CI/CIDSE Conference on Tuberculosis and HIV
The Challenge of Cure and Care
9th till 11th of March 1999, Wuerzburg, Germany

Executive Summary

Edited by
Medical Mission Institute
Unit for Health Services and HIV/AIDS
Salvatorstrasse 22
D-97074 Wuerzburg, Germany
Tel: + 49 931 804850
Fax: + 49 931 8048525
Email: mi.health@mail.uni-wuerzburg.de

Table of Contents

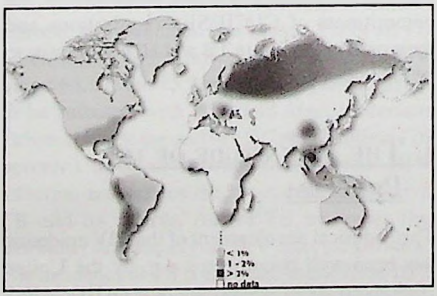
1. TB and HIV, the Challenge for the Church's Mission of Healing

The growing epidemic of human immune deficiency virus (HIV) has breathed new life into an old enemy – Tuberculosis (TB). In both developing and industrialised countries, TB has re-emerged as a serious health problem since the early eighties. Up to 70 percent of young adults in developing countries and fast developing countries are infected with Mycobacterium Tuberculosis, the germ causing the disease. They all carry a risk of getting ill during their lifetime. TB kills more youth and adults than any other infectious disease in the world today. It is a big killer comparable to malaria, diarrhoea or HIV/AIDS. More than 100.000 children die of TB each year.

The increase in the last two decades can partly be attributed to the following general factors, the growing migration from countries or settings where TB is common, the transmission of TB in situations of crowding (e.g. health care facilities, correctional facilities or shelters for the homeless, community housing), a deterioration of the health care infrastructure and the HIV/AIDS pandemic.

As more specific causes of the world-wide increase in TB mainly related to the health sector, experts also identified non-compliance with control programmes, inadequate diagnosis and treatment, ambulatory and self-administered treatment as contributing to the problem. This may lead to situations where TB becomes incurable, in particular when drug resistant species of the TB germ are causing the infection.

Figure 1: Global Spread of Drug resistant Forms of Tuberculosis



Source: IUATLD; 1999

TB and HIV/AIDS are problems which are not just additive, but augment the negative effects which each problem imposes on the human family. The HIV epidemic spurs the spread of TB and increases the TB risk for the whole population. For example, in Malawi the number of TB cases increased from 5300 in 1985 to just over 20 000 in 1996, of which about 60% are attributable to HIV. One third of the world-wide increase in the incidence of TB in the last five years can be attributed to HIV. The World Health Organisation (WHO) By the end of the century, an estimated 15 percent of TB cases will be attributed to HIV. estimates that, by the end of the century, HIV infection will annually cause nearly 1.5 million cases of TB disease that would not have occurred otherwise. TB is the leading cause of death among people who are living with HIV. It accounts for almost one-third of AIDS deaths world-wide, 40 percent of AIDS deaths in Africa and in Asia. Of nearly 31 million people world-wide who were HIV-positive in 1997, around one-third were believed to be infected with TB. In 1993, WHO took an unprecedented step and declared TB a global emergency, so great was the concern about the modern TB epidemic.

Since the late sixties, concepts of efficient TB control programmes have been outlined. There is no doubt that a number of interventions are known by which TB patients can be cured and the epidemic can be controlled. At the end of the second decade of the global spread of HIV, many lessons have also been learned with regard to HIV, in particular how to assure prevention and care for the infected and affected. Just to mention a few: there is blood transfusion safety, IEC (information, education, communication), prevention and control of sexual transmitted infections, treatment of opportunistic infections, voluntary testing, counselling and home based care. There is no doubt that causal factors for TB and HIV are linked. Therefore, there is an urgent need to work out synergistic strategies.

The Church feels challenged by its mission to address the issue, that 'despite the fact that tools for curing TB exist', they do not reach the people most in need. Further questions can be raised, such as, "What are the causes and the impact of the TB and HIV pandemic on societies and the

work of the Church? What are her role and her responsibilities in respect of the socio-medical services she is offering? In which way should they be developed in the future, to be able to give both a relevant as well a significant response?"

2. The Involvement of CARITAS and CIDSE Organisations in TB and HIV

Caritas Internationalis (CI) has 154 national member organisations throughout the world. These are engaged in relief, development and social work. CIDSE has a membership of 16 agencies in the more affluent countries of the world. These organisations fund development projects in countries of the South. What the two networks have in common is that they are both rooted in the Roman Catholic Church. Both are committed to the preferential option for the poor and both have been active in the field of HIV/AIDS for many years.

