

# THE 1% SCANDAL

## LIVING WITH HIV, DYING OF TB

### Summary

According to the most recent data available, a mere 1% of people living with HIV/AIDS (PLWHA) are reported to have been screened for TB (Figure 1).<sup>1</sup> Of those who were screened for TB, more than 1 in 4 had tuberculosis (Figure 2). Despite being preventable and treatable, tuberculosis remains the most common life-threatening opportunistic infection and a leading cause of death among PLWHA.<sup>2</sup> In Africa, which has the highest rates of both diseases, tuberculosis is the leading killer of PLWHA.<sup>3</sup> Autopsy studies have shown undiagnosed tuberculosis in 14-54% of people with HIV infection.<sup>4</sup> Without proper treatment, approximately 90% of PLWHA die within months of developing TB.<sup>5</sup> Drug-resistant TB strains pose a particular threat to those with HIV, with mortality rates from extensively drug-resistant TB (XDR-TB) exceeding 95% in Africa.<sup>6</sup>

Such widespread neglect on the part of HIV/AIDS programs and international HIV/AIDS donors is unacceptable. *We cannot be considered to be making progress toward Universal Access to HIV/AIDS treatment so long as people living with HIV are dying of TB.* Not only has the global community's collective negligence led to unnecessary disease and death; it has allowed TB to undermine the global response to HIV/AIDS, including the reductions in morbidity and mortality achieved through scaling-up of antiretroviral therapy.

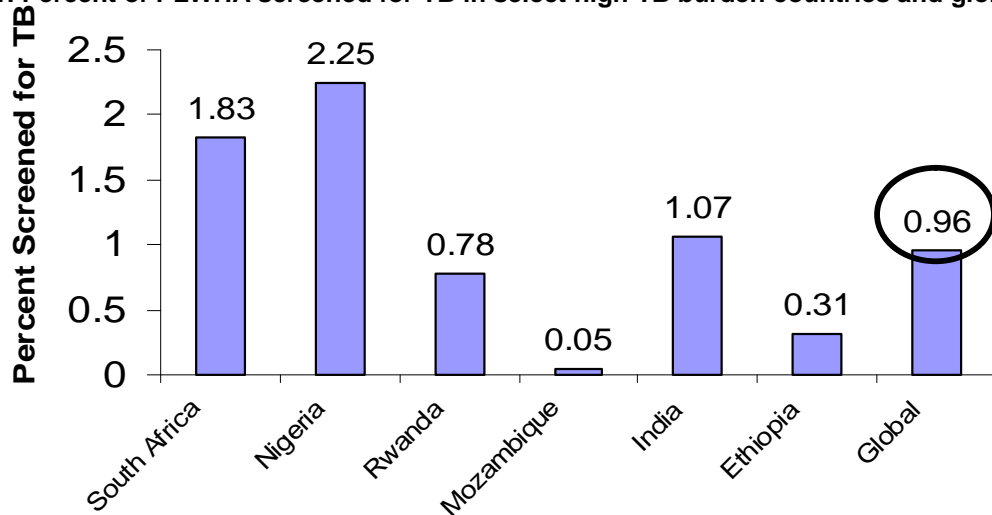
Civil society groups, including those from affected communities, are therefore calling for universal access to high-quality TB-HIV care by 2015, including diagnosis, treatment, preventive therapy, and infection control. Achieving universal access to existing TB-HIV interventions by 2015 is both necessary and achievable. Accomplishing this goal would reduce TB deaths in PLWHA by 80-90% with an investment of \$14 billion, according to WHO calculations.<sup>7</sup>

