

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA



ORGANISATION MONDIALE DE LA SANTE
BUREAU REGIONAL DE L'AFRIQUE

ORGANIZAÇÃO MUNDIAL DE SAÚDE
ESCRITORIO REGIONAL AFRICANO

REGIONAL COMMITTEE FOR AFRICA

AFR/RC52/RT/1
2 April 2002

Fifty-second session
Brazzaville, Congo, 19-23 August 2002

ORIGINAL: ENGLISH

Provisional agenda item 9.1

THE HEALTH SECTOR RESPONSE TO THE DUAL EPIDEMIC
OF TB AND HIV/AIDS

Round Table 1

CONTENTS

	Paragraphs
BACKGROUND	1-7
FRAMEWORK AND CHALLENGES	8-17
DISCUSSION POINTS	18-21
EXPECTED OUTCOMES	22-25

BACKGROUND

1. The dual and closely inter-related epidemics of tuberculosis and HIV/AIDS in Africa require urgent, strategic and effective action to reduce the associated disease burden and mortality. There has been an unprecedented increase in tuberculosis cases, related to HIV-induced immune-suppression, in the Region in the last 15 years. Available information indicates that approximately 30%-50% of newly diagnosed tuberculosis patients are also infected with HIV, and at least 40% of AIDS deaths are due to tuberculosis.¹ In some southern African countries, reported HIV prevalence among hospitalized tuberculosis patients ranges from 50% to 80%.²
2. The combined effect of the two epidemics is that health services are unable to provide adequate basic care and support services for the infected or affected populations. The dual epidemics are also exerting a negative impact on the ability of the workforce providing the needed services within the health sector, as health care workers themselves become victims. Thus, the capacity of tuberculosis programmes to provide adequate diagnostic and treatment services in line with the WHO-recommended directly observed therapy short-course strategy is severely undermined, while most countries have yet to embark upon HIV/AIDS care provision on a meaningful scale.
3. With an estimated regional incidence of 1.6 million new cases and 600,000 deaths each year³ in the region, tuberculosis has become one of the leading causes of adult mortality in recent years. Tuberculosis case notification rate⁴ in some southern African countries has increased from between 70 and 100 to between 200 and 500 per 100,000 population over the past 10 years and is among the highest in the world. WHO estimates that approximately one-third (200 million⁵) of the population in the African Region is already infected with the tubercle bacillus, which underscores the potentially catastrophic magnitude the tuberculosis epidemic is likely to attain in the near future, given the current trends in the spread of HIV.
4. HIV/AIDS is the leading cause of death in Africa where, in 2001,⁶ 28 million of the estimated global total of 40 million HIV-infected people lived. This represents approximately 10% of the adult population in a region already grappling with considerable human capital constraints. Of the 28 million infected people in Africa, approximately 53% are women. Furthermore, of the 24 countries worldwide where adult HIV sero-prevalence is 5% or above, 23 are in Africa, while more than 15% of adults are HIV-infected in eight southern African countries.
5. Although the overall HIV incidence on the continent appears to be levelling off, 3.4 million new infections occurred in 2001, approximately 2.2 million deaths are recorded annually and life expectancy in some southern African countries has dropped from above 50 years to about 40 years in the last 10 years.⁷ There are significant sub-regional variations in these regional estimates – southern Africa is most severely affected, with a prevalence of 19%, while the overall prevalence levels for West, Central and Eastern Africa are 3%,

¹WHO Global Tuberculosis Report, 2000.

²Report of the assessment of tuberculosis/HIV situation in Southern African countries. WHO/AFRO (1999).

³WHO/AFRO tuberculosis surveillance report (1997) - unpublished.

⁴WHO/AFRO tuberculosis surveillance report (1999) - unpublished.

⁵WHO/AFRO tuberculosis surveillance report (1997) - unpublished.

⁶WHO and UNAIDS HIV/AIDS surveillance report (2000).

⁷WHO and UNAIDS HIV/AIDS surveillance report (2000).

