



the Bridge

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International Federation of Red Cross and Red Crescent Societies, Europe Department



TB/HIV: the duel epidemic

Alex Wynter

Is HIV – the greatest risk factor for tuberculosis ever known – fuelling 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.

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 Pierpaolo 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-infection,' he told *The Bridge*. In the most pessimistic scenario, Europe is sitting on an epidemiological time bomb.

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.

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UpFront

Dr Erkebek Argymbaev

We do DOTS best

Central Asia provides new survey evidence that visiting nurses get the best results steering TB patients through treatment. Now the Kazakh Red Crescent plans to train them to address TB/HIV co-infection too.

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 upheaval, malnutrition, poor living conditions 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 poor health literacy of population. In the west of Kazakhstan, where the 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 multi-drug resistance. In Kazakhstan, over 5000 cases of drug-resistant TB have been already registered, and this is alarming.

Over the last five years the Red Crescent has been filling the gap between the services provided by TB institutions and individuals who have no access to them. This year, our National Society is running TB prevention and control programmes in six cities.

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 93 per cent of patients under the observation of Red Crescent nurses completed their course of treatment. The average is only something like 85 per cent.

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

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 assistance from former patients who are good at promoting DOTS.

We are now seriously concerned about rising HIV/AIDS which increases the spread of TB. Areas with high rates of tuberculosis overlap interaction. It's predicted that every year, 10 per cent of HIV-positive individuals will develop TB.

The Kazakhstan Red Crescent, in collaboration with the national AIDS centre and academic experts, has designed a programme to address this issue. We plan to provide 85 per cent of co-infected people 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 curriculum 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 Coordination Mechanism of 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

InBrief

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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 200 children died.

Elena Rubaeva, a Red Cross 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 but a fraction of a second.

Most people are still deeply traumatized and afraid that it could happen again. 'Fear is king in this town now,' says Rubaeva.

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 live with.

A Red Cross social worker says many child hostages, who had to drink their own urine 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 psycho-social support where 32 people serve as visiting nurses, social workers or psychologists. About 400 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 Stanislav Tsagaraev, director of the centre. It's an ambitious goal. ■ Rita Plonnikova

Supporting psychology

P psychological support must be firmly on the agenda for the 2006 European regional conference in Moscow. This was the conclusion of the European Network for Psychological Support (ENPS) conference in Budapest 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-selection, assessment and evaluation tools.

'The present situation shows the need to increase the value of basic psychological community-based support in our work, as opposed to just psychotherapeutic treatment,' said Maureen Mooney-Lassalle of the network's secretariat at the French Red Cross. 'This will increase local capacity-building and touch more people.' ■ Rita Plonnikova

Today's Solferino

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 as 'today's Solferino'.

'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,' said John McClure of the British Red Cross, who co-chaired the governance panel which led the process. 'The world expects the International Federation to use its global network of National Societies to achieve a greater impact.'

The process identified ten areas for improvement, a five-year framework for action and a 'Global Agenda' for better planning and more effective programmes and resource mobilization. ■ Philip Jamminga

One life, keep it

Four Toyota cars which criss-crossed Europe over the summer to promote the third year of the European Road Safety Campaign converged on Brussels on 13 September at the end of the tour.

The cars left Greece, Malta, Poland and Portugal in June and drove more than 40,000 kilometres through each EU member country, where the drivers joined local Red Cross workers to give road safety and first aid messages.

The 2005 campaign was coordinated by the British Red Cross, whose chief executive Sir Nicholas Young told the ceremony in Brussels that if first aiders arrived at accidents quickly enough, 'at least half' the lives lost could be saved.

Jacques Barrot, European Commissioner for transport, said the EU was still far from the objective it had set of halving the number of road deaths and governments needed to try harder.

The 2005 tour was the highlight of the third road safety campaign. The theme: *One Life, Keep it*. It was partly funded by the European Commission and sponsored by Toyota.

The campaign helps National Societies raise awareness about road safety measures and promote first aid skills.

Toyota wants to improve road infrastructure and raise safety awareness through the Toyota Fund for Europe. ■ Claudia Arnold

Death reduction: Fondazione Villa Maraini

Martin Fisher

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.

