

## **Spotlight: Integrating TB responses into HBC programmes**

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Given the fact that we have been fighting tuberculosis (TB) for far longer than we have been trying to tackle HIV, it is surprising how much TB prevention programmes could learn from those aimed at the latter epidemic.

It appears that the fight against HIV has been supported by greater levels of advocacy and funding in the past two decades than the battle against TB.

Health experts believe that because the TB epidemic was considered conquered years ago many people had become complacent towards it until it appeared to join forces with HIV.

There is increasing evidence to show that the prevalence of TB around the world is directly related to the spread of HIV. But the responses to these two diseases remain separate despite the fact that lessons learnt from the responses to HIV over the past two decades can be applied to the fight against TB.

We take pride in the fact that the effects of HIV are being contained and that communities are playing a pivotal role in this process. One example of this is the home-based care (HBC) initiative, which has demonstrated that communities are able to respond to the health challenges they face.

In Zimbabwe, where the government is reeling from an economic meltdown that affected the health-care system, the burden of HIV care has been made bearable through community participation in HBC.

But with TB now ranked as the leading cause of death among people living with HIV (PLHIV), it threatens to reverse what these communities have achieved through HBC. The providers of HBC, especially volunteer caregivers, are finding themselves caring for more and more people co-infected with HIV and TB. Approximately, 60% of all the new TB cases among people aged between 15 and 49 in Zimbabwe occur in PLHIV.

In situations like this, it becomes difficult to deal with HIV without also tackling TB. Disregarding the need to integrate TB prevention into HBC programmes means that caregivers are being thrust into the front lines of the fight against TB without the knowledge they need to handle the disease.

There are a number of points that people involved in TB or HIV programmes need to consider if they are to be successful in dealing with either of the intertwined epidemics.

The first and most obvious reason why the two epidemics have to be dealt with in an integrated way is that so many PLHIV are succumbing to TB, which attacks as an opportunistic infection. TB is curable in both HIV-positive and negative patients.

So, if HBC providers incorporate TB prevention and treatment into their programmes, they can start working towards preventing many of these avoidable deaths. Caregivers must be able to recognize the symptoms of TB in their patients and refer them for early treatment.

The caregivers involved in HBC programmes could be the missing link to ensuring increased adherence to treatment among TB patients. In Zimbabwe, an under-performing economy coupled with an ineffective public transport system is contributing to adherence failure among many TB patients who cannot afford the costs of going to collect their medication.

Treatment literacy and helping HIV-positive patients to adhere to treatment feature prominently in HBC checklists and organizations involved in care work in Zimbabwe are making great strides towards achieving this requirement, particularly with regards to HIV.

But the same cannot be said about TB despite the fact that there is a pressing need to ensure that TB patients adhere to treatment in order to reduce the types of treatment failures that can lead to drug resistance.

It would be helpful if the same levels of attention and resources being directed towards ensuring adherence to HIV treatment were also extended to TB because the same people who survive HIV may succumb to TB due to co-infection.

Statistics have indicated that the number of PLHIV with TB is growing. This means that HBC workers are being exposed to the disease. HBC providers should seriously consider training caregivers to recognize TB, particularly in the area of transmission control.

TB is known as an opportunistic infection that can affect PLHIV in the early stages of the disease. If community care workers are empowered to identify TB cases, this might help many PLHIV to be diagnosed and treated before the disease becomes advanced. In this way, we can protect the gains made so far in the fight against HIV.

In Zimbabwe, the low levels of community involvement in TB treatment and prevention can be attributed to state policies that place the responsibility for TB treatment solely in the hands of the government. The acute shortage of drugs and medical staff in the country is compromising TB programmes at a time when we cannot afford to make mistakes. An audit of the HBC providers in Zimbabwe reveals that they are better equipped to tackle TB than the government.

Given the opportunity, HBC programmes may perform better or at least complement the government's efforts towards responding to TB. HBC programmes can help with TB identification and treatment and can help ensure adherence.

These organizations could also act as hubs for drug distribution through a decentralized directly observed treatment short-course (DOTS) programme. This is critical, considering that public transport and hospitals are inaccessible to many people in the country.

HBC service providers offer the opportunity to bring treatment to the communities and improve adherence levels that have been compromised by the poor transport links to rural Zimbabwe. But it is also important that the integration of efforts to tackle TB and HIV start among policy-makers and donors. Often funding partners tell people implementing their programmes that their aid is only meant for PLHIV. This means that patients who have TB but have not yet been tested for HIV cannot benefit from HBC programmes.

During a recent discussion with people benefiting from HBC programmes, a man who had TB said he did not get the nutrition packs that others received because, "We are always told that this is only for HIV positive people."

In a similar case, a woman from Mashonaland failed to adhere to her TB treatment more than three times despite the fact that she was receiving HBC. This could have been avoided if programme staff were equipped to respond to TB issues.

If policy-makers and the public remain impervious the need to integrate the responses to the two epidemics then we are going to fail. We have nothing to lose but everything to gain by pooling our efforts and resources together to fight the two epidemics.

HBC offers an entry point for such an integrated response and could bring innumerable benefits for Zimbabwean people tackling HIV and TB.

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