



RUNAWAY TB EPIDEMIC – CAN WE CATCH UP?



Professor Anton Stoltz, chief of the Foundation for Professional Development's (FPD) Infectious Diseases Unit and founder of the equivalent facility at Pretoria Academic Hospital.

South Africa is doing 'some things right' in combatting a runaway TB epidemic that may be 10 times greater than government estimates, but dismal infection control at health care facilities and inadequate basic directly observed treatment short-course strategy (DOTS) need emergency attention.

This was the warning sounded by Professor Anton Stoltz, chief of the Foundation for Professional Development's (FPD) Infectious Diseases Unit and founder of the equivalent facility at Pretoria Academic Hospital.

Addressing the opening session of the country's first TB conference in Durban in July, Stoltz said the impression he got from feedback received from FPD mentors sent to 37 government facilities was that there 'is virtually no infection control'.

'It seems that there's no proper infection control anywhere. It's a real problem. We don't have places that have negative pressure that you can put the patient in. It's blowing all over the hospital. We're sitting on a time bomb. If health care workers start getting ill from MDR, as some are, what are we going to do, given our human resources situation?' he asked.

The FPD allocates one or two doctors plus a data capturer and mentor to each of the 37 government HIV and/or TB clinics and hospitals, so Stoltz, who pores over their detailed reports, is not grasping his claims out of thin air, so to speak.

Scary number crunching

In an interview with *Izindaba* after the TB conference, Stoltz anxiously queried the official government TB statistics of 7 000 MDR TB sufferers, saying the World Health Organization (WHO) TB Partnership put this at 10 000.

'But what worries me far more is this global study that shows that 20% of all TB going into the labs is now MDR. If you do your arithmetic based on 1 in every 100 South Africans having TB, that's 90 000 MDR patients, over 10 times the official estimate!'

Stoltz emphasised that 'we just don't know the figures, but only certain people are being tested for MDR and XDR, so we're missing a huge number of these folk walking among us. That's very frightening to me'.

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South Africa was spending generously on its TB control programme with 70% of the budget going to MDR and XDR TB. However, only around 20% of the budget was being dedicated to the DOTS, aimed at ensuring that people with TB complete their treatment, thus reducing the chances of developing MDR TB.

It cost around R377 to treat (and cure) TB, compared with around R50 000 to cure MDR TB, if the patient survives.

A potent contributor to the high costs of treating TB is the difficulty in diagnosing it in people infected with HIV. 'We struggle to find TB in people with HIV and it's expensive,' Stoltz said.

South Africa's TB cure rate stands at about 57%. This would have to be improved 'dramatically' if the country wanted to make any meaningful impact on the epidemic.

Stoltz identified three priorities: increase the basic TB cure rate, rethink the DOTS strategy and dramatically increase infection control. He said that on the government's own admission there are no data on 27% of people who go through its TB clinics. 'They could be dead, cured or defaulting, but they could also have MDR TB!' he warned.

Monitoring and evaluation needed urgent improvement.

'Get the basics right'

'If I could send out one message it would be prevent, prevent and prevent ordinary TB. Then you don't have to spend so much money on MDR/XDR'.

He highlighted a recent probe by the Medical Research Council (MRC) into the main reasons people defaulted on their TB treatment which cited the attitude of health care workers. Patients were reluctant to return to the clinic and face widespread demeaning and/or dismissive attitudes.



Stoltz also recommended staggering clinic appointment times and improving 'down referrals' to avoid scores or hundreds of people sitting and standing around all day in often dark, unventilated waiting areas.

'We have over six million HIV-positive people – so we initiate treatment and within a month the person is back, adding to the others there for the first time. All our clinics just overflow, get clogged.'

'We have limitless resources of wind and sunshine in this country, I really don't understand why we're not using them,' he said.

Another largely underreported phenomenon impacting on DOTS and DOTS-plus was the large population of patients with HIV dementia which resulted in them simply not taking their pills.

What Government is doing right...

Some of the things the government was doing right included working with all medical schools to put final-year students into clinics to mitigate the staffing crisis, giving the FPD about R15 million over the past 18 months to educate TB, STI and ART clinic workers and committing to making the new rapid test for MDR TB available within the next few months. The WHO-approved test will enable laboratories to diagnose MDR TB within a day, and not the 2 - 3 months as was the case previously.

South Africa's top researchers, policy makers, managers and providers have meanwhile released the outcome of a round-table discussion last year where they grappled with ARV access and the health system's capacity to cope with burgeoning demand.

The report, authored by Helen Schneider, Dingie van Rensburg

and David Coetzee, contains the key findings and policy recommendations from the meeting which they hope will feed into the country's National Strategic Plan. One of the main insights was that most of the existing programmes are still to a large extent doctor and pharmacy dependent.

Participants felt strongly that integrating ART with HIV-related primary health care services, particularly with TB, the prevention of mother-to-child transmission and maternal and child health services within a district health system, remains critical.

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Stoltz said he understood the necessity for streamlining HIV and TB treatment on the grounds of efficacy but unless a grip was obtained on infection control, putting patients suffering from both diseases in one room was 'asking for trouble'.

Nine key lessons

In summary, nine key overall lessons and recommendations for policy arose from evidence presented at last year's think-tank:

1. Shift the focus of ART implementation from ART sites to district/sub-district-based approaches.
2. Mobilise and strengthen the existing PHC system by reviewing the composition, staffing and support systems of PHC teams.
3. Integrate HIV and TB care, and provide both as one service within PHC settings.

4. Focus on PMTCT, and integrate the programme into the treatment of children and pregnant women.
5. Address loss to follow-up by introducing services more widely spread across the system and by strengthening systems for tracing dropouts.
6. Build trust in the public health system, by seeing the system from the household and patient's perspective so as to better understand barriers to use of services.
7. Simplify and standardise approaches to implementation for patients, programme governors and local providers to promote better access and enhanced quality.
8. Strengthen prevention and the health system response to other diseases and build the PHC and district health system.
9. Improve dialogue among researchers, policy makers and service providers to promote the transfer of lessons, and to harmonise and simplify approaches.

The chair of the Durban TB conference and former head of TB control in the health department, Dr Refiloe Matji, said for too long stakeholders have been working in silos with the impact on the TB epidemic fragmented. 'We need to build one team, follow up with one plan, towards one goal,' he said.

Perhaps the mounting crisis will galvanise role players into transforming think-tanks into battle tanks in a consolidated push to gain ascendancy over the twin epidemics.

Chris Bateman