

## **Eyes and ears: African TB conference highlights need for joint TB and HIV programmes**

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Among the six key principles of the Stop TB Strategy discussed at the 16th Union Africa Conference, organized by the International Union Against Tuberculosis and Lung Disease (The Union), is the need for collaboration between tuberculosis (TB) and HIV prevention and treatment programmes.

Many delegates at the conference, themed 'TB-HIV: A Challenge for National TB Programs and National AIDS Programs', agreed that such an approach was vital now that it is widely recognized that the HIV epidemic is fueling the spread of TB.

Zimbabwe, which is ranked the 20th most TB-affected country in the world, also has an untenably high HIV prevalence rate of 15.6%. We know that people living with HIV (PLHIV) are 50 times more susceptible to TB infection and that there are believed to be six times as many TB cases in Zimbabwe today as there were 20 years ago.

WHO estimates from 2005 indicate that 60% of all new adult TB cases occurred in PLHIV. TB is also considered the most prevalent and deadly opportunistic infection among PLHIV, causing 195,000 deaths in 2005 alone. Add these statistics together and you have a genuine case for advocacy.

The problem in Zimbabwe is that there is little collaboration between TB and HIV prevention and treatment programmes. But Dr Owen Mugurungi, Head of the AIDS and TB Unit under the Ministry of Health says that the department had started to forge a link between TB and HIV policies and services.

According to Mugurungi, all people with TB are screened for HIV and vice versa. This is meant to ensure that patients with either or both of the diseases receive all the help they need.

The private health-care sector is also doing all it can to integrate services aimed at tackling both diseases. Dr Karin Hatzold from Population Services International (PSI) said that all new patients registered with the organization's post-test support service centres are screened for TB via a questionnaire. If it is considered probable that they have the disease, patients are referred to a TB diagnostic centre for further clinical tests.

Data indicates that PSI is responsible for about 45% of voluntary counselling and testing (VCT) services in Zimbabwe through its New Start Centres. About 14% of HIV-positive patients being treated by PSI are referred for further tests.

It appears that the disconnect between HIV and TB programmes in Zimbabwe has not resulted from a lack of understanding over the connection between the two diseases. If anything, Zimbabwe has achieved a great deal on paper towards integrating the responses to these epidemics. Unfortunately little has been done on the ground to implement collaborative TB and HIV programmes.

"Fighting HIV and AIDS requires a stronger integrated response to tuberculosis and other AIDS-related diseases," said Dr Parirenyatwa, Zimbabwe's Minister of Health and Child Welfare. "But much more work needs to be done to integrate TB and HIV [responses]."

The efforts of the Ministry of Health and international agencies such as PSI should set the tone for effective collaborative action but plans to that effect are being hampered by myriad challenges.

Zimbabwe's is at the brink of economic collapse and this has greatly affected the delivery of health-care services. The 'brain drain' caused by health professionals migrating en masse to more developed countries has further crippled the country's hospitals and health sector.

If TB and HIV programmes are to be integrated, human resources will need to be improved at both the planning and implementing stages. Zimbabwe may have to resort to task shifting to get around this problem, which would involve allowing less qualified health-care workers to take on tasks usually managed by doctors and nurses.

The country is also struggling to get the funding it needs for TB and HIV prevention and treatment training, the development of TB and HIV materials and other advocacy, communication and social mobilization activities. In 2006, the budget allocated to addressing TB, HIV and multi-drug resistant strains of TB fell short by US\$ 0.4 million.

Zimbabwe is also struggling to mobilize funding for basic TB and HIV programmes and relies on the Global Fund to fight AIDS, Tuberculosis and Malaria for support. It is clear that the country will fail to implement joint TB and HIV programmes given the current economic climate.

Like most African countries, Zimbabwe is seriously lagging behind in its efforts to collect the kind of clear TB and HIV data that acts as an important starting point for collaborative activities. Zimbabwe has no figures on such activities in 2005. But this is not unusual and according to a Botswana delegate at the conference, his country is also lacking reliable data.

"In our country we have problems calculating how many patients accessing [antiretroviral therapy] are from TB programmes," he said.

This absence of data underlines the fact that many African countries, including Zimbabwe, have a long way to go before they can effectively plan for integrated responses for TB and HIV. According to WHO, Zimbabwe's efforts, "to address the needs arising from widespread TB and HIV co-infection are still in the developmental stage." These efforts need to be turned into action as soon as possible if disasters are to be averted.

While Zimbabwe continues to try to fight the two epidemics separately, the country is highly unlikely to be successful.

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