TB/HIV: the dual epidemic

Is HIV – the greatest risk factor for tuberculosis ever identified – fueling an upsurge in TB in Europe and Central Asia? Existing programmes for each disease must be adapted quickly.

Identifying TB in HIV-positive people is extremely difficult. Much more so than in people who aren’t. If you have HIV and develop TB and are not diagnosed quickly, you typically die within three months.’ This stark description of the consequences of TB/HIV co-infection came from Michael Luhan, of the Stop TB Partnership, on the last day of the September meeting in Kiev of the European Red Cross/Red Crescent Network on HIV/AIDS (ERNA).

‘It’s as if tuberculosis and the human immunodeficiency virus were combining in what the World Health Organization (WHO) has called a ‘considerable mutual interaction’ to form a threat greater than the sum of its parts. In February this year, WHO’s regional director for Europe, Dr Marc Danzon, wrote to member states to ask them to ‘ensure that TB is granted the highest priority’ on their health agendas.

‘The expected increase in TB incidence due to the current HIV/AIDS epidemic in Eastern Europe,’ he said, ‘could undermine the effectiveness of TB control efforts’. Danzon also drew attention to the danger of HIV and the drug-resistant TB typical of the region ‘overlapping’. It could already be happening. The most recent WHO statistics, for 2004, showed more than 370,000 new TB cases in its European region – the highest number for two decades.

In the East generally, according to the most recent report available from EuroHIV, the number of new HIV diagnoses (‘incidence’) declined in 2003. But ‘prevalence’ – the overall proportion of populations living with HIV – was still rising. EuroHIV says the situation in the region ‘remains alarming’ because the number of heterosexual infections is rising rapidly – a reality which quickly becomes anecdotally apparent in cities like Kiev, for example (see page 5). An enduring tradition, and in other countries that first got HIV epidemics.

Yet there is also a growing consensus among health professionals working in both fields that they want to adapt existing programmes for each disease to encompass measures aimed at the other; not create a third dragon – co-infection – out of two existing ones and wholly new programmes to tackle it.

Some actually feel that as far as Europe and Central Asia are concerned, for the time being, drug-resistant TB is the more pressing issue. This is still rising, for example, in Russia. Since The Bridge first reported on the TB/HIV axis in 2002, the epidemiological pairing has risen up the global agenda. The fourth meeting of the Global TB/HIV Working Group, in Addis Ababa last September, heard that collaboration between the TB and HIV communities was increasing.

Eighty per cent of them were in the former Soviet Union and Romania. HIV is the biggest single risk factor for tuberculosis ever identified. It parallels directly in the human body what poverty, poor diet and overcrowding have long been known to achieve in the genesis of active TB: it lowers resistance. Some research, cited in WHO’s 2003 ‘framework document’ for Europe and Central Asia, also suggests TB stimulates the HIV virus to reproduce itself faster.

A recent study published in the Archives of Internal Medicine found that 2.6 per cent of all new cases of TB in Europe were attributable to HIV co-infection, while 35 per cent of all adults worldwide with AIDS succumbed to TB.

Epidemiological time bomb ‘It takes at least six years to observe an increase in TB due to an increase in HIV,’ explains Pürpaulo de Colombani, the co-infection specialist at WHO’s regional office for Europe in Copenhagen. ‘So we’re not seeing the full impact yet in Eastern Europe, but there is a big threat.’ Another issue is that many countries haven’t yet developed reliable surveillance systems for tracking TB/HIV co-infections, he told The Bridge. In the most pessimistic scenario, Europe is sitting on an epidemiological time bomb.

TB medication for Red Cross out-patients, Belgorod, Russia. Photo: Alex Wynter/IFRC

Continues on page 8
The deterioration of the epidemiological situation in Kazakhstan coincided with the economic reforms of the early 1990s, when shrinking health budgets, unpaid salaries, poorly maintained health facilities, a severe shortage of drugs and laboratory supplies contributed to inadequate tuberculosis control. As a result, TB morbidity rose continuously and peaked in 2002 with 165 registered cases per 100,000 people. Several factors contributed to this, including economic recession, social upsets and the social stigma that prevents people seeking treatment.

The need to strengthen control over the spread of disease in the country became obvious. In Kazakhstan, the national programme aimed at protecting the population from rapidly spreading tuberculosis was first developed in 1998. Central Asian countries implement the DOTs strategy, recommended by the World Health Organization. This cures patients, saves lives and reduces disease transmission. DOTs has already contributed to a stabilization of the TB situation in Kazakhstan, Uzbekistan and Kyrgyzstan. But prevalence and mortality remain high because of insufficient resources, inadequate health facilities, unreliable drug supplies and the stigma attached to the disease. In the west of Kazakhstan, where TB burden is greatest, the incidence recorded in 2005 is more than 240 per 100,000, according to the Ministry of Health Coordination Council. Not all patients have access to treatment, especially in remote areas. This is one reason why people interrupt their course. Patients who start but do not complete drug treatment are more likely to develop multidrug resistance. In Kazakhstan, over 5000 cases of drug-resistant TB have already been registered, and this is alarming.

Over the last five years the Red Crescent has been filling the gap between the services provided to TB patients and the services that they are in need of. The network of TB/HIV co-infection too.

A Dangerous interaction

Dedicated staff and trained volunteers are involved in TB prevention and DOTS promotion through training sessions in communities and public-awareness activities. The youth network has developed a wide range of educational prevention activities. The Red Cross/Red Crescent model of treatment for tuberculosis, which we practice with the help of visiting nurses, is proving increasingly successful in fighting the disease. A study carried out last year in the three Central Asian republics, including Kazakhstan, showed that 93 per cent of patients under the observation of Red Crescent nurses completed their course of treatment. The average is only slightly higher, like 85 per cent.

