

South Africa

Overview of TB control system

TB control is said to be a priority for the DoH in South Africa. The DoH provides most of the TB services, having determined that diagnosis and treatment for TB should be free, helping to ensure access for all patients.

Surveillance, planning, operations

South Africa has an uncertain burden of TB and an erratic notification system. The case detection rate is unknown, but it is very unlikely to be 96% (see accompanying table). It is known that patients have been double-counted in quarterly reports because of the way in which transfers between treatment centres have been recorded, and because retreatment cases have been included among relapses. These problems have recently been remedied by procedural changes and re-training. A closer, retrospective analysis of suspects examined, and of notifications by province and by year could help to reconstruct a more reliable picture of the epidemic. Unfortunately, data on the number of suspects examined are not routinely collected to monitor case detection effort. The age distribution of smear-positive cases is characteristic of a population with a high rate of HIV infection among adults. Treatment success in the 2001 DOTS cohort was low (65%) because of the high rates of default (12%), death (7%), and transfer without follow-up (12%). Ten percent of patients completed treatment without evidence of smear conversion. More patients were registered for treatment in 2001 than were previously notified. A study to investigate the reasons why so many patients are lost to follow-up was reportedly underway in 2003.

The revised national TB control programme incorporating the DOTS strategy was first established in 1996, with the goal of extending TB control services to the whole country. To this end, a strategic plan for TB control from 2001–5 was developed and launched by the Minister of Health in 2002, and provincial plans were developed and signed by 7 of the 9 provinces. Provinces allocate funds to the districts, with TB funding as part of the overall primary care budget. Funding may be insufficient for some programme activities because budget allocation is not informed by the district plans. An NICC does not yet exist. A programme review took place in 2003.

TB control has been complicated

by the lack of political commitment in provinces following decentralization. However, the rapid increase in TB notification rates, coupled with high rates of HIV infection and the emergence of MDR-TB, have led central and provincial governments to identify joint TB and HIV/AIDS control as a priority.

A strategy for TB/HIV collaborative activities has been developed and implemented in 13 out of 183 sub-districts, and training programmes for joint control activities have been established in each province. There is no HIV surveillance system for TB patients (though an estimated 60% of adult TB patients are infected with HIV), and there are no plans to establish one, though

PROGRESS IN TB CONTROL IN SOUTH AFRICA

Indicators

• Treatment success 2001 cohort	65%
• DOTS detection rate, 2002	96%
• NTP budget available, 2003	NA
• Government contribution to NTP funding, including loans, 2003	NA
• Government contribution to total TB control costs, including loans, 2003	NA
• Government health spending used for TB, 2003	NA

Constraints to achieving targets

- Lack of sustained commitment to quality DOTS at some levels
- Insufficient staff and TB managers in districts and provinces
- Unequal access to laboratory services and poor quality data
- Failure to establish a uniform national recording and reporting system
- Poor coordination between TB/HIV activities
- Lack of private sector involvement in TB

Remedial actions needed

- Advocate to ensure political commitment
- Implement and closely monitor provincial TB plans, and provide support to poorly performing provinces
- Establish uniform recording and reporting system, and link resource distribution to requirements
- Improve staff capacity through management and supervision in districts and provinces
- Strengthen laboratory services through improved contractual arrangements
- Expand use of the Electronic TB Register to improve data quality at district level
- Strengthen coordination between TB and HIV/AIDS control and develop ART plan
- Develop PPM-DOTS plan

