IPPF
From choice, a world of possibilities
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HIVUpdate

access=life

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HIV and TB Co-infection

At least one third of the 33 million people living with HIV (PLHIV) are also likely to have tuberculosis (TB). TB is the leading cause of death among PLHIV in Africa and is responsible for at least 13% of all deaths in PLHIV worldwide. World TB day on 24th March serves as a reminder that our comprehensive response to HIV must address issues related to TB.

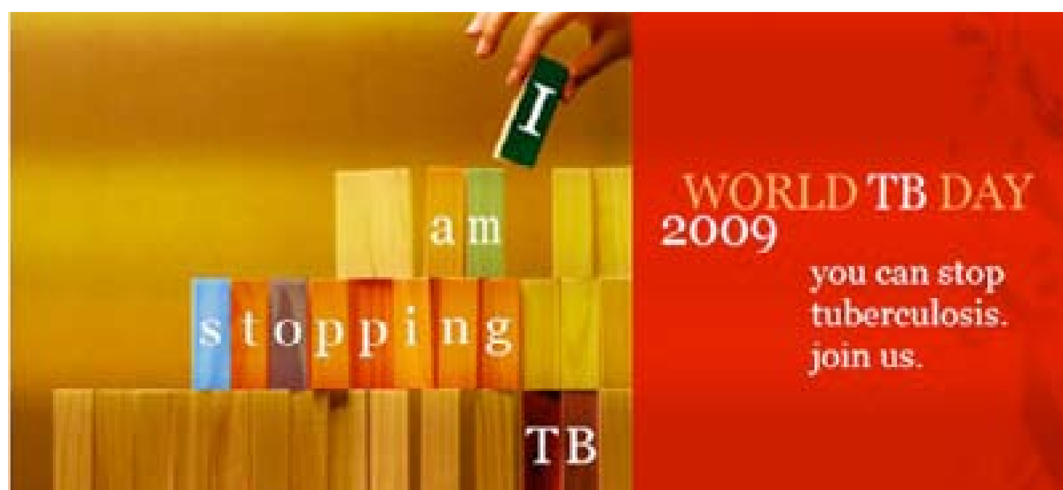
The threat of TB/HIV co-infection is well-documented. During the 1990s, failure to detect and treat HIV infection led to a huge upsurge in TB in Sub-Saharan Africa, especially in countries with high HIV prevalence. However, this 'dual epidemic' of TB and HIV is not inevitable. TB is curable and easily preventable making TB/HIV co-infection an avoidable threat – one that Alasdair Reed looks into in more depth in the main article of this Update (see page 2).

Many of the social determinants of HIV infection also contribute to TB infection – poverty, inequality and stigma – and there is a unique opportunity to share some of this knowledge to strengthen responses to TB/HIV co-infection. Aspects of TB adherence programmes such as Directly Observed Treatment Short-course (DOTS) could be applied to promote greater antiretroviral adherence. Similarly the global advocacy response to HIV could assist in galvanizing increased recognition of the importance of effective TB prevention and management.

Winstone Zulu, an international TB/HIV activist provides a perspective on issues facing people living with HIV who are co-infected with TB (see page 3). It is clear that many PLHIV still hide behind a TB diagnosis – scared to disclose their HIV status. The *People Living with HIV Stigma Index* will contribute to our understanding of this complex interplay between these two major infections.

Minimizing co-infection with TB in people living with HIV does not have to be costly, nor should it be the sole responsibility of TB programmes. There are numerous interventions that can be implemented and some practical steps that can be taken at the service delivery and advocacy levels to contribute to effective control of the dual epidemics of TB and HIV (see page 3). In order to address the TB/HIV co-epidemic, new tools are needed. These include rapid and accurate diagnostic tests, shorter and more potent treatments that are compatible with antiretroviral drugs, and a safe vaccine. IPPF needs to join the advocacy voices of initiatives like the Stop TB Partnership who are advocating for these new tools to be developed. To reverse this 'dual-epidemic' – especially in countries with a generalised HIV epidemic – we need all to be aware of, and include, TB in our work by developing strategic partnerships with local TB organisations.

Love
Kevin
Senior HIV Advisor



Tuberculosis: an avoidable threat to the global AIDS response

Tuberculosis (TB) is caused by infection with the bacteria **Mycobacterium tuberculosis**. It is spread, like the common cold, by an infectious person coughing or sneezing.

by Alasdair Reid, TB/HIV Adviser UNAIDS

One third of the world's population is infected with TB; however most people who are infected with TB never develop TB disease as the bacteria are dormant in the lung (known as latent TB infection). Only 5-10% of people who are infected actually go on to develop TB disease during their lifetime but this risk is increased when the body's immune system is weakened by malnutrition or HIV, for example. In people living with both latent TB infection and HIV the risk of active TB disease is 10% per year.

