDR patients there were contracting XDR-TB strains at an "intense rate".

Professor Greg Hussey, director of the Institute of Infectious Disease

and Molecular Medicine at the University of Cape Town, agreed that hospitals can be "dangerous environments", especially for patients with HIV-compromised immune systems. "It would protect the patient, in a sense, if they were treated in a home-setting," he said.

Hussey is among those who believe the scale of drug-resistant TB infection in South Africa demands an alternative approach. Hospitals are already over-stretched, he told IRIN/PlusNews, and lack the resources to cater for bored patients hospitalised for long periods.

"We make assumptions on the basis of what we think is best for patients, but if you're talking about issues around compliance, you need to have a patient who trusts what you're doing for them and you need to make the environment conducive to them taking the medication."

Hussey suggested that homes and communities may be the best environments for patients who are often reasonably well and don't have symptoms that would normally require hospitalisation.

<http://www.plusnews.org/Report.aspx?ReportId=77447>

## Patients Uncooperative in TB Treatment

NAMIBIA - The number of deaths in the Kunene Region caused by TB stand at 14 percent, according to officials from Health and Social Services. It is reported this "high death rate" is caused by the late arrival of patients.

The situation is worsened by the fact that some of the patients refuse to be tested for HIV.

This came to light during the commemoration of World TB Day last Friday.

The day was commemorated under the theme: "I am stopping TB."

Giving a brief insight of the TB situation in the region, Sister Asteria Evard, the chief health programme administrator for special disease programmes, said the region is facing TB challenges such as abuse of alcohol while on treatment, interruption of treatment for some days as well as that of defaulters.

"These challenges are leading to what we call multi-drug resistances,

whereby the patient is no longer responding to medication. This can also lead to a very dangerous TB that is not treatable," she stressed.

Evard noted that last year alone, Kunene registered 229 cases of TB infections. Opuwo recorded 112 cases while Khorixas and Outjo recorded 61 and 56 respectively.

Evard also said that despite all these challenges, there are control measures in place, among them the use of facility and community direct observed therapy (DOT), tracing of TB contacts and defaulters as well as the collection of sputum from TB suspects and treatment of confirmed cases.

She urged residents to join hands in the fight against TB, pointing out that Namibia is ranked number 2 on TB case notification in the world.

"The ministry together with the Global Fund have pulled resources together to fight the spread of TB within the Namibian nation. TB is

easily treated and nobody needs to die from it," said Evard.

Over a thousand people, mainly school children, attended the event.

Opuwo mayor Peter de Villiers, governor Dudu Mururua, Kunene's chief regional officer George Kamseb and regional health director Linda Nambundunga all graced the occasion.

At the same occasion, 16 voluntary community DOTs were awarded certificates and small gifts as a token of appreciation from the ministry, for their efforts in the fight against TB in the region.

Three former TB patients who were successfully treated also delivered testimonial speeches. Local bands, Povitanda and Sunset, spiced up the occasion.

<http://allafrica.com/stories/200804010187.html>

## Do not die, TB is curable

The Southern African region joined the rest of the world in commemorating World Tuberculosis (TB) Day, on 24 March. This is a day designed to build public awareness around tuberculosis. The theme for this year's campaign was "I am stopping TB", which places emphasis on the individual to take action and personal responsibility of stopping TB.

This year's commemoration celebrated the lives and stories of people affected by TB, women, men and children who have taken TB treatment, nurses, doctors, researchers, community workers- and anyone else who has contributed towards the global

fight against TB.

It is important however as the day is commemorated that "I am Stopping TB" should not be a theme that comes to mind once during the year but every day. There are basic facts that everyone should know about TB so that one can make an effort to prevent it.

Caused by a bacteria called Mycobacterium tuberculosis, TB is a serious but curable disease, which usually affects the lungs but can also affect lymph glands, bones, joints and kidneys.

The problem of TB is now compounded by the fact that it now kills up to half of all AIDS patients worldwide. People who are HIV positive are up to 50 times more likely to develop active TB in their lifetime than people who are HIV negative, (UNAIDS, 2007)

To avoid complications, there is need to detect TB early. The symptoms for TB vary from person to person but they mainly include loss of appetite, weight loss, a persistent cough, sometimes with blood, tiredness, fevers and night sweats.

Once diagnosed TB positive, it is very important to adhere to treatment and follow the prescribed instructions. If not treated long enough or if a patient doesn't take prescribed medication properly, or receive the right drugs, TB can become drug-resistant.

Given that the standard TB treatment is normally taken for six months, TB patients are more likely to drop out of treatment before it is completed than with other medication regimens. When a patient does not finish the full course of treatment, he or she can develop and spread drug resistant strains of TB that are much harder to treat and up to 100 times more expensive to cure, (WFP, 2004.)

If patients do not adhere to treatment, Multi Drug Resistant (MDR) TB or Extreme Drug Resistant (XDR) TB normally occurs. MDR TB can cause death within a few weeks in persons with HIV and AIDS. If taken earlier, treatment for MDR TB normally takes 18 to 24 months.

If left untreated, TB is a slowly progressive disease that can kill. That knowledge should be enough to make everyone commit to "stopping TB" by going in for regular health checks, getting tested for HIV so that if one tests positive, one knows how susceptible they are to HIV infection and support those in their communities who are living with TB and HIV.

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### Treatment burden for patients

MDR-TB treatment puts a heavy burden on patients. They are expected to take medication for more than 18 months beyond culture conversion. The medication has a high toxicity and can cause extreme side effects. The failure of treatment might also lead to XDR-TB.

### Other challenges

MDR-TB presents a host of other challenges to response efforts. Among these is the challenge of infection control to protect health-care workers and other patients in hospital wards. Most of the developing world faces a crippling health-care human resource shortage, making it difficult to respond to MDR-TB.

Many of these challenges, although they affect any country, are of greater concern for developing states. MDR-TB makes the challenge of responding to the disease far more taxing, especially to those countries that lag behind in their response to drug-sensitive TB such as Malawi.