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, free, in the Villa Maraini complex itself, the foundation also operates two harm reduction 'camper vans' – at Rome's Termini train 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

staff – and this is Villa Maraini's greatest strength – are former intravenous drug-users themselves who escaped the lure of 'mainlining'.

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 childhood 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 for 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 know everyone's habits,' he explained as a car pulled up and Luigi, a middle-class professional on his lunch break, well-dressed and clearly nervous, stepped out and approached. Marcello gave him two clean syringes and a small bottle of sterile water.

'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 knows she is a heroin addict but she has started the 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 the Movement or outside it.

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 'not designed 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 since 1979, when 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 buildings date back more than a hundred years and were used in the last century to treat tuberculosis patients, at a time when that disease afflicted Rome as much as it now does the newly-independent states of the former Soviet Union. After TB was conquered in the west, Villa Maraini became a home for children orphaned by the Second World War.

It would be fitting if the beautiful buildings – a haven from the bustle of Rome but in the very midst of the city – evolved to meet the needs of the new larger Europe. The Italian Red Cross is co-funding similar projects with sister National Societies from Honduras, Nicaragua, El Salvador, Bangladesh and India, and planning more. ■

Martin Fisher is co-editor of The Bridge and a former Budapest-based Reporting Officer for the International Federation.

Villa Maraini's beautiful grounds are a haven from central Rome, where its mobile units operate.
Photos: Ilona Ostis



Street credibility. Villa Maraini social worker and former drug-user distributes sterile injecting equipment. Photo: Ilona Ostis



Society

Russia's elderly: the battle for dignity

Alexander Matheou

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

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 'Participatory 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 rewarded by what are still meagre payments – the 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 1100 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 health 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 begin with patchy bus services and stops too 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 they were so rude to me I'll never go again,' said one pensioner. 'All the good doctors have gone private and you can never get to see the ones 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 week 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 'they want to get rid of us'. In Tomsk, western Siberia, our interviewees spoke of the unreliability of ambulances and the fear they would not come. 'If they hear 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 for being 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 to make sure we have enough left for bread. We eat meat even the dogs won't touch.'

Such strategies apply to utilities too: 'We watch 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 emerged of the terrible experiences of Soviet citizens during the twentieth century: exile, slave labour, camps, hunger, war and bereavement.

'I went eight years without eating bread,' one elderly person remembered. 'We used to make dough out of potato peel and sawdust and eat that. Nowadays whenever I buy bread I clutch it to my chest, bury my face in it and thank God it's mine.'

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 particular 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 homecare a priority.

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 spoke of a desire for social events, for excursions, for opportunities to meet people and interact. There was a general desire to stay active and for opportunities that would allow older people to be creative and feel needed. ■

Alexander Matheou is Head of Delegation with the International Federation in Moscow. (The complete PAR reports are available from him on alexander.matheou@ifrc.org)

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

Alex Wynter, Ilmira Gafiatullina

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 best abrupt, at worst downright hostile – 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.

Vitaly Vasilevich, 55, is deputy head of social services in the southern Russian city of Gopkin, and very much a veteran of the Soviet welfare system. Gopkin is also a place where, to some extent, the old stipendiary system of government funding of Red Cross work has been restored.

The Belgorod Red Cross branch, of which Gopkin is a part, was on its knees financially in the mid-nineties and almost had to suspend operations altogether. Then the local government reached into its pockets in 1996. When asked directly why he prefers to allocate some of his budget to the Red Cross rather than just hire more social workers, Vasilevich says visiting nurses 'are willing to do both social and medical work, to give injections and pay electricity bills.' In modern parlance, they are multi-skilled and don't pay too much attention to the letter of their job descriptions.

It is a similar story in the sprawling West District of Moscow, where the branch president, Tatyana Strongina, points out that her nurses have an 'If it needs doing, do it' attitude to their clients. They will, for example, help disabled people fight their way through the nightmarishly complex Russian procedure for acquiring official disabled status.