Being rooted in the Catholic Church determines the way of approaching HIV and TB. The Church's vision which has emerged from the Second Vatican Council is to take the essential tasks rooted in the Gospel – teaching, healing and social service – and to think of them in terms of a Church at the service of society as a whole. Therefore, nothing which affects human life is alien to the Church and its agencies – including illnesses which touch on the double taboos of sex and death. The preferential option for the poor means that, in the words of the Holy Father in the Jubilee Letter, 'Tertio Millennio Adveniente', we must "raise our voices on behalf of all the poor of the world", particularly the most excluded and those at the lines of rupture in society, because that is where Christ is and where His Church must be.

By taking this option for the poor seriously, CI founded a Working Group on HIV/AIDS more than 10 years ago, and later founded an AIDS Funding Network Group (AFNG) which includes CIDSE agencies in order to co-ordinate the response of partner agencies in the North with the challenges of AIDS in the South.

In October 1996, the AFNG discussed the necessity of reflecting on appropriate concepts regarding support of projects in relation to TB and HIV. Two general observations were made. First of all, TB largely determined the health needs of beneficiaries of those projects and secondly, in very many settings the referral of patients with TB to appropriate health service structures posed a huge problem. According to experiences in several projects, the co-effects of TB and HIV threatened the success of programmes and led to the setting up of parallel structures competing for scarce resources.

In further discussions, it became clear that the support and funding guidelines for programmes with a TB component varied widely among the said organisations. There was, for instance, no consensus on criteria for minimal quality assurance of projects. It was therefore decided to study the dimensions of the problem and the constraints mentioned during a 3-day conference. Rev. Dr. Jon Fuller, SJ, Ms. Colette Niclausse and Dr. Klemens Ochel as members of the CI AIDS Task Force and delegates in the AFNG formed the organising committee. The Medical Mission Institute in Wuerzburg was asked to host the venue. Caritas and CIDSE organisations from the North provided the resources and invited their partners from developing and fast developing countries. The 90 participants came from 36 countries, half of them from the 'South' and Eastern Europe.

The conference – "TB and HIV – The Challenge of Cure and Care" – aimed at contributing to a more adequate and improved response in the context of the Church's development aid and the Christian mission of healing. Through presentations by experts in the field of TB and HIV, the sharing of concrete project experience and support policies of donor organisations, the commitment of CI/CIDSE organisations and their partners to future TB and HIV work was to be enhanced.

3. The Magnitude of the Problem

The historical development of the HIV epidemic has been well documented e.g. by the United Nations co-sponsored programme on HIV/AIDS (UNAIDS). It issues regular updates on

prevalences for each country and for various population groups. Latin America saw early cases in the eighties and rates have risen gradually since. Africa has rapidly become the continent with the highest prevalences and the peak of the epidemic has drifted southwards over time. Asia remains the most frightening prospect for the future: the epidemic arrived a little later than in Africa but has risen in a few countries and the population is so large that small percentage increases mean that huge numbers of people are affected. While two thirds of the 33 million people with HIV live in sub-Saharan Africa, the epidemiology of HIV is characterised by its focal nature (State: end of 1998). Thus, within the sub-Saharan region, there is a more than 10 fold difference between countries, and, within countries there is often considerable variation between provinces or between rural and urban areas. Even within one city there may be considerable variation between apparently similar residential areas.

With regard to TB, two billion people are infected with TB bacilli world-wide. More than four million persons are estimated to become infected with both TB and HIV per year, of whom 80% are living in developing countries. While the epidemiology of HIV is focal in nature, TB is more evenly distributed across the poorer countries of the world. More than half the global burden of TB occurs in four highly populous countries: India, China, Indonesia and Bangladesh.

Annually, nine million people fall ill with active TB, two million in Africa alone. Nearly 3 million TB cases per year occur in South-east Asia per year, and over a quarter of a million TB in Eastern Europe. It is estimated that at least 8% of all TB cases world-wide show a connection to HIV infection. Of the 15.3 million people estimated to be infected with HIV and *Mycobacterium Tuberculosis* at the end of 1997, 11.7 million (76 percent) lived in sub-Saharan Africa. HIV infection accelerates the development of active TB and its course. Active TB increases the morbidity and fatality of HIV infected persons. The incidence of TB is expected to rise from 10.2 million cases by the year 2000 to 12 million by 2005.