7% and 8% respectively. The subregional distribution of AIDS prevalence is generally similar to tuberculosis.⁸ This state of affairs is of great concern to the health sector in Member States.

6. Economically, the tuberculosis/HIV/AIDS dual epidemic is trapping the Region's populations, especially the poor, marginalized and vulnerable groups, in a vicious circle of poverty and disease through increased morbidity and death. In the worst affected countries, the epidemic is slowing down economic growth by at least 1%-2% a year, greatly jeopardizing efforts to reduce poverty.⁹ Many such countries are expected to see their gross national product fall by 20%-25% by the year 2020. Studies have shown that households that have lost one breadwinner to HIV/AIDS see their income drop by up to 80%.

7. The purpose of this paper is to stimulate discussion to identify the key actions required to improve the health sector's response to the dual epidemic.

FRAMEWORK AND CHALLENGES

8. The health sector's response to HIV/AIDS and tuberculosis has, so far, been characterized by parallel approaches to the two diseases, with few attempts to exploit the synergistic benefit of the integration of strategically selected interventions. The volume of financial, human and other resources allocated to the health sector in general and to tuberculosis and HIV/AIDS interventions in particular has been grossly inadequate and has failed to keep pace with the increasing magnitude of the problem.

9. National tuberculosis programmes are implementing the directly observed therapy short-course strategy, whose key elements are:

- (a) case detection through sputum smear microscopy examination of suspected tuberculosis cases in general health services;
- (b) treatment, using a standardized short-course drug regimen under proper conditions, including direct observation for the first two months;
- (c) regular uninterrupted supply of essential tuberculosis drugs;
- (d) a monitoring system for programme supervision and evaluation; and
- (e) government commitment to the national tuberculosis control programme at country level.

10. HIV/AIDS programmes in the health sector have worked increasingly within the context of a multisectoral approach. Most countries are implementing some or all of the following interventions for prevention and care, which are in line with the regional HIV/AIDS/STI strategy and framework for implementation:

- (a) surveillance of HIV/AIDS/STI;
- (b) ensuring the safety of blood transfusion;
- (c) mass media campaigns for awareness-raising and behavioural change;
- (d) targeted behaviour interventions for vulnerable groups such as sex workers, mobile populations and the youth;
- (e) treatment of sexually transmitted infections; and
- (f) voluntary counselling and testing and prevention of mother-to-child transmission.

⁸WHO/AFRO tuberculosis surveillance report (1999) - unpublished.

⁹World Bank Report (2000).

11. Whereas 75% of Member States are currently implementing the directly observed therapy short-course strategy, there are serious problems of low geographic and target population coverage and poor tuberculosis treatment success rates, that need to be addressed. The average treatment success rate of 68% for the Region is far below the global target of 85%. Furthermore, most HIV/AIDS programmes have been implemented on a limited scale with relatively low geographic and beneficiary group coverage. The integration of HIV/AIDS activities within health systems in the Region has been fragmented and is unstructured in many countries. Decentralisation of programme management and the delivery of a package of services at primary care facilities have not been adequate in many countries.

12. Lessons learned from pilot projects in four countries have shown that maximum impact can be achieved if the control of the two epidemics is tackled in an integrated manner. Of crucial importance to combating the dual epidemics of tuberculosis/HIV/AIDS is the scaling up of coordinated implementation of proven interventions. This calls for joint planning by tuberculosis and HIV/AIDS programmes and close coordination in implementation, monitoring and evaluation. Voluntary counselling and testing has been found to be a vital entry point for making early detection possible, for conducting interventions for both HIV/AIDS and tuberculosis and facilitating stronger links and synergy between the two programmes.