The West District's client register includes the most desperate cases – the people whom the authorities will not or cannot help, she explains: 'People in the late stages of terminal cancer, the severely mentally ill, the bed-ridden, deep alcoholics.'

The local hospital discreetly reserves a few private rooms for the Red Cross branch, in which its nurses care for people otherwise regarded as beyond assistance. If one were looking for a tangible definition of what Red Cross humanitarian auxiliary work meant in practice, this would be hard to beat.

Interestingly, staff turnover among the Moscow West nurses is low. Strongina can only think of two or three who aren't veterans of several years standing.

The visiting nurse service survives in all the countries which, after 1991, formed new National Societies out of the branches of the old Soviet Red Cross, and beyond.

On this page, we profile three such women, from Russia, Ukraine and Kyrgyzstan. There are thousands more across the region, anonymous local heroes, with a reach it would be difficult to reproduce. ■



Soviet-era poster for visiting nurses. Courtesy Soviet Red Cross Museum, Moscow

Lena Khajinskaya Ukrainian Red Cross

Lena Khajinskaya lives on the front line of Kiev'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.'

Kiev's youngsters, still mildly intoxicated by the heady political street-party atmosphere in the city, have trouble believing you can be both beautiful and infected with the HIV virus, says Khajinskaya.



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 her to manage.

Now they produce some 200 kilogrammes of honey a year, which is sold to help support local

She suggested both her sexually active grown-up sons and their girlfriends got tested. They did; the results were negative.

Khajinskaya, 40, simply does not view preaching abstinence as a viable anti-HIV strategy when it comes to young men in their late teens and early twenties. 'I make sure there are always condoms in the house.'

Also trained as a laboratory technician, Khajinskaya joined the Red Cross because of a simple house move. Her husband is a pathologist.

Like many Ukrainian families, they feel they have no choice but to be 100 per cent upfront about sexual matters and the dangers of injecting drugs – especially now that HIV is seen as having broken out of the drug-user community into the wider population through heterosexual 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 married friends of the family. 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-old. A lot of time.' ■

Valentina Merculova Russian Red Cross

Red Cross welfare work. It also goes to families on welfare and patients as aid in-kind.

Merculova points out bees are quick to punish haste or clumsiness. In spring the hives have to be thoroughly cleaned, and bees are not the most easily evicted of creatures.

In summer, they put the hives out in fields away from houses; the area is famous for its wild flowers. It's hard work and bee-keeping requires a very deft touch.

Yet a third demand on Merculova's energy are the two grandchildren she is raising herself to help out a chronically sick daughter-in-law. 'Work,' she says, meaning her patients, 'feels like a holiday.'

Merculova was born during the second world war. Her father was killed fighting 'somewhere in Germany, we don't know where, the letter didn't say'; her two older brothers, also in the Red Army, survived.

Trained as a medical nurse, she began her Red Cross career as a teacher in camps for Young Pioneers. She won her first prize 'for good works' from the Russian Red Cross in 1971, and the Solovoy award for charity in 1998 – the highest the RRC can bestow.

Merculova does not feel the changes of the past 15 years in Russia too deeply. 'Our work in the Red Cross is much the same as it always was,' she says.

Belgorod region, with iron-ore mining and thriving agriculture (all now privatized and taxed), did well under communism and it does well now. It is visibly a world away from the 'shooting galleries' of Irkutsk or the economically devastated far north-east.

Merculova's main concern is her fellow pensioners, and she does not seem to believe the 2002 pension reforms are enough: 'The government really needs to pay more attention to the elderly.' Yet demographic change has had its effect. Local young people are drawn away to the bright lights of Moscow and St Petersburg, or even the regional capital, Belgorod.

'This village is dying,' says Merculova, standing amid her hives in Melovoye, in the super-fertile area of the country Russians call the 'black earth zone'.

'There are only old people left,' she says. 'But I don't complain. I can work, I can move around, and once in a while I can go to Moscow myself for conferences of bee-keepers.' ■



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 stabilized 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 reject 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 Crescent 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 treatment being interrupted, which can lead to the multi-drug 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 economically 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 just too poor to have a chance of being healthy,' 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 Oldzhobaeva, a frail and gaunt woman who looks much more than her 20 years. A TB patient with the classic look of the consumptive.