The TB germ, *M. Tuberculosis*, is highly prevalent in much of the developing world and in poor urban parts of industrialised countries. In these communities, people typically become infected in childhood, but a healthy immune system usually keeps the infection in check. In the past, before the era of HIV, only 5 to 15% "carriers" of TB bacilli ever developed active tuberculosis. TB germs are spread through the air from patients with active pulmonary tuberculosis. For people living with HIV and TB, the risk of developing active TB is 30 to 50 fold higher than for people infected with TB alone. Over the next four years, the spread of HIV will result in more than 3 million new TB cases among both HIV-positive and HIV-negative people.

Three million people throughout the world die of TB annually, one third of them in Asia. The highest mortality rates have been documented in Africa where 91–100 persons per 100,000 die of TB. That means that every twentieth death is caused by TB. TB is the cause of 7% of all deaths in developing countries. It is assumed that 26% of TB deaths in adults could be prevented.

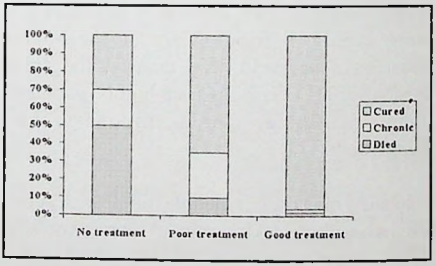
The average prevalence of TB infection in countries of sub-Saharan Africa is reported to be 40–50% in the age group 15 to 49 years. Relevant studies in Uganda, Rwanda and in the Republic of the Congo (formerly Zaire) reveal an infection rate of 60 to 100% in adults among the above-mentioned age groups. Incidence (number of new cases per year) as well as prevalence (number of cases alive at any time) of TB show a five to ten times higher figure in developing countries compared to industrial ones and are continuing to rise. A doubling of figures was found in Uganda within a period of 4 years. Although factors like war, poverty, malnutrition, overpopulation and alcoholism are important in the promotion of TB, the spread of HIV infection is the most important risk factor in developing countries. It is said that HIV infection resulted in an additional 150,000 TB deaths in Africa alone during 1990. The number of sputum negative cases is rising. In Africa, 20% of TB cases in the HIV infected are sputum negative, and in Asia it is said to be one quarter of all cases. This is important because diagnosis and treatment of those patients are very difficult.

4. Important medical Aspects of TB

TB is a contagious disease, which spreads through the air. Only people who are sick with pulmonary TB are infectious. *Tubercle bacilli* can only be made visible in sputum smears under the microscope by acid fast staining. Therefore, other names are used such as acid fast bacilli (AFB) for *Mycobacterium Tuberculosis* or "smear positive" or "sputum positive" cases for patients. When infectious people cough, sneeze, talk or spit, they propel TB germs known as bacilli into the air. A person needs only to inhale one of these to be infected. The probability that TB will be transmitted depends on the infectiousness of the person with tuberculosis, an environment in which exposure occurs, and the duration of the exposure. Persons of the highest risk of becoming infected with *Mycobacterium Tuberculosis* are close contacts, particularly children. Infection rates usually range from 21 % to 23 % for the contacts of infectious TB-patients. HIV infected persons with TB disease are not considered more infectious than non-HIV-infected persons with TB disease, although HIV-infected patients are more vulnerable to becoming infected with TB and to developing tuberculosis after exposure to TB than are non HIV-infected persons. Left untreated, each person with active TB will infect on average between 10 and 15 people in each year. But people infected with TB will not necessarily develop the disease. The immune system 'walls off' the TB bacilli which, protected by a thick waxy coat, can lie dormant for years and years. If someone's immune system is weakened, the chances of getting sick are greater. Some medical conditions increase the risk that TB-infection will progress to disease. The risk is approximately three times greater among diabetics and up to more than one hundred times greater among people with HIV-infection. Other predisposing conditions include substance abuse (esp. drug injection), recent infection with M. TB (within the past two years), findings suggestive of previous TB (in a person who received inadequate or no treatment), prolonged corticosteroid therapy, cancer of the head and neck, renal diseases, chronic malabsorption syndromes and low body weight.

The emergence of strains of Mycobacterium Tuberculosis that are resistant to anti-mycobacterial agents is a world-wide problem. The WHO and the International Union Against TB and Lung Diseases (IUATLD) have established a global project of drug resistance surveillance that is based on standard epidemiological methods and quality control through an extensive network of reference laboratories. The highest rates of multi-drug-resistant TB have been reported in Nepal (48%), Gujarat State, India (33,8%), New York City (30,1%), Bolivia (15,3%) and Korea (14,5%). Only sporadic data from countries in the Eastern European region are available, but case studies in congregate settings in the Baltic States and Russia have produced frightening results. MDR-TB is caused by inconsistent or partial treatment, e.g. when patients do not take all their medicines regularly for the required period because they start to feel better, when doctors and health workers prescribe the wrong drugs or the wrong combination of drugs, or when the drug supply is unreliable.