Patients under Red Crescent observation receive food parcels, hot meals, vitamins supplements and hygiene kits to meet their most urgent needs, facilitate therapy and motivate them to continue treatment.

We do DOTS best

We have also been developing the programme and have explored providing psychological support to out-patients. A special room was opened by the Red Crescent in Almaty earlier this year for those seeking expert advice, or just the company of people experiencing similar troubles. We value volunteer experience from former patients who are good at providing DOTS.

The Red Crescent, in collaboration with the national AIDS centre and academic experts, has designed a programme to address this issue. We plan to provide per cent of out-patients with Red Crescent social and psychological support.

At least three groups of visiting nurses will work with out-patients and their families. For that we need to develop the existing curricula to train nurses, volunteers and medical staff. The training will include the problem of stigma, which prevents many people seeking treatment.

We also hope that by being part of the Country Coordinating Mechanism, the Global Fund to Fight AIDS, Tuberculosis and Malaria, we will be able to attract additional funding to implement the programme more effectively.

Dr Erkebek Argymbaev is President of the Kazakhstan Red Crescent

We do DOTS best

The opinions expressed are those of the contributors and not necessarily those of the International Federation of Red Cross and Red Crescent Societies or the International Committee of the Red Cross.

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About 400 local people attended art, computer or sports classes.

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A year of torment

The people of Beslan held three days of ceremonies at the beginning of September to mark the first anniversary of the violent end of the siege at School Number One, in which nearly 300 children died. Eleonora Zaikina, a psychologist, says virtually none of the surviving former hostages could be said to have ‘got over it’ in any real sense. And in grieving for a lost child, a year is a fraction of a second.

Most people are still deeply traumatized and afraid that it could happen again. ‘There is a lingering sense in this town now,’ says Ruhava.

Families are going through new crises of their own, she adds. Many parents’ relationships have broken down and they are on the verge of divorce: children have become aggressive and difficult to manage: A Red Cross worker says many child hostages, who had drunk their own wine in the siege, now cannot sleep without a bottle of water nearby.

After an international appeal, the Russian Red Cross set up a centre for psychological support, which saw 32 people serve as visiting nurses, social workers or psychologists. About 200 local people attend art, computer or sports classes.

‘The entire population of Beslan is suffering and we want to try to help revive normal life and social ties,’ says Kamislav Dagirzade, the Red Cross’s social director of the centre. It’s an ambitious goal.

Supporting psychology

Psychological support must be considered part of the agenda for the 2006 European regional conference in Moscow. This was the conclusion of the European Network for Psychological Support (ENPS), which was presented to the general assembly of the Red Cross/Red Crescent Societies in September, which included representatives from 26 National Societies.

After demand for psychological support for migration, health emergencies and in the wake of terrorist attacks, the ENPS called for a higher profile for Red Cross/ Red Crescent contributions to psycho-social support, and increased management support for the work in the field.

ENPS promotes the holistic approach to health defined by the World Health Organization’s constitution as a ‘state of complete physical, mental and social well-being, not merely the absence of disease or infirmity.’

The European network is also developing a database that includes training, volunteer-registration, assessment and evaluation tools.

The process shows the need to increase the value of basic psychological community-based support in our work, as opposed to just psychotrauma- specific treatment’, said Maarten Monney-Lassalle of the network’s secretariat at the French Red Cross. This will increase local capacity building and touch more people.

Today’s Sforreino

The final report of the Federation of the Future process, which was being presented to the general assembly in Seoul in November, describes the global challenges facing the Red Cross/Red Crescent movement and the challenges facing Red Crescent/Society.

AIDS is killing over 8000 people a day, the report says. ‘More than half the world’s population live on less than $1 a day. And access to basic health services and clean water is still a dream for the majority.’

The report is the outcome of a two-year consultation process on the main issues facing the International Federation and includes a blueprint to help it achieve the aims of Strategy 2010 and remain relevant and effective.

‘The Federation of the Future is about renewing our commitment to scale-up our work and make a difference to the lives of vulnerable people everywhere,’ says John McClure of the British Red Cross, who co-chaired the governing council of the global movement for psychological support.

The world expects the Red Cross/R Red Crescent contributions to psychological support to be fully in place by 2010.

One Life, keep it

I n our Toyota cars which crisscross Europe over the summer to promote the third year of road safety measures, Safety Campaign, converged on Brussels on 13 September at the end of the two-year consultation process on the main issues facing the International Federation and includes a blueprint to help it achieve the aims of Strategy 2010 and remain relevant and effective.

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Death reduction: Fondazione Villa Maraini

Martin Fisher

Walking into Villa Maraini’s impressively wooded and peaceful grounds from the streets of central Rome, you move altogether from one world to another. Yet although the atmosphere inside could not be less like the surroundings, the programmes the buildings house are very much in tune with the city’s darkest corners. I spent four days there in the summer, watching social workers and Red Cross volunteers helping people choose life.

The Fondazione Villa Maraini was set up in 1976 as a joint venture with the Italian Red Cross by Dr. Massimo Barra, the dynamic vice-president of the International Federation and a man who believes life can be successfully reclaimed even from the depths of heroin addiction. Barra argues that drug rehabilitation therapies must be tailored to the individual, not vice versa. ‘Villa Maraini has never refused anyone,’ he has said. ‘If a drug user who wants to give up is to be considered sick, whoever is unwilling to give up is twice as sick and needs extra attention.’

He also says harm reduction work with drug users (‘death reduction’ he calls it) has beaten back HIV in Spain, France and Italy and could provide a model for Central Europe.

Apart from the wide range of residential and out-patient services available, on site, in the Villa Maraini complex itself, the foundation also operates two harm reduction ‘camper vans’ – at Rome’s Termini station and in Tor Bella Monaca, one of the city’s most deprived neighbourhoods.