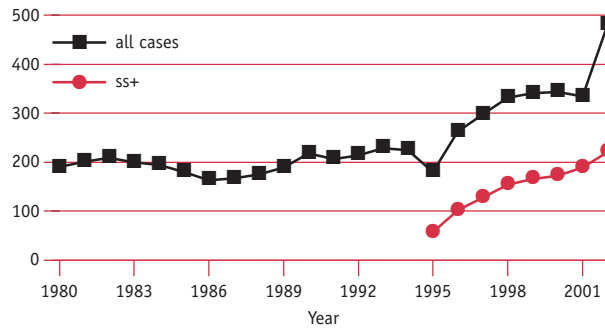
NA indicates not available

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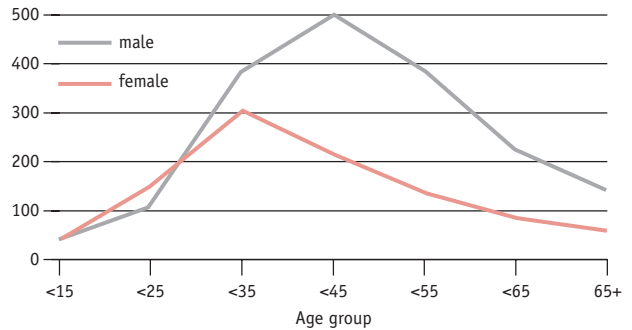
LATEST ESTIMATES ^a		TRENDS	1999	2000	2001	2002
Population	44 759 187	DOTS population coverage (%)	66	77	77	98
Global rank (by est. number of cases)	9	Notification rate (all cases/100 000 pop)	341	344	334	481
Incidence (all cases/100 000 pop)	558	Notification rate (new ss+/100 000 pop)	166	173	189	221
Incidence (new ss+/100 000 pop)	227	Detection of all cases (%)	75	71	64	86
Prevalence (ss+/100 000 pop)	192	Detection of new ss+ cases (%)	90	88	89	97
TB mortality per 100 000 pop	79	DOTS detection of new ss+ (%)	68	72	76	96
% of adult (15-49y) TB cases HIV+	60	DOTS detection of new ss+/coverage(%)	103	93	99	98
% of new cases multi-drug resistant	1.5	DOTS treatment success (new ss+, %)	60	66	65	—

Notification rate (per 100 000 pop)

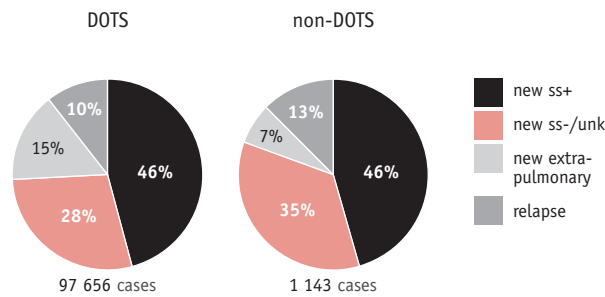
Notification (all cases) = 215 120 in 2002



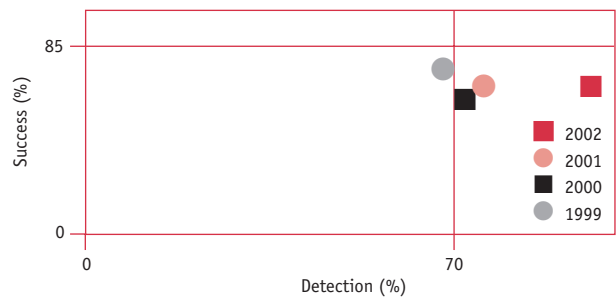
Notification rate by age and sex (new ss+)^b



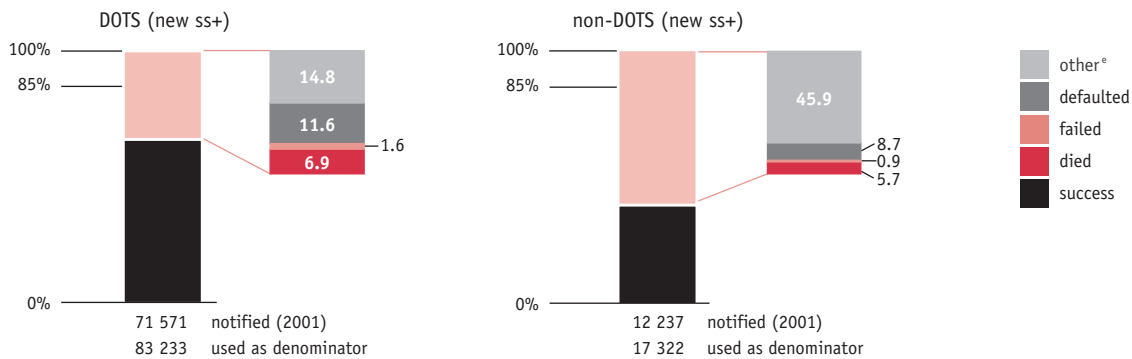
Case types notified^c



DOTS progress towards targets^d



Treatment outcomes^e



Notes

ss+ Indicates smear-positive; ss-, smear-negative; pop, population; unk, unknown.