TB disease commonly presents with symptoms such as a persistent cough lasting for more than 2-3 weeks, weight loss, fever, night sweats and coughing up blood. TB disease usually affects the lungs but can affect any part of the body.

TB is both treatable and preventable. TB disease is treated with a course of four antibiotics taken over at least six months. Cure rates are as high in people living with HIV (PLHIV) who complete treatment as in those who do not have HIV; however mortality rates are much higher among PLHIV. Rapid progression of TB, delays in seeking care and difficulties in making a diagnosis of TB in PLHIV increase the death rate.

The main tool for diagnosing TB is microscopic examination of sputum that has been specially stained. TB is diagnosed when bacteria are seen and the patient is said to have sputum positive TB. This test is over 100 years old, it is time-consuming and requires considerable training. Furthermore, it is not as effective in diagnosing TB among PLHIV because TB of the lungs is often sputum negative and TB disease often occurs outside the lungs (extrapulmonary TB). New tools for improving the diagnosis and treatment of TB in PLHIV are urgently needed.

Most TB could be prevented by making sure that all cases of infectious TB are detected rapidly, treated and cured. Each case of infectious TB is likely to infect an estimated 18 other people before they are detected and cured. TB can spread particularly rapidly among vulnerable groups of PLHIV when they congregate together, such as at HIV care clinics, prisons, harm reduction service centres, and workplaces in high HIV prevalence settings. Simple infection control practices can greatly reduce the risk of TB spread in such settings.

Communities can play a major role in preventing the spread of TB by promoting cough hygiene (covering the mouth when coughing or sneezing), encouraging anyone with a cough for more than 2-3 weeks to be tested for TB and supporting those who are on TB treatment to complete their treatment.

Effective antiretroviral therapy (ART) will reduce the risk of TB in PLHIV, however their risk of TB on ART will still be much greater than someone who is not HIV infected. Regular TB screening for populations at risk of TB, such as PLHIV, can help to detect and treat TB disease early thus saving lives and reducing spread. Adults and children living with HIV who do not have TB disease but have latent TB infection can be treated with isoniazid preventive therapy (IPT) for six months which greatly reduces their risk of developing the disease. The current vaccine against TB is most effective in reducing the risk of severe TB in children. Research into a new TB vaccine which is equally effective for adults is a priority.

The emergence of extensively drug resistant TB (XDR-TB) – an effectively untreatable form of TB with very high death rates among PLHIV – demonstrates the grave consequences for PLHIV if they do not have adequate access to high quality, effective TB prevention, diagnostic and treatment services.

While we wait for the development of more effective diagnostics, treatments and vaccines for TB it is vital that PLHIV have universal access to TB prevention, diagnosis and treatment services in order to reduce the unnecessary burden of TB disease and death. Coordinated action and collaboration between the TB and HIV programmes is essential to ensure that no more PLHIV will die unnecessarily from TB.

For policy guidance or further information on TB/HIV collaboration go to the WHO TB/HIV website http://www.who.int/tb/hiv/en/

To find out more about XDR-TB and HIV and drug resistant TB in general http://www.who.int/tb/xdr/en/index.html

The Stop TB partnership web has general information about the global response to TB http://www.stoptb.org/

Information about the TB/HIV Working Group of the Stop TB Partnership is available at http://www.stoptb.org/wg/tb_hiv/

Enhancing media coverage on TB

That TB continues to kill millions when a cure is available clearly indicates the need for enhanced communication strategies.

by Anushree Mishra, Director, Panos Global AIDS Programme (GAP)

Work on HIV and other development issues have shown the importance of moving beyond merely building awareness to empowering communities and societies through processes of dialogue and debate. One step is to build a critical mass of people, especially journalists, who understand TB as a development issue and its root causes in social inequalities.

The Panos Global AIDS Programme (GAP) has worked with the media on TB issues for the past six years to ensure that health practitioners, activists and people who have had TB engage more effectively with the media. In addition, Panos has been building the capacity of journalists, editors and media professionals to cover TB in the real-life situations that usually impede good health reporting. At the Stop TB Partners' Forum in Rio De Janeiro (March 23-25), Panos GAP is facilitating the participation of ten journalists from selected high burden countries. Journalists will be trained on clinical, epidemiological and social issues around TB as well as sensitivities around reporting TB. Panos will also produce a daily newsletter, Panoscope, in Portuguese and English with the latest news from the Forum.