### Years of Knowledge

For two decades the HIV/AIDS community has known that TB and HIV/AIDS are intimately linked, particularly in sub-Saharan Africa where HIV/AIDS has caused TB incidence to triple since 1990.<sup>8</sup> In 2002, officials from WHO's Stop TB Department clarified the need for TB testing for PLWHA, stating "...those found to be both HIV-positive and with active TB need referral for TB treatment; those without active TB should be offered TB preventive treatment with isoniazid."<sup>9</sup> On January 21, 2004, the World Health Organization and UNAIDS unveiled plans to expand collaboration between national tuberculosis and HIV/AIDS programs, promising that "TB case-finding will be intensified in high HIV prevalence settings by introducing screening and testing for tuberculosis into HIV/AIDS service delivery points."<sup>10</sup>

As Nelson Mandela said in 2004, “We cannot successfully fight HIV/AIDS without also fighting TB.” Yet after years of promising TB screening for PLWHA, HIV programs are still failing to identify the most likely infection to kill those accessing HIV services.

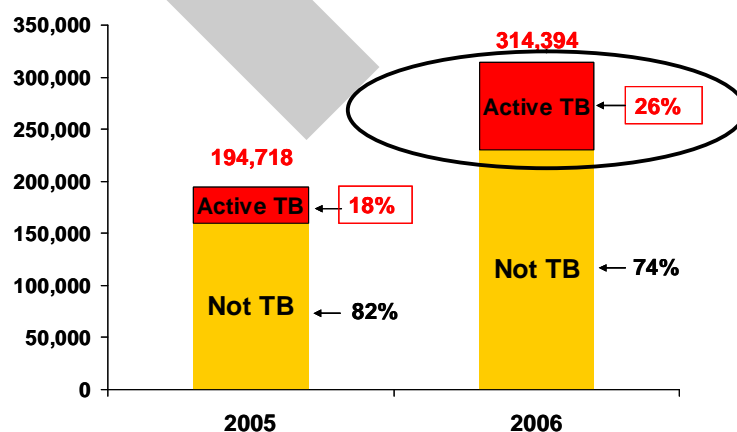
**Figure 1. Percent of PLWHA screened for TB in select high TB burden countries and globally.**



Sources: WHO. 2008. Global Tuberculosis Control: Surveillance, Planning, Financing. Nigeria data from Nigeria Country TB-HIV Report, 2008. Data from 2007.

According to the WHO 2008 Global Tuberculosis Control report, the most recent data show a total of 314,394 HIV-positive people attending HIV care services were screened for TB. This is a total of 0.96% of the total 33 million estimated PLWHA. Similar very low rates play out among the available data at the country level, with data collected from South Africa in 2006 and Nigeria in 2007 showing that only 1.83% and 2.25% respectively of the estimated number of people living with HIV had been screened for TB.

**Figure 2. Global outcomes of screening PLWHA for tuberculosis.**



Source: WHO. 2008. WHO Stop TB Department.

Country-level HIV/AIDS programs are not the only actors failing on this issue. The leading sources of international HIV/AIDS funding—PEPFAR, the Global Fund to Fight AIDS, TB and Malaria,

**No more people living with HIV, dying from TB!**

and the World Bank Multi-country AIDS Program—do not routinely monitor how many PLWHA are being screened for TB in HIV/AIDS programs they support, although PEPFAR does urge funding recipients to screen PLWHA for TB. As of August 2008, none of the three biggest donors were reporting the proportion of PLWHA being screened for TB.

## **IMMEDIATE RECOMMENDATIONS**

**To finally stop people living with HIV from dying of TB, we need bold action from all sectors:**

**HIV/AIDS PROGRAMS:** Screening a tiny fraction of PLWHA for TB is unacceptable. Screen all PLWHA accessing HIV/AIDS care for TB and make the “3 Is”—intensified case finding, infection control, and isoniazid preventive therapy—central to HIV/AIDS services and universally available.

**INTERNATIONAL LEADERS:** Affected countries, donors, and technical agencies must join together to craft a plan to ensure universal access to high quality TB-HIV care by the year 2015—moving in coordination with the goal of universal access on HIV by 2010.