Yet Sooronova rejoices 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.

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 was the first to get sick. Doctors diagnosed TB and he was hospitalized. The family savings went on his treatment.

When Meirim too fell ill things did not look good. But three months on DOTS under Red Crescent supervision have turned her round. ■

Towards Moscow 2006

At the 2002 Berlin conference, the Red Cross/Red Crescent set itself the task of working with 'people in the shadows'. Next year's regional gathering in Moscow will provide a chance to review progress.

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 Morzsanyi, 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 reappearance of TB. We have to consider the potential for coincidence of the two infections.

Davron Mukhamadiev, 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 Coordination 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 re-

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 Irkutsk. The early signs are encouraging. We're confident it works.

Tanevska: 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.

Is drug use really a humanitarian issue?

Morzsanyi: Drug use has a humanitarian impact, so what we do is to participate in education from the youngest ages through Red Cross Youth. We never treat drug addicts as criminals and avoid stigmatizing them. The Red Cross alone cannot solve it. National Societies in Europe should exchange best practices and useful information, but at the same time work with health authorities and other actors.

Mukhamadiev: This issue has often been discussed at conferences and meetings. Different organizations can hold conflicting opinions. From the Red Crescent point of view, I believe drug use is a grave humanitarian issue. We should send a message, especially to our youth, about the negative impact of drug abuse. For my country, right on the 'heroin trail' from Afghanistan to the West, it raises serious concerns.

Shishkina: As the Red Cross we have to try to help people addicted to drugs, to keep them alive until they can snap out of it. That's not to say harm reduction isn't controversial in Russia, as it has been elsewhere.

Tanevska: Certainly. The Red Cross should always look to the most vulnerable. Very often, their lifestyle means drug users are excluded from society and they generate problems that have an impact on the community. The questions are: who are the drug users and what kind of problems are they facing?

most needy people. And in this country we are the only people who can get to those who are truly needy and marginalized. And we're sure there will be more and more of them, especially people needing help in their own homes.

Tanevska: I really like the work the Red Cross is doing. For sure there is a space for improvement. Maybe the improvement of partnershipbuilding with different stakeholders can be one answer, but it varies from country to country.

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

Morzsanyi: 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.

Mukhamadiev: 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 health promotion activities and disaster preparedness. The issue of recruitment was raised at the last Red Cross/Red Crescent Youth Conference, which concluded that the Movement could be more modern and flexible and provide more opportunities for young people to make a difference where they live and work.

Shishkina: Our projects are still popular with young people. First aid training is popular. Events 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 organizing workshops.

Tanevska: I know many cases where youth are really the main actors in the realization of



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We shouldn't interfere with the liberty of branches.



Davron Mukhamadiev:
Drug use is a grave humanitarian issue.



Valentina Shishkina:
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Sonja Tanevska:
There are many programmes where youth are the main actors.

gistered case 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 Tanevska, Regional Health Delegate, International Federation, Budapest: It is very important for National Societies to develop comprehensive plans and form partnerships 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 each of the programmes for 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?

Morzsanyi: There is a correlation between harm reduction and strategy. Prevention is a part of harm reduction, and what the Hungarian Red Cross does through the youth programme in more than 80 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.

Mukhamadiev: 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

Given the range of health and social problems, is the Red Cross/Red Crescent struggling to stay focused?

Morzsanyi: I think this is a fundamental question for today's Red Cross. Problems may be different from one branch to another. I am quite confident that the answers given at local level are appropriate because they are the ones who know the specific problems and their own capacity. At headquarters level we should not interfere with the liberty of the branches. There is a danger of doing too many things and not focusing. We have many programmes in social welfare and health. They are justified; there is a need for them and we have the capacity to do them. But a better focus and a better concept of how to identify the most relevant would be beneficial.

Mukhamadiev: Since 1999 the Red Crescent has paid a lot of attention to health issues. Community-based activities include health promotion and first aid implemented by branches. Every year we train more than 2000 rural volunteers. Prevention of TB and HIV/AIDS through education and awareness campaigns and community-based health promotion (including water and sanitation) are our main priorities.