Avoiding co-infection: practical steps

There are a number of simple yet essential activities that all MAs can take to reduce TB/HIV co-infection.

The prevention, detection and treatment of TB is essential to stop the growth of TB/HIV co-infection. Three essential activities that all sexual and reproductive health (SRH) programmes can implement to protect people with HIV from TB infection are referred to as the 'Three I's.[1] They are:

- **Infection control** Prevention measures to decrease the risk of TB transmission.
- **Intensified case finding** Detection of TB through TB screening, or referral of PLHIV.
- **Isoniazid preventive therapy** Treatment for people latently infected with TB – especially PLHIV – with an antibiotic that greatly decreases the risk of developing active TB.

1 WHO (2004) *Interim policy on collaborative TB/HIV activities.* Available from http://whqlibdoc.who.int/hq/2004/who_htm_tb_2004.330.pdf

Included in these three areas are a number of simple activities that Member Associations can include in their SRH and HIV programmes. These could include:

1. **Information, Education and Communication (IEC):** Ask the national TB programme for simple educational materials to help people protect themselves from TB. These could include posters to display at service delivery points on cough etiquette and information on local TB screening and treatment services.
2. **Clinic ventilation:** Initial research shows that one of the primary places that PLHIV get TB is in the waiting room of an HIV clinic. This can be reduced by better ventilating facilities, for example by having a policy of always keeping windows open or installing whirlybird roof vents.
3. **Triage:** In a clinic, advance symptomatic patients to the front of the line for the services they are seeking if they have an acute cough or are showing any of the other symptoms of TB. This will reduce the chance of infection in the waiting room.
4. **Training healthcare providers:** Improve the training of healthcare workers to recognize the symptoms of TB. This can be as simple as a healthcare worker asking the patient whether they are currently taking TB treatment and if not, using a simple checklist to ascertain whether they have any of the key symptoms of TB such as: a cough, shortness of breath, fever, night sweats or recent unintentional weight loss. Any positive response indicates that the person could have TB and should be tested.
5. **Screening and referrals:** Start routinely screening for and treating TB in PLHIV. If this is not possible, partner with local TB organizations and refer for TB screening and treatment.

For more information on any of these activities, and for further simple suggestions, please see 'Think TB in people with HIV' http://www.aidsmap.com/cms1191146.asp

Some personal reflections

HIV and TB are closely intertwined. TB is the leading cause of death among people living with HIV in Africa – including my home country Zambia – and a major cause of death elsewhere. Yet in 2006, less than one percent of people living with HIV were even screened for TB.

By Winstone Zulu

I am living with HIV and became sick with TB in 1997. I recognized the symptoms from seeing my family sick with TB. When I went in for an X-ray and a sputum test, the most common diagnostics for TB, my results came back negative.

Not believing the results, I took my brother's anti-TB drugs and began to feel better within three days. I went to get tested again, and continued taking the full regimen of antibiotics. Four months later, I was diagnosed with TB. I could be dead now if I'd waited for it to be diagnosed.

I do not blame the doctors who misdiagnosed me. The truth is that sputum microscopy was developed more than 100 years ago and can only detect at best half of all active cases of TB. Patients are often diagnosed after weeks or months of waiting, during which time they spread the disease and may even die.

Even patients who are diagnosed and have access to treatment are not guaranteed a cure. Today's first-line TB drugs are more than 40 years old and must be taken for six to nine months. If treatment is not completed properly, TB bacilli can mutate to become resistant to these line drugs – known as multi-drug resistant TB (MDR-TB). MDR-TB usually takes 18 to 24 months to treat and the likelihood of cure is lower. Extensively drug-resistant TB (XDR-TB) is even more dangerous because in 90% of cases it is fatal as there is no cure.

There is hope. An ambitious international effort called the Global Plan to Stop TB would save 14 million lives by improving TB screening and developing more effect TB tests and vaccines. Bringing these new tools to reality will require perseverance and political will. However, the current initiative is vastly underfunded. It is up to the world's governments to bring an end to TB and deliver renewed hope to those of us living with HIV.

Winstone Zulu is an international TB/HIV activist and an advisory board member of AIDS-Free World. He is currently a Visiting Fellow in the Journalism School at Ryerson University, Toronto, Canada. To see a short video documenting his story visit www.stoptb.org/assets/video/wm9/hi/tbcd_zulu.wmv

The people at IPPF

Fahmi Arizal

HIV Programme Officer, Indonesian Planned Parenthood Association (IPPA)

I have been working for IPPA since 1999 and am responsible for planning, coordinating, implementing, monitoring and evaluating sexually transmitted infection programmes including HIV.