Figure 2: Fate of Cases of Pulmonary Tuberculosis under various Treatment Programmes



Source: Styblo, 1986

From a public health perspective, poorly supervised and incomplete treatment of TB is worse than no treatment at all. When people fail to complete standard treatment regimens or are given the wrong treatment, they may remain infectious at the time that the bacilli in their lungs develop resistance to anti-TB drugs. People infected by them will have the same drug-resistant strain. Drug-resistant TB is more difficult and more expensive to treat, and more likely to be fatal. In industrialised countries, TB

treatment costs around US $2,000 per patient, but rises more than 100-fold to up to US $250,000 per patient with MDR-TB. Up to 50 million people may actually be infected with drug-resistant TB. There is no cure affordable to developing countries for some multidrug-resistant (MDR) strains, defined as resistant to the two most important drugs, isoniazid and rifampicin.

5. Interactions between TB and HIV Programmes

When the estimates of adult HIV prevalence are plotted against the Global TB Programme's estimated TB incidence for African countries, a striking relationship can be seen. None of the countries severely affected by HIV have been successful in keeping TB rates down. In these countries, 60–70% of TB cases are also infected with HIV. In countries with severe HIV epidemics, it is not possible to control TB without controlling HIV.

HIV has adversely affected TB control programmes both directly (through increases in the number of patients to take care of and by making diagnosis more difficult), but also indirectly through its negative effect on health-seeking behaviour and on the interaction between patient and provider at the health services. The control of TB in areas with a high prevalence of HIV infection is therefore, to a considerable degree, dependant on the success of the HIV control programme.

TB diagnosis and treatment are vital components of any HIV care program. Considerable opportunities exist for synergy between TB and HIV programmes. The decentralisation and increasing autonomy of districts that the health sector reform is bringing to many countries should be used as an opportunity to enhance the concerted management of the dual epidemics. Possible actions include: training; community care; IEC manuals and guidelines; advocacy; surveillance; collaboration with NGOs; social mobilisation.

The health sector reform, which is currently taking place in low or middle income countries following the implementation of structural adjustment programmes, advocates the use of rational measures aimed at increasing efficiency of health services. However, the negative effects on national TB control programmes in many countries underline that cuts in governments' social budgets have had the effect of favouring the development of the private medical and pharmaceutical sector, rather than rationalising the choice of priorities. The emphasis on cost recovery in basic health services is penalising the poorest groups, most vulnerable also for TB and HIV.

6. Practice and Potential for Community Care Organisations

In developing and fast developing countries there is a need to explore new ways of providing care for TB patients based on community participation. Community participation is a process by which individuals and families assume responsibility for their own and their communities' health and welfare, and develop the capacity to contribute to their and the community's development. Providing care for TB patients in the community with the aim to contribute to their cure has the potential to reduce patient load on hospitals and health centres, decrease costs to patients and their families, improve adherence by making treatment more accessible, and reduces the risk of nosocomial transmission to health care workers and other patients.

However, it is not an approach which can be applied easily. According to a study by WHO in 1997, the provision of TB care offered by community based organisations fell short of internationally recommended standards in most of the community care organisations assessed. Obstacles were identified that undermined the provision of adequate care: the charitable and compassionate attitude to provide moral support and palliation for an incurable disease, as well as the lack of knowledge and the fear of TB, and the failure to recognise its clinical and

epidemiological importance for HIV/AIDS patients. Further problems which arise with the use of community health workers are sustainability and high turnover. Ways must be found to address the following issues:

- the establishing of close co-operation between national TB control programmes at district level, hospitals, health centres, and community care organisations;
- the development of training methods and materials for community health workers;
- training of community health workers in order to achieve a high level of motivation and efficiency;
- the development of a supervision system of community health workers;
- the use of a national TB control programme system of registration, recording and reporting by community care organisations;
- ensuring the availability of transport for national TB control programme staff who supervise community health workers;
- the delivery, storage and supply of drugs.

7. Points Raised in the Presentations

Peter Godfrey-Faussett, Researcher from the London School of Tropical Medicine and Hygiene and External Consultant for WHO and UNAIDS, addressed the issues of differences and synergism between the two pandemics of TB and HIV. He pointed out what should be the responsibilities of and expectations from church organisations with respect to:

- social mobilisation,
- political engagement,
- development of a long-term vision,
- complementation or strengthening of government structures as well as the need to collaborate with the latter,
- sharing between organisation of lessons learned in community based work,
- promotion of technical principles.