Many of Villa Maraini’s patients are first referred to the centre by the police. About half its 120 staff – and this is Villa Maraini’s greatest strength – are former intravenous drug users themselves, who escaped the lure of ‘maintaining’. They are walking, talking adverts for rehabilitation.

Marcello, a former heroin addict in his early forties who works in the mobile units, explains that ‘swapping needles spreads diseases like HIV/AIDS and hepatitis – persuading people not to is our role.’ He tells drug-users to return their needles and put them in a special bin strategically placed alongside the van’s passenger door. Most do.

A way out of drugs

Marcello and his fellow social workers are a vital bridge to the drug user community. As child- hood friends from Magliana, another tough Rome district, they started injecting heroin together and turned to petty crime to pay for it. Inevitably this led to jail. But one of them, Roberto, found a group run by Villa Maraini’s prison service, and then recruited Marcello, Antonio and Gino. Together they found a way out of drugs.

The make-up of the Villa Maraini mobile teams is the same in both locations: a social worker who is a former drug user, a doctor, a psychologist and Italian Red Cross volunteers.

There is, of course, only one way to do ‘needle exchange’, as harm reduction is often referred to in short. Villa Maraini’s services are dispensed in a completely neutral fashion, driven only by the humanitarian imperative. There is no attempt to distinguish between ‘deserving’ and ‘undeserving’ cases.

On the day I went out with them, Marcello sat patiently in the Tor Bella Monaca van, parked on wasteland beside a busy motorway. ‘It’s fundamental to my job to be approachable to people, you become friends of people, get them to think about things in a different way,’ he explained as a car pulled up and Luigi, a middle-class professor, got out, looking a bit nervous, hugging his young, beautiful girlfriend. ‘He’ll stay a couple hours but won’t take any risks,’ said Marcello. ‘With other people I can’t be sure they won’t overdose.’

It’s a different story, most of the time, at Termini station, as darkness sets in and the Villa Maraini mobile team prepares for its night’s work.

A dishevelled woman in her early thirties was the first client during my visit. Marcello queried how she is a heroin addict but she has started her evening on pills of some kind, ‘Stay near the van so we can keep an eye on you,’ he tells her as he hands over a needle. She reappears after five minutes, looking shaky but not obviously overdosing.

There is an international consensus in favour of harm reduction as an effective public health measure – the Red Cross/Red Crescent 2002 Berlin regional conference, for example, unanimously supported harm reduction. But this does not mean it will never again be controversial anywhere, inside or outside the Movement.

The last few years have seen intense discussion about drug policy in Italy, with – according to the European Union’s Lisbon-based drug agency – a shift in favour of prevention, with harm reduction initiatives now encouraged to ‘lead away from drug use’ being discouraged.

But the agency’s annual report last year said heroin use had stabilised in many countries and the ‘trend in drug-related deaths is now downwards after many years on the rise’. The HIV epidemic among injecting drug users may be slowing in some new EU member states, it added, at the same time as measures to reduce drug-related harm are intensifying.

Group therapy

Anna Maria Ruggerini, a psychologist who runs Villa Maraini’s helpline, says persuading users they need to give up their drug, to them possibly ‘the most beautiful thing in the world’, is the hard part. ‘These days, drug addiction cuts across all social lines, and many people are secret addicts, especially to cocaine.’

The people who use Ruggerini’s service, which she compares to a day-hospital, ‘can’t or won’t attend a therapeutic community’. Instead they follow a weekly programme that includes an interview with a psychologist and a group therapy session, usually for three years.

Some of the foundation’s most important work has been done in prison deprogramming sessions for social workers and Red Cross volunteers started organising support activities for drug-dependent prisoners in the Rebibbia and Regina Coeli jails.

But one of the newest services is the emergency unit, begun in 1994, largely as a result of the experience of the mobile team at the Termini station, whose staff repeatedly witnessed the horrors of both overdose and opiate withdrawal.

After six months, the emergency unit went twenty-four hours and now intervenes to ease the agony of ‘cold turkey’ and save people from death through overdose.

Increasingly, Villa Maraini is creating a model for the rest of the world. Many National Societies from Eastern Europe and Central Asia have visited. The original Villa Maraini was set up in 1976 as a joint venture with the Italian Red Cross by Dr. Massimo Barra, the dynamic vice-president of the International Federation.

Villa Maraini in Rome has long been a trailblazer in harm reduction for drug users. Now its services could offer a model for National Societies battling disease spread by needle-sharing.

Villa Maraini’s beautiful grounds are a haven from central Rome, where its mobile units operate.

Photo: Ilona Ostis
The Red Cross has been working with local government and veterans' associations to find out what Russia's impoverished elderly people really think. The ground-breaking research found access to healthcare with dignity high on the list of priorities.

Society

Russia’s elderly: the battle for dignity

Alexander Matheou

I set my alarm for five in the morning. Although I’m so full of fear and tension that I never get any sleep. I catch the first bus to the polyclinic. The path to the entrance is a slope of ice in winter. Still I get there as early as I can to collect my number in the queue. Then the hours of waiting begin.’

Throughout our research, elderly people spoke of accessing health care as one of the greatest traumas of their lives. It is not just a question of resources. Often the facilities are there: it’s using them that’s the problem.

Some elderly people we interviewed spoke highly of individual doctors, but a majority told of very negative experiences. Again and again, older people described the humiliation they suffered at the hands of medical staff, and how seeking treatment was an emotionally painful process deeply injurious to their dignity.

Appreciation of the Red Cross often centred on nothing more than the simple kindness of its nurses (see opposite page: An enduring tradition).