My desire to help those living with HIV started when I saw a whole family who were suffering from stigma and discrimination just because one of them was HIV positive. My heart went out to them and since then I have tried to help in every way I can to improve access to information and services for people living with HIV. I have been an outreach worker, a counsellor, a buddy, a facilitator and am now a programme officer.

One particular interest of mine is enabling communities to be more involved in the response to HIV. I have recently helped IPPA to become a civil society principal recipient for the Global Fund for AIDS, Tuberculosis and Malaria. Our main role is to strengthen the community system which includes prevention, care and support, institutional capacity, networking and sustainability.

I continue to have such a passion as an HIV programme officer because when I look at my friends and family I think that they could still easily be impacted by HIV. Our work is not finished yet – especially around stigma and discrimination and access to prevention information and services.

IPPF sign-ons

Closing the Global Fund funding gap

IPPF have signed an open letter to the Finance Ministers of the G7 who met in Rome, Italy on 14 February 2009. The letter urges G7 nations to take a leading role in pledging new money to the Global Fund to Fight AIDS, Tuberculosis and Malaria which is facing a $5 billion dollar gap in funding for 2009 and 2010. If not supported by Global Fund health programmes, some of the most vulnerable populations in the world will feel double or triple the impact of this international economic crisis.

Events and key dates

World TB Day

24 March

www.stoptb.org/events/world_tb_day/2009

AIDS 2031 Mobilising Social Capital Workshop

30 March – 1 April

Salzburg, Austria

20th International Harm Reduction Conference

19-23 April

Bangkok, Thailand

www.ihra.net/Thailand/

FORO 2009: Fifth Latin American and Caribbean Forum on HIV/AIDS

22-26 June

Lima, Peru

www.forovih2009.org.pe

HIV Competencies Workshop

7-10 July

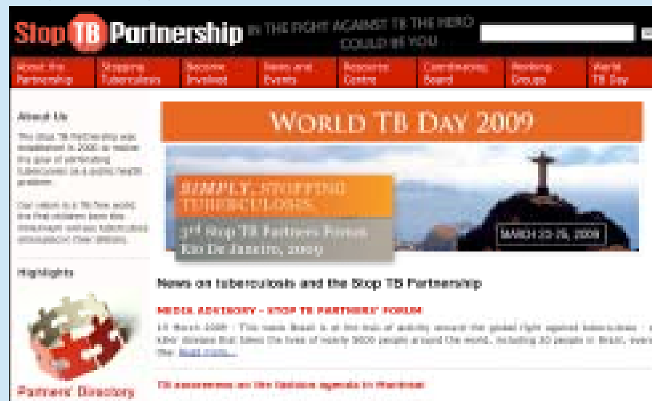
Mumbai, India

Internet resources

The Stop TB Partnership

www.stoptb.org

The Stop TB Partnership was established in 2000 to realize the goal of eliminating tuberculosis as a public health problem. The website contains a variety of information and resources about stopping TB, news, World TB Day, and how to become involved in the partnership.



Paulo Longo Research Initiative

http://plri.wordpress.com

The Paulo Longo Research Initiative (PLRI) is a collaboration of scholars, policy analysts and sex workers. They aim to develop and consolidate ethical, interdisciplinary scholarship on sex work to encourage policy that helps improve the lives of men, women and transgenders who sell or buy sex. The blog explains who the PLRI are and what they hope to achieve. It also contains photos, slideshows, bibliographies, links and other resources on sex work policy and research.

HIV team & contact details

Kevin Osborne	Senior HIV Advisor	kosborne@ippf.org
Ale Trossero	Senior HIV Officer: Linking SRH and HIV	atrossero@ippf.org
Dieneke ter Huurne	HIV Officer: Prevention, Treatment and Care	dthuurne@ippf.org
Lucy Stackpool-Moore	HIV Officer: Stigma	lstackpoolmoore@ippf.org
Adam Garner	HIV Officer: Youth	agarner@ippf.org
Jon Hopkins	HIV Research & Administrative Assistant	jhopkins@ippf.org

International Planned Parenthood Federation
4 Newhams Row, London SE1 3UZ
United Kingdom
tel +44 (0) 20 7939 8200
fax +44 (0) 20 7939 8300
email HIVinfo@ippf.org
web www.ippf.org