13. An integrated package of prevention and care interventions should also include:

- (a) provision of counselling and testing services for HIV/AIDS patients at tuberculosis and general out-patient clinical services;
- (b) HIV prevention counselling and information for patients with dual infection;
- (c) isoniazid preventive therapy for people testing positive for HIV;
- (d) provision of Cotrimoxazole prophylaxis;
- (e) provision of treatment for other HIV-related opportunistic infections and introduction of anti-retrovirals;
- (f) prevention of mother-to-child transmission; and
- (g) community-based care, support and follow-up.

14. Over the past two decades, countries in the African Region have generally experienced poor economic performance, wars and civil strife and inefficient use of the scarce resources available. Consequently, despite efforts by governments to improve access to health care, deficiencies in the health sector appear to be growing. In addition, health systems are understaffed, and facilities for diagnosis and the supply of drugs and other essential items are inadequate. Although HIV/AIDS and tuberculosis are included in the health sector development plans of Member States, they are usually not allocated adequate resources. In some cases, the implementation of reforms has not adequately taken into account the need to protect the basic components of control programmes. Competition with other national priorities has limited the availability of national financial resources and support from the local community which are the best means of sustaining effective health sector reforms.

15. In recent years, however, most African countries have recognized the gravity of the problems of tuberculosis and HIV/AIDS in the Region and the need for accelerated national action to combat them. The Global Tuberculosis Drug Facility, a fund set up to improve access to tuberculosis drugs in poor countries, has been in operation since January 2001. African heads of state and government, at their summit meeting in Abuja in April 2001, issued the Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases

as an indication of their resolve to urgently address the dual epidemic, including through revitalisation of their health systems.

16. In June 2001, the United Nations General Assembly special session on HIV/AIDS developed a Global Platform for Action which calls for intensified action and greatly increased resources to fight the epidemic. The Global Fund for AIDS, tuberculosis and malaria has now been established to urgently increase funding available for country activities. All these initiatives present new opportunities to intensify efforts in combating this dual epidemic.

17. Actions to be undertaken include:

- (a) improving low coverage and providing equitable access to key interventions for tuberculosis and HIV/AIDS resulting from slow and uncoordinated implementation of recommended strategies;
- (b) identifying and overcoming barriers to collaboration between tuberculosis and HIV/AIDS control programmes, notably, the lack of policy and structural mechanisms for promoting effective collaboration;
- (c) creating linkages between actors and services, thereby optimizing the use of scarce resources;
- (d) fostering stronger community participation in tuberculosis and HIV activities, and thereby reducing stigma and increasing the utilization of key services;
- (e) increasing access to anti-retrovirals and affordable, quality drugs and commodities at all levels for the management of opportunistic infections;
- (f) ensuring the availability of sufficient numbers of skilled counsellors and care providers at service provision levels;
- (g) enforcing policy and legislation governing the management of tuberculosis and HIV by public and private sectors; and
- (h) addressing, in a wider context, the poverty-related aspects of the dual epidemics.

DISCUSSION POINTS

18. What are the key actions to be undertaken by countries and partners with a view to putting in place the mechanisms, partnerships and resources needed for the implementation of scaled up tuberculosis and HIV prevention and care interventions, building on the stated political commitment of the Abuja summit and other similar summits?

19. How can countries improve access to:

- (a) drugs for treatment of tuberculosis and other opportunistic infections;
- (b) anti-retroviral drugs; and
- (c) other consumables (diagnostic kits, condoms and infection control items such as gloves and syringes)?

20. How can countries rapidly increase the provision of quality voluntary counselling and testing as well as other preventive services?

21. What actions need to be undertaken with regard to health care services, families and communities in order to reduce the stigmas attached to tuberculosis and HIV/AIDS?

EXPECTED OUTCOMES

22. Agreement on key actions to be undertaken by countries and support to be provided by WHO and partners to adopt the proposed regional guidelines for tuberculosis and HIV prevention and control.

23. Agreement on the key steps to be taken by countries to improve access to drugs.

24. Recommendations on actions needed to scale up voluntary counselling and testing and other preventive services.

25. Recommendations on key actions to be undertaken by countries to reduce the stigmas attached to tuberculosis and HIV/AIDS.