Jacques H. Grosset, from the Faculty of Medicine, working in the Hospital Pitié Salpêtrière in Paris and Consultant for WHO and IUATLD, spoke about medical aspects of TB, in particular the necessity to cure patients. The counter effects of well meant, but inefficient treatment not respecting medical standards, is disastrous not only for the individual but for the community, particularly by aggravating the epidemic and the suffering of humans. According to him, solutions to existing difficulties lie mainly in a mobilisation of manpower and resources, both in industrialised and developing countries, to implement the Directly Observed Therapy strategy (DOTs) recommended by WHO. In industrialised countries, political commitment to assure effective treatment to all who need it, should be renewed, some specialised clinics should be maintained where they are needed, the search for new drugs should be actively supported and adequate measures taken to limit the diffusion of resistant tubercle bacilli. In developing countries, all influential personalities including public health managers and politicians should understand that successful completion of therapy – in other words the cure of patients – is the responsibility of the provider who undertakes to treat TB patients, and that chemotherapy can be successful only within the framework of the overall clinical and social management of patients and their contacts. The absolute need for a regular supply of drugs and for the patients to really swallow all prescribed drugs at an adequate dosage should be re-emphasised in all settings. The use of combined drug formulations is strongly recommended as well as the use of drugs included in blister packs. The DOTs strategy recommended by WHO and all experts in the world should be applied because its five components are the minimal prerequisites for a successful intervention against TB. These five components are the following:

- government commitment
- case detection by microscopy
- short-course chemotherapy administered free of charge, under close control (of course, the way to organise the control depends upon the local facilities and may involve different partners)
- regular drug supply
- establishment and maintenance of monitoring mechanisms of case detection and treatment outcomes.

Pierre Chaulet, former professor of TB and Lung Diseases, Algiers University, Algeria, and a Consultant for WHO and IUATLD, presented issues around socio-political aspects of the health sector in developing and fast developing countries, in particular outcomes of structural adjustment programmes and the health sector reform. He did his utmost to argue about reviewing the uncritical, unbalanced and incoherent integration of TB and HIV control on primary level. A well designed programme is not expensive to run – approximately $1 US per capita of population per year in developing countries, depending on the drug regimens used, principally due to differences in salaries. He concluded that the promotion of lung health, among it the control of TB, is a collective responsibility, shared by the state, NGOs and religious communities, the population and the health professionals of each country. For the health professionals involved in tuberculosis and lung diseases, this responsibility is particularly burdensome. According to him, between the approaches of the World Bank and 'Mother Theresa', there is a whole social space to fill in order to organise, and if necessary invent, new institutional forms of national solidarity and international co-operation.

Corlien M. Varkevisser, Public Health Consultant, Royal Tropical Institute Amsterdam, reported on her socio-medical and anthropological studies in respect to TB, HIV/AIDS and leprosy. The major part of her presentation dealt with stigma. It can be defined as 'an attribute, an undesirable state of difference that discredits or disqualifies the individual from full social acceptance'. This undesirable difference can be physical, or social, or both. Despite the fact that there are counter forces in society that might mitigate stigma (parents do not easily drop a child, children, especially daughters, do not easily drop a parent) husband – wife relationships are more fragile, as these relationships can be dissolved when one of the partners is affected by any of the above mentioned diseases. This increases social vulnerability and leads to settings of risk behaviour. This is reinforced by some community perceptions about possible causes of stigmatising diseases: punishment of God for sin committed in a previous or present life, promiscuity, trespassing of sexual taboos. These beliefs create a double stigma for the patient, as (s)he is believed to deserve the disease. Women are hit especially hard by the accusation of sexual looseness, as in many, if not all societies sexual norms are much stricter for females than for males. Even parents may withdraw from a HIV positive adolescent or turn angry because of the double shame brought on the family. Adults can cope better than adolescents with such accusations by putting the blame on others (witchcraft is a possible explanation for any misfortune). Fully participatory and community based approaches of 'information, education communication (IEC)' activities are needed to work on a solution.

Mara Rossi, AIDS Co-ordinator, Ndola Diocese, Zambia, presented the programme of her diocese as a specific example of the Church's response. She started by saying that the Church's mission is none other than that of Jesus, to "preach the good news to the poor, proclaiming freedom for prisoners and recovery of sight for the blind, releasing the oppressed and proclaiming the year of the Lord's favour". The fact that people with HIV/AIDS or TB ask fundamental questions related to God and heaven, life and death, forgiveness and condemnation, salvation and eternity, underlines that we have to deal not only with medical problems, but also with social, psychological and spiritual/moral issues. They present themselves not only on the level of the individual, but also on many others like the families, the societies and even on the international level of justice and equity. Greater involvement to respond to these issues is needed not only from lay people, but also from the clergy. Finally, she stressed that the Church is already taking a leading role in asking for debt relief and denouncing the existing world disparity, which is at the roots of the pandemics of TB and HIV/AIDS. This task of being voice of the voiceless should be intensified and shared by all Christians and people of good will.