**HIGH BURDEN COUNTRIES:** We call on heads of state and ministers of health to take the lead by committing to a goal of universal access by 2015 on TB-HIV care. Country plans should be developed in direct and substantive consultation with communities affected by TB and HIV and should extend further than existing plans—providing a clear roadmap to universal access to screening and treatment or preventive therapy as well as plans for intensified case finding and infection control measures in line with WHO recommendations. Resource gaps should be made clear for donor funding.

**PEPFAR:** Building on progress, particularly in ramping up HIV testing for TB patients in a number of its focus countries, PEPFAR must continue to scale up TB-HIV collaborative efforts. The same focus on HIV testing in TB settings must be extended to TB screening in HIV settings. PEPFAR should set a target date by which every person receiving HIV services supported by the program will be screened for TB. The program should work proactively with each country to help craft a plan to ensure universal TB screening and work with recipient countries to see TB-HIV scale-up implemented as a top priority. In addition, PEPFAR should double its current TB-HIV expenditures to \$300 million in FY2009.

**GLOBAL FUND:** The Global Fund must further operationalize its stated commitment to collaborative TB-HIV services within the country programs it funds. TB screening of PLWHA should be considered the basic standard of care in highly impacted countries. Proposal guidelines and the Technical Review Panel process should make it clearer that TB components are required in HIV applications and expect countries to provide *a plan to screen every PLWHA receiving services for TB and ensure follow-up care*, or explain why this is not included. In addition, TB screening of PLWHA should be tracked and reported moving forward.

**WORLD BANK:** While there is still an enormous gap in Bank funding for TB in Africa, the World Bank is a major donor for HIV/AIDS efforts. The Bank should significantly increase resources for TB-HIV collaborative services, within its Africa Multi-Country AIDS Program (Africa MAP) and health sector lending, toward achieving universal access to TB-HIV care.

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<sup>1</sup> World Health Organization. 2008. Global tuberculosis control: surveillance, planning, financing : WHO report 2008. Data from 2006 WHO/HTM/TB/2008.393.

<sup>2</sup> World Health Organization. 2008. The Three I's: Intensified Case Finding (ICF), Isoniazid Preventive Therapy (IPT) and TB Infection Control (IC) for people living with HIV. Report of a WHO Joint HIV and TB Department Meeting. Geneva, Switzerland, April 2-4, 2008. Online. [http://www.who.int/hiv/pub/meetingreports/WHO\\_3Is\\_meeting\\_report.pdf](http://www.who.int/hiv/pub/meetingreports/WHO_3Is_meeting_report.pdf). Accessed 3 August, 2008.

<sup>3</sup> Gandhi N, et al. 2006. Extensively drug-resistant tuberculosis as a cause of death in patients co-infected with tuberculosis and HIV in a rural area of South Africa. *The Lancet*. 368:1575-1580.

<sup>4</sup> World Health Organization. TB/HIV: General Context and Implementation Issues. Presentation delivered to the 2008 Lambeth Conference July 28, 2008, Kent, UK.

<sup>5</sup> WHO. Frequently asked questions about TB and HIV. Online. <http://www.who.int/tb/hiv/faq/en/>. Accessed 3 August, 2008.

<sup>6</sup> WHO. 2008. The Three I's.

<sup>7</sup> K. Floyd, WHO, June 2008. unpublished calculations based on the *Global Plan*

<sup>8</sup> World Bank. 2008. *The World Bank's Commitment to HIV/AIDS in Africa: Our Agenda for Action, 2007-2011*. Washington, DC.

<sup>9</sup> Godfrey-Faussett et al. 2002. How human immunodeficiency virus voluntary testing can contribute to tuberculosis control. *Bulletin of the World Health Organization* vol.80 no.12.

<sup>10</sup> World Health Organization. 2004. Interim Policy on Collaborative TB/HIV Activities. World Health Organization, Geneva. Ref. in <http://www.who.int/mediacentre/news/releases/2004/pr5/en/>