Over the past 12 months, the International Federation and the Russian Red Cross (RRC), together with veterans’ associations and local government agencies, have been carrying out detailed research into the plight of Russia’s elderly and their continuing battle for dignity in a society barely recognizable from the one they grew up in.

This ‘Participation Action Research’ (PAR) – in Tomsk, Karelia, Belgorod, Samara, Ingushetia and Chukotka – was also designed to promote dialogue between the state, the Red Cross and other agencies and older people themselves. It’s hoped it will lead to a national strategy for RRC work with older people.

The research allowed the Red Cross to see the world through the eyes of older people themselves. It included sensitivity training for people who work with the elderly, as well as focus groups and home interviews with older people and group discussion.

Humanitarian concern for Russia’s elderly people has historically focused on the inadequacy of pensions, and the consequences of the loss of savings in the economic and currency reforms of the early 1990s.

Over the past five years the ‘big picture’ on Russian pensions, in terms of their size and regularity, has improved. But older people are angry that a lifetime’s labour should be rewar ded by what are still meagre payments – that just lowest just over 30 US dollars a month.

There is anger that pensions do not provide sufficient compensation for labour; that decent pensions are more a ‘reward’ – for veterans of the Great Patriotic War, for example – than a right.

Even some people on the highest pensions, about 3000 roubles a month, described spending around 1000 on utilities. Most agreed that at least half their income is given straight back to the state for bills.

What is left of a pension does not qualify as a ‘safety net’. Most said there was just enough for a poor diet; boosted by produce from an allotment. The trouble starts when anything additional to food and utilities is required.

Rude doctors

Some of the elderly people we spoke to actually put access to healthy care and the cost of medicines above the size of their pensions as the main concern of their lives.

In Karelia, a republic on the Finnish border whose timber industry suffered badly from the loss of subsidized Soviet supplies, problems began with patchy bus services and stops far from the polyclinic. There older people wait in long queues fighting their way through the first-come, first-served system.

‘I never went to our hospital before but before was so rude to me I’ll never go again,’ said one pensioner. ‘All the good doctors have gone away and you can never get to see the one who are free.’ Interviewees also said hospitals were reluctant (and sometimes refused) to hospitalize older people.

Pensioners have to collect prescriptions from hospitals, free but valid only for ten days. If they can’t find a helpful chemist, the whole exhausting nightmare of visiting the polyclinic has to be repeated. Often the ‘free’ medicine has run out and the elderly are forced to pay for a commercial substitute. This issue came up in every focus group in Karelia.

Participants also referred to the experiences of having to pay for such supposedly free care. According to one: ‘I have to pay every time I get a test. Last time I gave some blood and it cost 35 roubles.’

Some went as far as to accuse the government of deliberately making health care inaccessible to older people because ‘there’s no money in the budget for it’. In Tomsk, western Siberia, our interviewees spoke of the unreliability of ailments and the fear they would not be treated even if you’re over 70; said one, ‘they don’t rush.’

Yet it was felt there is no government policy of active exclusion – just an array of bureaucratic and economic circumstances that combine to thwart the elderly.

Older people who enjoy the support of family and friends or are still able to generate some income independently are better off, as are those whose pensions have been increased as a reward for services in the war or as a veteran of labour. Those with pasts less distinguished in the eyes of the state are likely to be more vulnerable.

Interviewees included older people who had never worked, or done so only briefly, because they had spent their lives caring for loved ones. ‘For 52 years I looked after my deaf, blind and disabled daughter and never had a chance to work,’ said one. ‘As a result my pension is only 1000 roubles.’

Just coping

When survival strategies were discussed, most people said they were ‘just about coping’, but it became clear this entailed significant hardships. One elderly person told us: ‘In the second half of the month we economize strictly on money. We can make sure we have enough left for bread. We eat bread every day.’

Such strategies apply to utilities too: ‘We are TV in the dark,’ said another: ‘Anything to keep the costs down.’

Such references to ‘coping’, we came to realize, did not imply a reasonable quality of life but a continuing and scarcely credible Russian capacity to endure. Stories about the terrible experiences of Soviet citizens during the twentieth century: exile, slave labour, camps, hunger and beatings, people ‘one pensioner’ remembered: ‘We used to watch TV in the dark’ – said another: ‘Anything to keep the costs down.’

Wars and disasters. One elderly person told us: ‘In the second half of the month we economize strictly on money. We can make sure we have enough left for bread. We eat bread every day.’

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What can be done? In our discussions with older people there was never any desire for handouts or additional services. The emphasis was always on how existing structures could be made more receptive to the elderly, and how older people could have more say.

Essentially, concerns were grounded in the existing relationship between older people and the state, and particularly with its health services.

Older people also want support in negotiating healthcare from non-state agencies. Participants asked for advice on medicines and – a particu lar worry for old people targeted by door-to- door con men – how to avoid fake medicines.

Many interviewees, worried at the prospect of becoming housebound, requested both state and non-state actors make more social security available. They asked for opportunities to tell officials about the impact reforms are having. This was a recurrent theme throughout the research: the inability to influence the people and structures that decide so much about the lives of the elderly.

Many pensioners were proud of having stood up to the government recently and won concessions on the monetisation of benefits. Others were barely aware it had happened. There was a consensus among participants that there needs to be better information about the benefits available to older people, and that radio was the best medium for disseminating it.

Much of the discussion focused on ways that older people could enjoy life more and find it more rewarding. Many participants expressed a desire for social events, for excursions, for opportunities to meet people and interact.

There was a general desire to be creative and for opportunities that would allow older people to be creative and feel needed.

A woman counts her money at the bank. Many elderly people were pauperized by the inflation and currency reforms of the 1990s. Photo: Heidi Bradner/Panos Pictures
An enduring tradition

Visiting nurses...