Jon Fuller, SJ, Assistant Clinical Professor of Medicine, Boston University School of Medicine and Assistant Director, Adult Clinical AIDS Program, Boston Medical Centre, gave the keynote

address on ethical issues in the treatment of TB. He strongly argued for a more elaborated way of theological thinking in that respect. He said that there are two major themes in catholic ethical tradition which have contributed to the specific manner of proceeding. The two principles are gradualism and the toleration or counselling of lesser evil: the psychological perspective is that of heroic generosity. The principle of gradualism which has been developed especially in the area of individual pastoral care is based upon the recognition that as humans we are always in process as we grow towards greater holiness, maturity and personal integration. It supports encouraging those in need of our care to take whatever next small step is possible as they move towards a larger, long-term goal. In respect to the second principle, the Catholic Church has a long tradition of ethical analysis of the question of whether it is permissible to support an activity that is admittedly morally wrong if doing so could avoid an even more gravely wrong activity. An example for this may be seen in the legalisation and regulation of prostitution and might be seen as a forebear to the legalisation of certain kinds of drug use to prevent their association with organised crime and enormous black markets. This moral-ethical teaching leads to the art of doing what is possible, of recognising that all the resources that we would like to have at hand may not be there and under such circumstances we do what we can. At least giving someone a piece of bread is better than not being able to give them anything at all, that providing pain relief and simple measures of hygiene may not save someone's life but they can provide a dignified setting in which to die. Members of the Church are conditioned to do what ever is possible, even though that may not be very much. *Fuller* pointed out that in respect to treatment of TB the generosity and zeal to do something must be tempered by a consideration of the impact of our efforts not just on an individual, but on the common good and the public health. We have been trained that something is better than nothing, but in this circumstance we are shocked to realise that nothing is better than something. Even though brief but incomplete treatment may benefit an individual at least temporarily, in the long run if we are really concerned about the community, non-treatment of TB is better than inadequate treatment. He drew the conclusion that the ethical and even spiritual lesson that has to be learned from HIV and TB is not generosity, but humility: to recognise our poverty if our resources are not adequate and to face the difficult ethical question of withholding therapy unless and until donors and partners can guarantee the structure to complete therapy. Decision – makers in church programmes need to consider a contract for donor agencies and partners in the South not to engage in TB therapy unless and until it will be done properly. This problem is also mirrored in the AIDS epidemic since the introduction of specific, antiviral therapies. Finally, while reflecting on volunteerism especially by people in developing countries, he questions, what it means to ask people to volunteer their time if -as a result – their children will eat less, or will not be able to have their school fees paid? Ethical issues arise from the fact that "you in the North are accustomed to volunteering from your surplus, but those from the South have volunteered from the little that they had to live on."

Other presentations dealt with case studies from programmes in Cambodia, Uganda and East Timor, or outlined the point of view of CI/CIDSE organisations in the North. Staff from the German Leprosy Relief Association and the Medical Mission Institute provided talks on lessons learned in respect to operating TB control programmes, supervision of laboratory facilities, aspects of TB control in prison and appropriate means of prevention of TB transmission in health care settings.

An indication that this conference was making a difference compared to other medical conferences was a session devoted to a theological reflection. *Fr. Enda McDonagh*, St. Patrick College, Maynooth, Ireland, and Member of Caritas Internationalis HIV/AIDS Taskforce, reflected on the proceedings of the conference by taking the stands of a theologian. He started by saying that it was something of a shock, when we thought that TB had been finally wiped out, to find it coming back and to find it in this deadly combination with HIV/AIDS, a kind of a dual death blow as it were. This requests our