^a See Methods for data sources.

^b The sum of cases notified by age and sex is less than the number of new smear-positive cases notified for some countries.

^c Non-DOTS is blank for countries which are 100% DOTS, or where no non-DOTS data were reported.

^d DOTS progress towards targets: DOTS detection rate for given year, DOTS success rate for cohort registered in previous year.

^e "Other" includes transfer out and not evaluated, still on treatment, and other unknown.

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voluntary counselling and testing are offered to TB patients. There is no plan, as yet, to involve the NTP in ART delivery.

Data on MDR-TB are collected within the framework of the WHO/IUATLD global project on anti-TB drug resistance surveillance. Drug susceptibility testing is routinely carried out for all retreatment cases, and a standardized treatment regimen is provided. Provincial surveys done in 2001–2 show MDR-TB rates of 0.9–2.6% among new patients, and 1.7–13.7% among previously treated patients. Each province has an MDR-TB treatment centre. As of October 2003, there were about 4000 MDR-TB patients on treatment with drugs costing an average of US\$ 3400 per patient. An application has not been made to the GLC for concessionally priced second-line drugs. The laboratory network is still underdeveloped in South Africa. A laboratory manual has been developed but not finalized.

Although DOTS now reaches 180 districts (98%), the quality of DOTS has deteriorated in some of the districts. Staff will be trained in management and supervision to improve performance. Health care workers in facilities are leaving their posts due to high work loads caused by understaffing or inequitable distribution of staff in some areas, and due to an increase in the number of TB patients infected with HIV. The deaths of health care workers from AIDS have

also reduced the work force. Salaried home-based caregivers are now being trained to provide treatment, and community health workers are being trained in the management of both TB and HIV patients. Plans for staff development were drawn up by some provincial departments of health. An inpatient care unit has been established at national level. Service agreements between the NHLS and the provinces have been developed, which should help to improve service provision.

The goals of the NTP now are to complete the expansion of DOTS, monitor the quality of DOTS, increase access to laboratory services, increase collaboration with NGO hospitals through the development of service agreements, and expand joint TB/HIV activities using funds from the GFATM.

Partnerships

National technical partnerships have been established through collaborations with NGOs, the university research community, and other government departments. IUATLD, KNCV, and WHO provide external technical support for TB control. DFID is assisting the programme with operational research and with strengthening services at the district level. CDC has helped to implement standard recording and reporting through development of the Electronic TB Register. KNCV helped develop the

2001–5 national plan for TB control. USAID, DFID, and the Government of Belgium provide financial support for NGOs involved in TB activities, training, research, and for collaboration between TB and HIV/AIDS programmes.

Budgets and expenditures

South Africa did not report financial data. The total budget for TB control is difficult to attain as budgets are largely decentralized and data are not available from all districts and provinces. Based on a recent costing analysis,¹ the total costs of TB control in South Africa were estimated at around US\$ 300 million in 2003.

While there is no dedicated national TB budget, the National Treasury provides funds for TB control along with several other health care programmes directly to Provincial Departments of Health through the Equity Share Grant for Health. Provincial Departments of Health generally make allocations to TB control based on financial data from the previous year and manage the overall health budgets that are accessed by district health management teams.

In 2003, the GFATM awarded US\$ 25.1 million for TB/HIV activities in South Africa, to be implemented primarily through NGOs. The budget for the first year is US\$ 1.5 million. However, funds have not yet been disbursed.

¹ Floyd K, Blanc L, Raviglione M, Lee J-W. Resources required for global tuberculosis control. *Science* 2002; 295:2040-2041