One point about the Red Cross quickly emerges from the Participatory Action Research carried out in various Russian republics over the past two years (see opposite page: Russia's elderly).

Compared to the state medical staff – often at war with, or worn down by outright hostility – pensioners find themselves dealing with, Red Cross nurses are models of warmth and kindness. The Red Cross visiting nurse is a Soviet-era tradition, whose relevance some might now assume to be in decline. The opposite is true. Borodin Vasileivich, 55, is deputy head of a Red Cross branch in the super-fertile region of Uzbekistan. Observing and recording goes on through the nightmarishly complex Russian procedure for acquiring official disabled status. The Unity of Help register includes the most desperate cases – the people whom the authorities will not or cannot help, he explains: ‘People in the late stages of terminal cancer, the severely mentally ill, the bedridden, deep alcoholics.’

In modern parlance, they are multi-skilled anonymous local heroes, with a reach it is difficult to beat. ‘Where they saw people who were healthy, beautiful and HIV-positive,’ says one of the Kiev visiting nurses, ‘if it needs doing, do it’ attitude. The Kiev visiting nurses think of Dasha often when both staff and other children shunned her. But Khajinskaya also worries, as any mother would, for her three sons, who are 8, 19 and 21. ‘I took them with me to our centre,’ she says, ‘where they saw people who were healthy, beautiful and HIV-positive.’

Sooronova explains: ‘They live on bread and tea.’ They initially moved from their home in a remote village to a tobacco plantation but could not make ends meet and came to Bishkek. Akhmatbek Akhmatbekzakiev was the first to get sick. Doctors diagnosed TB and he was hospitalized. The family savings went on him. When Meirim too fell ill they did not look good. But three months on DOTs under Red Crescent supervision have turned his round.

Lena Khajinskaya

Ukrainian Red Cross

Lena Khajinskaya lives on the front line of the Red Cross’s battle against HIV in more senses than one. As a visiting nurse in the Kiev Red Cross HIV programme, she has become used to cases like Dasha’s – an HIV-positive 8-year-old who lost both her parents to AIDS and is now herself on double antiretroviral therapy. Her medical condition is, at least, no worse than it was two years ago when the Red Cross found her. The Kiev visiting nurses think of Dasha often because she is part of a phenomenon more commonly associated with Africa than Europe: ‘AIDS orphans’. And also because she had to be withdrawn from a state institution after a month when both staff and other children shunned her. But Khajinskaya also worries, as any mother would, for her three sons, who are 8, 19 and 21. ‘I took them with me to our centre,’ she says, ‘where they saw people who were healthy, beautiful and HIV-positive.’

Valentina Merculova

Russian Red Cross

Valentina Merculova, a Russian Red Cross (RRC) visiting nurse, has kept bees as a hobby all her adult life. When collective agriculture finally ended in 1994, the Gopkin branch of the Red Cross acquired ten hives from farms that were closing and gave them to Merculova to manage. The family live in a space of about six square meters. Two out of seven in the family have no choice but to be 100 per cent upfront about sexual matters and the dangers of inject- ing drugs – especially now that HIV is seen as having broken out of the drug community into the wider population through hetero-sexual transmission. ‘If we want to live in a democratic society,’ she says, ‘everyone has got to have the right to the full facts about these things.’

Khajinskaya, whose Red Cross work involves mainly adults living with HIV, speaks of some transformed families. The wife is HIV-positive; the husband, who knew this before they got married ‘but was very much in love’, isn’t. ‘They are waiting to see if they can have children.’ No one in Ukraine thinks the arrival of antiretroviral therapy has reduced the urgency of HIV prevention. For people with a medical background like Lena and her husband, this means being totally frank with their children. ‘I spend time talking to the boys about the way things are,’ she says, ‘including the eight-year-olds. A lot of time.

Svetlana Sooronova

Kyrgyz Red Crescent

Svetlana Sooronova is one of four Red Crescent visiting nurses in Bishkek carrying out direct observation of home-based TB patients – the vital DOTS strategy that has helped stabilize tuberculosis in many countries. ‘We help sick people in high-risk groups complete treatment’, says Sooronova. ‘Mainly they are socially vulnerable people: the unemployed, alcoholics, homeless, and ex-prisoners. Many do not have enough money to get to hospital or a doctor. Their relatives expect them through fear of getting infected. They rely on us.’

As the patients improve, they come to the Red Crescent canteen to get the medicine and hot meal. It is an essential support for poor and lonely people, according to Sooronova. ‘The main thing is to keep hope of recovery alive,’ she says. ‘Then the treatment will work.’

Red Cross societies implement tuberculosis control programmes in 14 locations in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. Observing and recording goes on for up to eight months. This significantly decreases the risk of treat- ment being interrupted, which can lead to the multidrug resistant form of the disease that is far more difficult to cure. The educational work done by Red Crescent nurses and volunteers plays a key role.

Three days a week Sooronova picks her way through the slums of Bishkek, crowded with people who have moved from Kyrgyzstan’s eco-nomically devastated south to look for work in the booming capital. The living conditions are straight out of the textbook on how TB spreads. ‘These people are one, two, three meters away from each other, a chance of being bitten by bedbugs, Sooronova explains. ‘They live on bread and tea.’

We pass through a tiny yard where children play in the dirt and settle in a dimly-lit shack. Sooronova introduces Meirim Oldzhoobaeva, a frail and gaunt woman who looks much more than her 21 years. A TB patient with the classic look of the consumptive. Meirim Sooronova rejoins in Meirim’s progress on DOTS. ‘When I first saw her four months ago, she was very weak, bed-ridden and plagued by a hacking cough.’