commitment and for each of us there are different causes for involvement. If we are to think of 2000 years of Christianity, we must think that there were 2000 years of these kinds of commitments and causes. In particular, the idea of development, of development of the whole person and of the whole human community is something that comes naturally to people who believe in one God, who believe that God is a loving God, who believe in one human family, who believe that the human family was created for fulfilment by the one God, that our commitment to development comes naturally, or should come naturally. In the particular situation in which we are when focusing on health care, we see that the healing work itself is deeply rooted in our understanding of God's relations with humanity. God's commitment to the healing and transformation of humanity and the world was Jesus' mission, Jesus' commitment, Jesus' cause. He created a new human community by attending first of all to the ill, to the hungry, to the so-called sinners, to the excluded, to the poor. But one of the essential features really was, that he established a community of equals. This was part of the thrust of the strategy of God becoming one, of Jesus seeking out the deprived and the excluded so there would be no doubt about the equality of relationship or partnership that would be established. If we stress the need to co-operate, it means that we co-operate with one another and we co-operate in the service of the different dimensions of each community and each person, so that this kind of integral vision of the person and integral service of the person is typified now by bringing together TB and HIV/AIDS. This is part of the kind of bonding which involves inclusivity, participation in the area we are talking about, and it is the bonding that was established between God and humanity, between God and creation, at the price of the life and death of Jesus Christ. The God who bonded with us and with creation is now enabling us to bond with the people in this kind of distress and the people who would serve them. We must be aware that there is a resource of love and healing that we will need to attend to. But it is that alertness to the final mystery of these particular people – and the mystery of sustaining them and healing them, of transforming them – that seems to give a further and richer quality to how we respond to people with HIV/AIDS or TB. As we do that, we come into that presence and power of the mystery we call God. There are risks involved, like transmission of the TB germ while caring for patients. These are risks that have to be shared and risks that have to be reduced. The risk, that God has taken by his incarnation, is part of what enables us to move out of ourselves.

8. Résumé of the Conference on TB and HIV/AIDS

There is no doubt that both the TB and the HIV/AIDS pandemic pose a challenge to the specific mission of the Christian Churches. But before coming to concrete responses, the general context, which will be present in the future, can be summarised as follows: all people involved will continuously be confronted with a lack of commitment, which is due to basic obstacles such as,

- lack of good epidemiological data on each of the dual epidemics
- lack of professional consensus about cost-effective approaches to TB control, STD control and HIV containment and
- reluctance to monitor effectiveness (coverage and outcome) of ongoing TB and HIV/AIDS programmes.

HIV and TB programmes till now usually function separately from each other. Both infections have a mutually enhancing impact on each other e.g. in the natural history of the disease and thus on the respective control programmes:

- All programmes have to deal with an increased number of patients.
- Problems arise in respect of diagnosis.
- Treatment becomes more complicated.
- Despite all efforts, morbidity and mortality will increase.
- Stigma will be experienced by a wider group of people. This affects health seeking behaviour and the adherence to treatment adversely.
- The risk of nosocomial and institutional transmission has a negative impact on staff motivation.

Diagnosis and cure of TB should be a concern in any case of symptomatic HIV infection. Despite all constraints, considerable opportunities for synergy between TB and HIV programmes do exist. Decentralisation and the increasing autonomy of districts which health sector reform is bringing to many countries should be used as an opportunity to enhance the concerted management of the dual epidemics. Possible actions include: training; community care; IEC manuals and guidelines; advocacy; surveillance; collaboration with NGOs; and social mobilisation.

Real progress in controlling TB and providing care for HIV can only be achieved with a dual strategy targeting both epidemics: **TB control and HIV prevention**. This will first require gathering the resources needed for action. The continuum of care model, nowadays developed in 'AIDS home based care programmes' can assure comprehensiveness, integration, continuity and accessibility of care. Strengthening of this model and its components at all levels can make cure possible in many settings which are out of reach for vertical programmes. However, community involvement is not a 'magic bullet' and does not lead easily to success. Shortcomings may arise from the charitable and compassionate attitude to provide moral support and palliation for an incurable disease, the lack of knowledge, the fear of TB and the failure to recognise its clinical and epidemiological importance for HIV/AIDS patients.

9. Summary of the Outcome of the Working Groups

To facilitate mutual sharing of experiences and to achieve common viewpoints, working groups have been organised during the conference. They worked on specific questions and formulated resolutions at the end. These can be summarised as follows:

