



ARE WE LOSING THE TB BATTLE?

South Africa's tuberculosis treatment success lags 14% behind 2 other HIV-ravaged countries, Kenya and Tanzania, leading to the 'inescapable conclusion' that we need to examine the performance of our own systems instead of blaming HIV.

This is the opinion of Dr Lindiwe Mvusi, Director of South Africa's national TB control programme.

Mvusi told *Izindaba* that although the national health department's TB detection rates compared favourably with those in Kenya and Tanzania, local treatment efficacy needed boosting in nearly every province.

In spite of far fewer resources and less sophistication, Kenya and Tanzania were outperforming us 'by doing the basics correctly', and having small laboratory rooms for TB smear microscopy at virtually every clinic. 'That enables them to diagnose then and there and start DOTS immediately by connecting the patient with a person in their community,' Mvusi explained.

Not even close

South Africa does not have smear microscopy in clinics and relies on the National Health Laboratory Service for providing this service from district hospitals upwards.

Mvusi put recent improved detection down to improved TB awareness among both health care staff and the general population.

One-quarter of a million South Africans were diagnosed with TB in 2003 (latest available statistics and double where it was 5 years ago), with an average increase of some 31 000 cases every year.

According to the latest Stats-SA Mortality and Causes of Death figures, TB moved from being the leading cause of death in 4 provinces in 1997 through being the leading cause of death in all 9 provinces in 1999 to being the leading

cause of death in 7 provinces in 2001 (second leading cause of death in Limpopo and the Free State).

Mvusi said that with 68% of the country's new smear-positive TB patients successfully completing treatment, 7% of the remainder dying and 12% defaulting, South Africa was 'not even close' to its targeted cure rate of 85%. A further 14% of patients transferred to other health facilities and their treatment outcome was unknown. These included many public hospital and private sector patients and those treated by some mines, the military and Correctional Services.

'Once we get a handle on these, the statistics will surely take a further upward jump — without a change in actual incidence,' Mvusi said.

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Swallowing a bitter pill

Kenya and Tanzania's TB treatment success rates stood at 80% and 81% while their HIV-positive prevalence rates stand at 6.7% and 8.8%, respectively. South Africa's HIV-positive prevalence was 29.7% last year.

The South African health department puts the rate of HIV co-infection at 55% of all TB patients and with steep increases in HIV prevalence in the mid-90s, greatly increasing numbers of people are presenting with severely compromised immunity.

Mvusi believes that patient compliance, while lying at the heart of



Dr Lindiwe Mvusi, South Africa's national tuberculosis control programme director.

successful treatment, is 'an oversimplification', because several systemic preconditions implied by DOTS need to be met first to allow patients to play their part effectively.

Compliance secondary to...

These preconditions included government committing sufficient human and financial resources, improved access to quality-assured TB sputum microscopy, special attention for case detection among HIV-infected people and other high-risk groups, standardised short-course chemotherapy with socially supportive treatment services including DOTS, and uninterrupted quality-assured anti-TB drugs with reliable drug procurement and distribution systems, plus recording and reporting systems that allowed for individual patient and overall programme assessment.

Mvusi warned that while '99.5%' of sub-districts had adopted and implemented the community-based treatment approach, general weaknesses in the primary health care system had led to the DOTS programme regressing in many.



Labs and staff the keys

Inadequate decentralisation of laboratory services meant turnaround time on smear microscopy tests varied from 2 days to 2 weeks (the Eastern Cape and Limpopo tending towards 2 weeks). This sent 'the wrong signal' to patients, while a shortage of health care professionals and high turnover of voluntary treatment supporters had undermined the quality of crucial face-to-face communication.

Few patients receive a thorough explanation of their treatment or the implications of interrupting it, simply because nurses faced too much pressure and could not afford the time this took.

Volunteers on the other hand tended to 'drop out' because their activity was unremunerated, often under-recognised and under-supervised. 'They just feel oppressed by the insoluble problems of poverty that their patients carry,' Mvusi observed.

Only the Free State had a database of all community health workers and managers, enabling their activities, geographical location and stipend payments to be mapped, thus preventing duplication with NGOs and better resource distribution. This had made the Free State the second most successful province for TB treatment after the Western Cape.

NGO/government 'apartheid'

Weak links between NGOs and government clinics were a source of serious concern.



The TB ward at Tugela Ferry Hospital.

'In most areas NGOs do their own thing and health authorities are not even aware they're there – much closer collaboration is required between district managements and facility managers just to set out terms of reference, reporting mechanisms and indicators.'

While TB was part of the government's mass media campaign on HIV and AIDS (*Khomanani*), it received relatively low priority at just 4% of the R106-million *Khomanani* budget between 2001 and 2004.

Mvusi said the only other major media project to deal with TB was Soul City.

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Unsurprisingly, while there was a high public awareness of TB (> 90%), knowledge of symptoms remained quite low. Only 65% of respondents in 2 *Khomanani* surveys identified a persistent cough as symptomatic.

Mvusi believes this shows that the public's grasp of treatment is 'even more limited'.

'In short, the public health sector has developed a basic technical ability to manage TB at primary health care level countrywide, but has not created a patient-friendly and supportive service – despite TB being a condition that cries out for these qualities.'

A study done by the MRC and US Centers for Disease Control and prevention had identified the main risk factors for treatment default as:

- the quality of the relationship between patient and service provider
- substance use during treatment



- socio-economic factors
- perceptions about the effects and side-effects of treatment.

Mvusi said these highlighted a need to strengthen health system support for patients and their families. 'We need to sensitise health workers to the weight of social factors in determining treatment outcomes and improve communication with patients. Treatment support must be conducted in a way that patients feel empowered rather than policed,' she said.

Hope for staffing crisis?

Mvusi is pinning much of her hope for creating laboratories at the most far-flung clinics on the new mid-level health worker category currently being legislated for.

The mid-level worker laws will probably only be finalised in the 2006/7 financial year, meaning candidates would still need to be trained.

The delay will have far-reaching effects in a TB fight in which more than 55% of the 125 000 known TB cases were attributed to HIV infection last year (SA National Tuberculosis Association (SANTA) figures). Mvusi said the comparable figure in KwaZulu-Natal stood at 60%.

Chris Bateman