The family live in a space of about six square meters. Two out of seven in the family have already contracted TB. The other is Meirim’s father, Akhmatbek, who is also now better.
In this first issue of *The Bridge* to cover the whole of the European and Central Asian region, we asked some key players to describe the health challenges they face. With its unique ground-level network of volunteers and nurses, few organizations are better placed to confront the twin evils of TB and HIV than the Red Cross/Red Crescent: the poverty that fuels the former, the needle-sharing that – in this region – still mainly fuels the latter, and the deadly axis they form.

**How worried are you about the combination of HIV and TB?**

**Eva Morzsayni:** Secretary General, Hungarian Red Cross: In Hungary we are fortunate because in the early 1980s there was a very successful national prevention campaign, so we could stop the spread of AIDS. The number of people infected in Hungary is not more than 1000. So we do not see a direct relationship between HIV and TB. At the same time, the appearance of homelessness and poverty has caused a rampance of TB. We have to consider the potential coincidence of the two infections.

**Davron Mubakhamadiev:** Vice-President, Kyrgyz Red Crescent: An ‘alliance’ between HIV and TB became a major concern in the former Soviet countries that faced severe socio-economic crisis. Poverty, chronic unemployment, poor access to health services and education, an increased flow of drugs – all these factors are causing TB and HIV epidemics in the country. The Tajik government works with the Global Fund through its Country Coordinating Mechanism. The Red Crescent, as a part of the latter, has initiated health education in communities, especially among the most poor who are at real risk from deadly infections.

**Valentina Shishkina:** Head of Operations, Russian Red Cross: We have implemented HIV and TB programmes separately, but we are now trying to develop strategies to deal with co-infection. Russia is a country where both TB and HIV are very urgent. Health ministry figures show that in 2003 there were 3133 registered cases of co-infection: 7678 last year. We do fear HIV is going to fuel TB, because HIV is growing very fast and latent TB is common.

**Sonja Tanevka:** Regional Health Delegate, International Federation, Budapest: It is very important for National Societies to develop comprehensive plans and form partnerships, for example, with NGOs and governments. In that sense, they should follow up the development of both diseases and react. I agree it’s very important to strengthen such programmes, not just HIV and TB, and then if needed create a link between them, but certainly not develop another new programme. The International Federation is ready to help.

**Is harm reduction working as a strategy to prevent the spread of HIV?**

**Mubakhamadiev:** There is a correlation between harm reduction and TB. Prevenion is a part of harm reduction, and what the Hungarian Red Cross does through the youth programme in more than 90 schools is approach young people with information about sex, condoms and family values. I believe this is what the Red Cross has the capacity to do.

**Mubakhamadiev:** In Tajikistan, this approach was first introduced two years ago. We adapted the practice of our Italian colleagues at Villa Maraini. We involved community and religious leaders to promote a healthy lifestyle. Now we can say yes, it works. People start to listen. The signs are good.

**Shishkina:** Well as far as the distribution of clean needles is concerned, the main experience of harm reduction we have is the project in Tyumen. The signs are encouraging. We’re confident it works.

**Tanevka:** Changing policy and improving society’s response to these communities has been shown to happen. And needle exchange together with other assistance like psychological support and referral to social institutions directly improves the quality of people’s lives.

**Do you think the Red Cross/Red Crescent is keeping up with the times, especially in its work with the young?**

**Morzsayni:** We’ve been able to facilitate the development of the Hungarian Red Cross youth branch, which can act quite independently and run its own programmes. They rely on adults for some things and do not want to be fully separate from the Red Cross. Our society is open to new ideas. Openness is the key to our adaptability, and this is where Red Cross youth are vital.

**Mubakhamadiev:** Most members and volunteers are young people – students and teenagers. We are proud of our new generation of volunteers who work in communities, carrying out youth promotion activities and disaster preparedness.

**Shishkina:** Our projects are still popular with young people today. We have a youth crisis centre as an event we hold to mark things like World TB Day, and so on. We say, come to the Red Cross and you will be able to realize your potential. Russian youngsters are trying to find their place, like everywhere. Young people might get their first chance to be leaders in the Red Cross, through simple things like community activities.

**Tanevka:** I know many cases where youth are really the main actors in the realization of health and care projects. The Romanian Red Cross TB project, for example, and the Macedonian Red Cross drug prevention project, and others. Many others. But there could be greater involvement of youth in project development and better volunteer management.

**What do you hope the Moscow conference next year will achieve?**

**Morzsayni:** This is the regional conference for Europe, so what we would like to achieve is for it to be clear to everyone that there is only one Europe – no ‘EU Europe’ and then the rest. Programming should also go in this direction. We hope Moscow will maintain the spirit of Berlin 2002 and make a significant contribution to our service to the most vulnerable communities. The conference will provide an opportunity for European National Societies to hear the needs of people in the newly independent states.

**Shishkina:** We’re looking forward to presenting the new model for working with TB patients we’ve been developing. We took an active part in Berlin in 2002. I was the chair of the TB group. I felt we achieved a lot. I hope we can sustain the momentum.