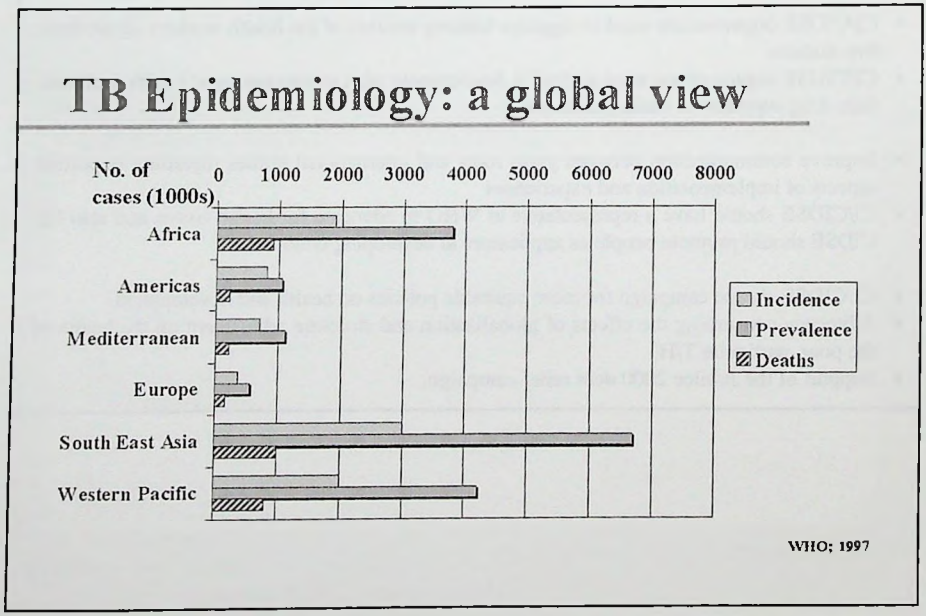
- Representatives from participating organisations should present the results to relevant bodies of the Church e.g. the Pontifical Council for Health Care Workers, and request that it should be distributed to all Bishops' Conferences in the world and also to all Catholic health institutions.
- CI/CIDSE organisations should designate a representative international body to be responsible for the follow-up of the conference.
- CI/CIDSE should have a working group on TB/HIV/AIDS in order to publicise the outcome of the conference. It should be put into the Caritas work plan at the General Assembly.
- The Working Group should bring together both decision makers and donors.
- The Working Group should elaborate a draft policy and an agenda for future action.
- The Working Group for Action should also be responsible for advocacy.
- They should follow-up on priority areas in regard to performance by bi-laterals, multi-laterals and NGOs.
- CI/CIDSE organisations need to organise more training courses for the health workers about these two matters.
- CI/CIDSE organisations need to draft a development plan to support solutions for basic problems (like lab, drug supplies, etc.) or basic health needs.
- CI/CIDSE should have a representative at WHO as an advocate for health issues;
- CI/CIDSE should campaign for more equitable policies on health and development
- More efficient advocacy is also necessary concerning the effects of globalization and structural adjustment on the health of the poor, particular in respect to TB and HIV.
- Support of the Jubilee 2000 debt relief campaign should be supported.

10. ANNEXES

Table 1: State of performance of national TB control programmes

Countries with Very poor performance of TB Control		Countries which made important progress in TB Control	Countries with successful TB Control Programs
Low income countries	Middle income countries		
• Ethiopia • Afghanistan • India • Myanmar (Burma) • Nigeria • Pakistan • Sudan • Uganda	• Brazil • Indonesia • Iran • Mexico • Philippines • Russian Confederation • South African Republic • Thailand	• Bangladesh • Peru • Vietnam	• Armenia • Cambodia • Cuba • Malawi • Morocco • Mongolia • Nicaragua • Oman • Slowenia

Figure 3:



Elements of an Agenda for Action

- Two representatives — one from a northern country and one from a southern country should present the results of the conference to the Pontifical Council for Health Care and request that it should be distributed to all Bishops' Conferences in the world and also to all Catholic health institutions
- CI/CIDSE organisations need to designate an international body to be responsible for the follow-up of the conference
- Reservation: In doing the above we are concerned that a balance of power be maintained which allows partners to fully participate in the process
- CI/CIDSE should have a working group on TB/HIV/AIDS in order to publicise the outcome of the conference. It should be put into the Caritas work plan at the General Assembly
- Working Group for both deciders and donors
- The proposed working group should elaborate a draft policy and an agenda for action
- Working group for action plan making and for advocacy
- Select specific areas for priority attention until the year 2000
- Follow-up on these priority areas in regard to performance by bi-laterals, multi-laterals and implementing NGOs
- Workshop to establish co-ordination between deciders and other partners like NGO's and Church's institutions

- CI/CIDSE organisations need to organise training courses of the health workers about these two matters
- CI/CIDSE organisations need to draft a development plan to support basic health problems (lab, drug supplies) or basic health needs

- Improve communication between grass roots and international bodies regarding important aspects of implementation and experiences
- CI/CIDSE should have a representative at WHO to advocate for health issues and also CI/CIDSE should promote people as applicators in developing countries

- CI/CIDSE should campaign for more equitable policies on health and development
- Advocacy concerning the effects of globalization and structure adjustment on the health of the poor, particular T/H
- Support of the Jubilee 2000 debt relief campaign.