



ZIMBABWE MELTDOWN FUELLING MDRTB?



'Margaret' (surname unknown), 11, a TB patient at the NGO-supported Mashambanzou Clinic in Zimbabwe that started life as a paediatric palliative care unit and now helps 80% of its children get onto TB or ARV drugs – though adherence is pitiful and getting worse.

Zimbabwe, with an estimated HIV prevalence rate of 18.1%, currently has 6 times the number of TB cases than it did 20 years ago when its leading TB NGO declared the war on TB to have been 'won'.

According to the latest World Health Organization (WHO) data, Zimbabwe has the lowest treatment success rate among all the high-burden TB countries, with just over half of all cases successfully treated.

This emerged at last November's International Conference on TB and Lung Disease in Cape Town where the need for collaboration between TB and HIV prevention and treatment programmes was repeatedly emphasised by the world's top TB experts.

Zimbabwe, on the verge of economic meltdown with its health system in tatters, has just one laboratory able to carry out key bacterial culture and drug sensitivity tests, resulting in massive under-diagnosing and/or inappropriate treatment.

Says Ellen Ndimande of the Zimbabwe Association for the Rehabilitation and Prevention of Tuberculosis (RAPT), 'From 1954 we had an increasingly successful fight against TB but the past few years have shown us that the disease has re-emerged to become the number one killer of people with HIV'.

Progressive attitudes of little help

Unlike neighbouring South Africa, Zimbabwe declared HIV a national emergency in 2002 and its Minister of Health and Child Welfare, David Parirenyatwa, actually admits that not enough has been done to tackle the growing threat. He told Partners Zimbabwe, an affiliation of civil society stakeholders formed to respond more effectively to HIV/AIDS, TB and related health issues, 'we have not done enough to address TB ... the focus on HIV has largely driven our attention from TB and this is something we must redress as a matter of urgency'.

Parirenyatwa said his country had recently launched the fixed-dose combination for TB treatment which would make it easier for the uptake of drugs and adherence, but 'much more work needs to be done to integrate TB and HIV'. He said his ministry needed 'to push up the management systems' in order to have appropriate advocacy on TB. Little is known about how big a problem drug-resistant TB is in Zimbabwe, although conditions appear to be ideal for multidrug-resistant (MDR) forms to flourish.

World's lowest treatment success rate

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Without a complete course of antibiotics, the remainder stand a good chance of TB recurring in a drug-resistant form. This can only worsen as current fuel shortages dramatically cut transport options, making trips to clinics and, as a result, TB drug adherence, even more difficult.

Indicators of health care system failure include a maternal mortality ratio that exceeds 550 per 100 000 and a 50% rise in under-5 mortality since 1990.

Paradoxically, sky-rocketing inflation has made migration to neighbouring countries for work even more frenetic. Porous borders between Zimbabwe and South Africa provide a convenient gateway for drug-resistant TB to take the same path.

Lynde Francis, director of The Centre, a community-based care facility in Harare, said, 'we're sure that we are seeing MDRTB, but because there is no laboratory that can do the culture or sensitivity tests we don't have the evidence to prove it'.

'The government is saying that because we do not have any drugs for TB patients there is no point in testing for MDRTB,' she added. One result of this lack of support and information was that people with TB were beginning to face virtually the same social stigma as people with HIV, Francis said.

Many now believed that a positive TB test automatically meant you were HIV positive as well, 'and so they are



avoiding even getting tested,' she said.

Diagnosis, management and treatment of TB in Zimbabwe, particularly among people living with HIV (PLHIV), could not be improved without significant increases in and acceleration of investments in services, as well as in patient literacy about TB.

In June 2005, a proposal to strengthen the national TB control programme was submitted to the 5th round of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Enhanced TB programme just begun

A year-and-a-half later, the grant agreement was signed (December 2006), and today about one-third of the R82 million (~ US\$ 12 million) funds has reached the country and implementation is just commencing.

One phenomenon that has slightly mitigated the twin pandemics in Zimbabwe has been some community participation in home-based care (HBC), particularly around HIV/AIDS. However, with TB now the leading cause of death among PLHIV, lack of TB knowledge among these front-line caregivers is rendering them increasingly desperate. Approximately 60% of all new TB cases among Zimbabweans aged 15 - 49 years occur in HIV-positive people.

The low levels of community involvement in TB treatment and prevention were attributed by Partners Zimbabwe to state policies that place the responsibility for this solely in the hands of government. The organisation said the acute shortage of drugs and medical staff in the country was compromising TB programmes 'at a time when we cannot afford to make mistakes'. An audit of the HBC providers in Zimbabwe reveals that they are better equipped to tackle TB than the government.

Given the opportunity, HBC programmes could perform better, or at least complement government's efforts towards responding to TB. A Partners'

spokesperson said HBC programmes could help with TB identification and treatment and help ensure adherence.

The organisations could also act as hubs for drug distribution through a decentralised directly observed treatment short-course (DOTS) programme. 'This is critical, considering that public transport and hospitals are inaccessible to many people in the country,' she added. HIV/TB campaign co-ordination was urgently required among both policy makers and donors.

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'Often funding partners tell people implementing their programmes that their aid is only meant for PLHIV. This means that patients who have TB but have not yet been tested for HIV cannot benefit from HBC programmes.'

Success 'impossible' without integration

If policy makers and funders continued to remain impervious to the need to integrate responses to the two epidemics, 'we are going to fail,' she predicted.

The private health care sector's Population Services International (PSI) said that all new patients registered with their post-test support services were screened for TB via a questionnaire.

Dr Karin Hatzold of PSI said that if it was 'considered probable' that a patient had the disease, they were referred to a TB diagnostic centre for further clinical tests.

PSI is responsible for about 45% of voluntary counselling and testing services in Zimbabwe through its New Start centres.

About 14% of HIV-positive patients treated by PSI are being referred for further tests.

Observers say that the only possible way Zimbabwe can begin to make an impact on its twin pandemics is to 'task shift' – allow less-qualified health care workers to take on tasks usually managed by doctors and nurses. As it is, most health care institutions are run by medical interns and unregistered nurses. Junior doctors earn the equivalent of R300 per month.

Funding the fight against the twin pandemics remains one of the biggest challenges.

In 2006 the government budget allocated to addressing TB, HIV and MDRTB fell short by about R2.68 million (US\$0.4million). The lack of reliable TB and HIV data to support collaborative activities is another major stumbling block. Zimbabwe has no figures at all from 2005.

The WHO told Cape Town conference delegates that Zimbabwe's efforts to address the needs arising from widespread HIV/TB co-infection were 'still in the developmental stage'. A lack of integrated and speedy implementation would 'spell disaster,' the WHO spokesman warned.

Indicators of health care system failure include a maternal mortality ratio that exceeds 550 per 100 000 and a 50% rise in under-5 mortality since 1990. People requiring public sector hospitalisation must bring their own drips, IV fluids and needles. Vacancy rates at these institutions vary from 44% (nurses) to 89% (technicians).

Many of the urban poor among the 700 000 whose homes were destroyed in the infamous Operation Murambatsvina (drive out trash) have been unable to re-establish themselves on drug treatment after dispersal to remote areas outside Harare.

Chris Bateman