**Tanevka:** Agreements among national society leaders to put greater efforts into health and care programmes.
**Kiev**

9th ERNA meeting applauds harm reduction work

M any governments in this re- gion don’t realize we simply have to work with drug users,” according to Dr Anders Milton, the president of the Red Cross/Red Crescent European Regional Network on HIV/AIDS (ERNA), speaking to The Bridge at its Kiev meeting in September. Delegates spent a whole day dis- cussing ‘harm reduction’: counsel- ing and the no-questions-asked distribution of condoms and clean needles intended to reduce the damage done to people by drug use. Dr Milton said the first step to drug-free communities is proma- te ‘harm reduction was ‘grabbing the use. Dr Milton said the first step need to reduce the distribution of condoms and clean needles was to introduce harm reduction programmes in countries where the Russian Red Cross does needle exchange: there is also a project for prevention through peer education in Krasnodar. Zagainova, a 20-year Red Cross veteran and the manager of the Red Cross harm reduction pro- gramme in Krasnodar, said ‘The Bridge was her life in Central Asia was first noticed in the city in 1999. Young people quickly began to inject, rather than smoke or snort it, ‘through sheer ignorance and because that’s what pushers told them to do. Sharing needles (the most efficient way of trans- mitting the HIV virus) became ‘a kind of adolescent rite of passage, a blood-brother ceremony,’ she explained. In the space of only a few years the tide was in the grip of an HIV epidemic that threatened to cut down many of its young people before their adult lives had even begun. Yet Zagainova says that the tide may have turned against HIV in the past two years. No one can prove scientifically it’s because of harm reduction, she says, but the statistics are encouraging and the anecdotal evidence strong. Professor Gerry Stimson of the International Harm Reduction Association, which provides technical advice to governments, cited the example of the UK, where there is a nearly 20-year-old bipar- tisan consensus in favour of needle exchange. A total of 2000 needle exchange points have been established in Britain, he said. The evidence base for harm reduction was still not conclusive; only ‘a few’ academic studies showed a drop in actual HIV prevalence as a result of it. Professor Stimson told ERNA dele- gates. But in Britain the prevan- cie of HIV among injecting drug users had stabilized at around one per cent. Delegates from 36 National Societies split up into five working groups to agree messages for Moscow 2006. Three put ‘pursu- ing governments on harm reduc- tion at the top of their agenda – including getting laws changed on the basis of evidence gathered by community workers like Red Cross branches. One group wanted a call for drug addiction to be reclassified as a ‘public health problem’; an- other concluded harm reduction for the Red Cross/Red Crescent was ‘possible but difficult’. The ERNA meeting, in ninth, was hosted by the Ukrainian Red Cross.

**Bulgaria**

‘Solitude is the worst disease’

H eighty-year-old Kina Yakimova lives in Lovech, a small town north-east of Sofia, and her situation is typical of many of her generation. After four decades of hard work, she is alone. Her monthly pension of around 45 euros a month goes nowhere. In winter she cannot afford heating. Now the Swiss Red Cross has helped the Bulgarian Red Cross introduce a home care service in Lovech and four other locations in the country, mobilizing clients to meet and do things together.

‘Solitude is the worst disease,’ says Yakimova. ‘Before, I cried every day. Now, sometimes, I feel almost happy, waiting until they come.’ They are the nurses and home helps who visit several times a week, fetching Yakimova’s shop- ping, cleaning her apartment, paying bills, doing whatever needs to be done. As she suffers from hypertension and diabetes, they also take her blood pressure and give her insulin shots. Yakimova is also looking forward to a home-warming party the Red Cross branch is planning.

But the men and women of Bulgaria’s elderly self-help groups are also contributing to the well- being of others. Last Christmas, they brought presents to elderly people and disabled in residential care near Lovech. And as Red Cross volunteers they helped to sort out clothes and food for flood victims a year ago.

By Patricia Maurerhofer, Swiss Red Cross

**Kosovo**

Health education for Roma

T hey are a forgotten footnote to a conflict largely forgotten by the outside world. Kosovo’s Roma, who fled their homes du- ring the war six years ago after they were seen as siding with the Serbs. Those still inside Kosovo live in makeshift camps never meant to be permanent. They rarely venture outside KFOR-guarded areas, lim- ited access to employment, health- care and education even more than usual. Since 1999, the local Red Cross, the IRC, KFOR, Caritas Kosovo, the Voice of Roma and other NGOs and UN agencies have been sup- porting Roma people with food and clothes and soon Yakimova, Cesmin Lug and Kablar. But specialist Roma groups say the international community has largely failed the most vulnerable members of Europe’s most vulne- rable minority, especially in the health field. You don’t have to be a doctor to recognize that northern Kosovo’s Roma camps are unhealthy places. They barely qualify even as shanties. There is no sewerage. Mothers complain their children suffer from chronic skin diseases and lice. People look anaemic. Stench and squaller are everywhere.

The depth of poverty seems more typical of Africa or Asia than Europe. Unemployment is the norm. Organized education and health- care are extremely limited. In the- ory, Roma children have access to schools in the north; few attend regularly.

A local Red Cross doctor does visit the Roma camps to check conditions, and a nurse appointed by the authorities in the northern town of Mitrovica, which came to symbolise the rift between ethnic divi- sions, visits every weekday. But this effort is far from enough. The national and international authorities responsible for Kosovo also seem no closer to solving the acute problem of lead pollution, which has killed at least one Roma child, according to the World Health Organization (WHO), pos- sibly many more.

Hundreds of Roma have been living next to a disused and still contaminated lead mine in Mitrovica, their flimsy wooded huts only a few hundred metres from toxic slag heaps. The wind blows poisonous dust through the camp. WHO describes the situation as an environmental disaster, but the refugees have yet to be moved. Some of them say they are afraid to go anywhere else.

Although supposedly free, health-care often ends up costing money in Kosovo. This highlights the need for income-generation programs as much as humanitarian relief.

It’s hard to know where to break into the cycle of poverty: poor health, lack of education and discrim- ination that so afflicts the Roma, in Kosovo – if it were possible – worse than elsewhere in Central Europe.

By Vjosa Macula, Organizational Development and Youth Programme Manager, International Federation, Kosovo

**Round and About**
The Red Cross/EU Office has been looking at how National Societies deploy resources in the health field. It found that the new EU members are in the front line of the fight against HIV/AIDS.

Luc Henskens, Nathalie Marchboro-Holker

Letter from Brussels

Health in the new EU

The Red Cross/EU Office has been looking at how National Societies deploy resources in the health field. It found that the new EU members are in the front line of the fight against HIV/AIDS.