Shishkina: Our priority groups are defined in our strategic plans. In Russia like elsewhere the Red Cross now really has to select the

health and care projects. The Romanian Red Cross TB project, for example, and the Macedonian Red Cross drug prevention project, or the Albanian Red Cross TB/HIV prevention project, and 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?

Morzsanyi: 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.

Mukhamadiev: I 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 understand 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.

Tanevska: Agreements among national society leaders to put greater efforts into health and care programmes. ■

Round and About

Kiev

9th ERNA meeting applauds harm reduction work

Many governments in this region don't realize we simply have to work with drug addicts,' 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 discussing 'harm reduction': counselling 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 in the advocacy battle to promote harm reduction was 'grabbing governments by the lapels'.

Lynette Lowndes, head of the International Federation's Europe department, told delegates the

single most moving experience she'd had in the region was 'going round Irkutsk in Siberia with Anna Zagainova and her colleagues from the Russian Red Cross while they distributed clean needles to sex workers.' Irkutsk is the only place in the Russian Federation where the Russian Red Cross does needle exchange; there is also a project for HIV prevention through peer education in Krasnodar.

Zagainova, a 20-year Red Cross veteran and the manager of the Red Cross harm reduction programme in Irkutsk, told *The Bridge* cheap heroin from 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 transmitting 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 city 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 bipartisan 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 delegates. But in Britain the prevalence 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 'pursuing governments' on harm reduction 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'; another concluded harm reduction for the Red Cross/Red Crescent was 'possible but difficult'.

The ERNA meeting, its ninth, was hosted by the Ukrainian Red Cross. ■ AW



ERNA delegate and local hero. Anna Zagainova, Russian Red Cross, Irkutsk. Photo: AW/IFRC

Bulgaria

'Solitude is the worst disease'

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 meagre 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 house-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 Mauerhofer, Swiss Red Cross



Nurse and patient, Bulgaria. Photo: Patricia Mauerhofer/Swiss Red Cross

Kosovo

Health education for Roma

They are a forgotten footnote to a conflict largely forgotten by the outside world: Kosovo's Roma, who fled their homes during 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, limiting access to employment, health-care and education even more severely than usual.

Since 1999, the local Red Cross, the ICRC, KFOR, Caritas Kosovo, the Voice of Roma and other NGOs and UN agencies have been supporting Roma people with food and other aid in camps like Zitkovac, Cesmin Lug and Kablar.

But specialist Roma groups say the international community has largely failed the most vulnerable members of Europe's most vulnerable 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 squalor 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 theory, 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 symbolize Kosovo's ethnic divisions, 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), possibly many more.

Hundreds of Roma have been living next to a disused but still contaminated lead smelter 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 programmes as much as humanitarian relief.

It's hard to know where to break into the cycle of poverty, poor health, lack of education and discrimination 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



Roma camp, northern Kosovo. Photo: Shpend Emin/IFRC



Continued from page 1

*The main lesson
the African experience
of TB/HIV holds
for Europe is that
professional synergy
in programme work
is possible.*

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, this is emphatically a time when, like the SARS outbreak, the world needs the World Health Organization, with which the International 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 2004 WHO published its 'interim policy on collaborative TB/HIV activities'. 'Interim' because of the research gaps in this field – centred above 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 within programmes for the other, although based on voluntary HIV testing.

The preventive 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 countries, according to WHO. (The diagnosis of TB still depends on microscope work with smears – a century-old technique – by skilled technicians.)

Co-trimoxazole therapy, which has been found to prevent several bacterial and parasitic infections in people living with HIV, would meanwhile be given to TB patients.

TB/HIV is a new area in terms of policy. According to de Colombani: 'Changing people's minds

in favour of internationally-agreed strategies is vital, both for TB and TB/HIV.'

De Colombani'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 better 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 strategy for TB,' he says, 'but we still face problems because of resistance in some countries from doctors and administrators who cling to the old Soviet 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 priority' for both – Russia, Belarus, Estonia, Latvia, Lithuania, Moldova and Ukraine – are former Soviet republics.