The Red Cross/EU Office

But in sub-Saharan Africa, Asia and Eastern Europe, of those who need it the proportion with access to the full package of collaborative TB/HIV activities remains low.

Above all, there is a critical time when, like the SARS outbreak, the world needs the World Health Organization, with which the Interna- tiona1 Federation reached agreement earlier this year, to step up cooperation in several key health sectors. It has often been observed that TB, especially, and HIV are ‘diseases without borders.’

In 1994 WHO published its ‘interim policy on collaborative TB/HIV activities’. ‘Interim’ because of the research gaps in this field – central to all on whether encouraging results found in tests with individual drugs on small samples will translate to the public health context, and also on how new antiretroviral and TB drugs interact.

The interim policy – undoubtedly the single most important public document in this area (available at www.who.int) – describes itself as a ‘rolling policy which will be continuously updated to reflect new evidence’.

It recommends greatly increased collaboration and increased case-finding of each disease with programs for the other, although based on voluntary HIV testing.

The preventative TB drug isoniazid should be given to HIV individuals with latent infection with Mycobacterium tuberculosis in whom active TB has been safely ruled-out – a ‘critically important’ step possibly not feasible in developing count- ries, according to WHO in the interim policy. (The diagnosis of TB still depends on microscopic work with smears – a century-old technique – by skilled technicians.)

Co-trimoxazole therapy, which has been shown to prevent several bacterial and parasitic infec- tions in people living with HIV, would mean, while be given to TB patients.

TB/HIV is a new area in terms of policy. Accord- ing to de Colombani: ‘Changing people’s minds in favour of internationally-agreed strategies is vital, both for TB and TB/HIV.’

Dr Colombari’s Copenhagen-based colleague, Dr Risards Zaleskis, WHO’s regional adviser for tuberculosis control, says that many countries in Eastern Europe and Central Asia are facing ‘real epidemiological deterioration, not just before reporting, and this is mostly due to the social and economic situation and disruption of health systems.’

‘The task now is to implement the agreed stra- tegy for TB,’ he says, ‘but we still face problems because of resistance in some countries from doctors and administrators who cling to the old system.’

Mars, Venus

WHO has grouped the 52 nations of its vast European region – stretching from Portugal to Kazakhstan – into three categories for each disease. All the countries which are ‘high prior- ity’ for both Russia, Belarus, Estonia, Latvia, Lithuania, Moldova and Ukraine – are former Soviet republics.

The International Federation has been combin- ing its TB and HIV/AIDS programs in Eastern Europe for several years now. And the ongoing Russian TB program includes ‘healthy HIV/AIDS component’, according to programme officers in Moscow and Geneva.

Russian health ministry figures show that in 2003 there were 3133 registered cases for HIV infection; this rose to 7678 last year. Valentina Shishkina, head of operations for the Russian Red Cross, says her ‘treatment of patients is now trying to develop strategies to deal with co-infection. We do fear HIV is going to fuel TB, because growing very fast and latent TB is common.’

There is also no doubt that both HIV preven- tion work and TB treatment supervision (DOTS) are the kind of labour-intensive, community- based work that the Red Cross specializes in and excels at.

The Red Cross/EU Office

The Red Cross/EU Office has been looking at how National Societies deploy resources in the health field. It found that the new EU members are in the front line of the fight against HIV/AIDS.

Continued from page 1

The answer, which will probably surprise no one, is 100 per cent, at least as far as our research shows. Young people, especially, pay a high price for HIV in Europe. According to the most recent statistics from EuroHIV, in 2003 under-30s repre- sented 29 per cent of new HIV cases in western Europe; 45 per cent in central Europe and 73 per cent in eastern Europe.

Is the Red Cross addressing the challenge? The Red Cross/EU Office wanted to find out exactly how the Movement is deploying its resources to meet this and other health issues in Europe. Our survey questionnaire was sent to all health departments of the European Union National Societies, and won respon- ses from eight new and thirteen pre- enlargement EU National Societies.

The findings update a similar health-activity exercise conducted by the Red Cross in 2002.

The mapping aims to provide an overview of priorities in the health field, identify areas of common interest for future cooperation, iden- tify health challenges National Societies are facing and can offer support, and facilitate networking amongst them.

First aid and blood donation are still the lead- ing components in almost all National Societies across the EU. But expanded investment in psychosocial support since the 2002 mapping exercise has pushed it into third place, ahead of health education and care, and cultural activities and prevention work.

We found important East-West differences too, which reflect the different histories and economies of the regions. All but one of the eight new EU National Society respondents worked in food and nutrition, the main challenge for the future, National Societies clustered around these in particular: demographic change and ageing; financing health and care and the general increased demand for their services; reform; and the fight against social exclusion and inequality.

Three national societies saw advocacy as a challenge for the future, then one or two also opted for each of HIV/AIDS, support for refugees and asylum seekers, quality control, training, organizational issues, epidemiological develop- ments, family, mental health, drugs and lifestyle.

All these issues have been listed by the Euro- pean Commission priorities and should be included in the next Health and Consumer Protection Programme.

We hope the mapping exercise will be a good starting point for National Societies to develop programmes active in a particular specific field. And we also welcome the setting up of a Working Group on Elderly People – coordinated by the Austrian Red Cross.

Luc Henskens is Director of the Red Cross/EU Office. Nathalie Marchboro-Holker is its Programme Officer for health.

Professor Peter Godfrey-Fausset, a leading expert on TB/HIV co-infection in Africa based at the London School of Hygiene and Tropical Medicine, explains that ‘top-down medical’ tuberculosis and community-based HIV prog- rammes have traditionally come from different perspectives. Or as the report on the Addis meet- ing put it: ‘TB programmes are from Mars, HIV programmes are from Venus.’

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