The International Federation has been combining its TB and HIV/AIDS programmes in Eastern Europe for several years now. And the ongoing Russian TB programme includes 'heavy HIV/AIDS component', according to programme officers in Moscow and Geneva.

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

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

Professor Peter Godfrey-Faussett, 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 programmes have traditionally come from different perspectives. Or as the report on the Addis meeting put it: 'TB programmes are from Mars, HIV programmes are from Venus.'

'But the main lesson Europe might take from the African experience,' says Godfrey-Faussett, is that 'there is huge synergy that emerges when the two sets of professionals get round the table and work out what they're trying to achieve.'

This may be what has started to happen in Russia, where a coordinating body for TB/HIV, including the ministries of health and justice, WHO, the International Federation's Moscow delegation and the development NGO Globus, held its first meeting in September.

In some areas, Russian doctors were beginning to be at least neutral between optimism and pessimism about TB. 'The situation has stabilized – no more,' says Dr Bonchuk Stefanovich, chief physician at the regional TB dispensary in Belgorod. '1997 was a turning point, but we are still not back to the pre-1991 situation.'

Drug resistance, as ever, is the big fear. Dr Stefanovich added: 'If out-patients drop out of their course, someone will try to fetch them. But this is difficult work. The law provides for mandatory treatment, but there's no real practical mechanism for it.'

Historic popular ambivalence about TB in Russia – that it got 'treated in the spring and forgotten in winter,' as one health worker put it – has always been a hurdle. Co-infection, and the threat TB poses to the ever-growing number of people living with HIV in countries like Russia, Estonia and Latvia, will concentrate minds anew. ■

Alex Wynter is co-editor of *The Bridge*



Letter from Brussels

Luc Henskens, Nathalie Marchioro-Holzer

Health in the new EU



Here's a question: if just over 60 per cent of pre-enlargement EU National Societies do fieldwork in the battle against HIV/AIDS, what proportion of the 2004 EU joiners do?

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 represented 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 we got responses from eight accession and twelve pre-enlargement EU National Societies.

The findings update a similar health-activity mapping exercise from 2002.

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

First aid and blood donation are still the leading common denominators in health among National Societies across the EU. But expanded investment in psycho-social 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 nutritional aid', organised voluntary blood donations and trained for emergency preparedness, compared to between half and just over half of the pre-enlargement group.

On the other hand, many more of the pre-enlargement National Societies ran programmes to integrate refugees and asylum seekers (migration in the EU is still overwhelmingly westward) or maintained visiting services, compared to the new members.

Four new EU National Societies applied for funds from the European Commission in the past year and three were successful. But six wanted also more information on funding opportunities in Brussels. The questionnaire – which has generated up-to-date contact details and information on relevant field of activities for each National Society – will help us to plug these gaps.

The 2007–2013 Health and Consumer Protection Programme, for example, could provide National Societies with a programme funding source.

Complete well-being

The 1946 constitution of the World Health Organization (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' We asked National Societies to choose between that and the public health definition: 'the health of a population, the sanitation situation of a community, the general sanitary services and the administration of care services.'

All but one (the Swedes) of the pre-enlargement National Societies opted for WHO's holistic definition; five of the new members chose the public health definition. (The Slovenian Red

Cross wanted to use both and the Latvian Red Cross chose a different one altogether.) The Red Cross/EU Office will examine this definitional question in some detail. 'Health' is less easily defined than might be first thought.

Asked what they saw as the main challenges 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 developments, family, mental health, drugs and lifestyle. All these issues have been listed by the European Commission as priorities and should be included in the next Health and Consumer Protection Programme.

13 'old' EU National Societies (the Austrian, Belgian, British, Danish, Finnish, French, German, Hellenic, Italian, Luxembourg, Netherlands, Spanish and Swedish Red Cross) responded to our questionnaire, as did eight 'new' EU ones (the Czech, Estonian, Hungarian, Latvian, Lithuanian, Polish, Slovak and Slovenian Red Cross).

We hope the mapping exercise will be a good starting point for National Societies to develop partnerships with others 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 Marchioro-Holzer is its Programme Officer for health.

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