Background: TB in Namibia

- Government funded DR-TB programme commenced.
- Revised guidelines based in the 2008 Emergency Update of the Guidelines for the Programmatic Management of Drug-Resistant Tuberculosis issued; followed by development of comprehensive guidelines for the clinical management of DR-TB.
- Second-line anti-TB medicines were procured using government funding.
- WHO, CDC, The Union and KNCV provided technical assistance for trainings, case management and laboratory strengthening.
- Liquid culture was introduced in 2007 to accelerate diagnosis and to facilitate patient monitoring.
- Central level committee was established to advise on case management, and a medical officer for DR-TB was appointed.
- Health workers (including rehabilitation technicians, social workers and community DOT supporters) were trained on PMDT.
- A database of treatment regimens maintained at national level was introduced in 2010 to track the medicine utilisation at facility level.
- Health facilities were upgraded to improve TB infection control, focusing on health facilities that had been designated as DR-TB treatment sites.
- TB treatment delivered within the general health services with only health facility-based and community-based direct observation of treatment (DOT).
- The 2007 XDR-TB outbreak in neighbouring South Africa sparked public alarm.
- Routine DST intensified in the selected patient categories according to national guidelines.
- 116 MDR-TB cases were notified in 2007.

Response

- 1180 patients have been commenced on DR-TB treatment since 2008, with regimens being approved by a central level expert committee.
- The cases are concentrated in a few regions in central and northern Namibia.
- Hospital-based management failed in the nomadic San community due to sociocultural factors (a promising community-based treatment programme has since been established).
- Rapid staff turnover continues to undermine capacity building efforts.
- Outcome analyses for 2008 (221 patients) and 2009 cohorts (246 patients) revealed treatment success rates of 44% and 47% respectively.
- Default and death rates were very high in both cohorts, with marginally better treatment outcomes in HIV negative patients compared to TB/HIV patients.

Results

- Implementation of PMDT in a resource-limited setting is possible with government commitment, technical support and stakeholder engagement.
- Psychosocial patient support and local peculiarities in different patient populations should be addressed. PMDT should entail human resource development and retention; and strengthening the public health role of the laboratory. Factors associated with poor treatment outcomes, including TB/HIV co-infection, should be further investigated and addressed.

Conclusions and Recommendations

Implementational of PMDT in a limited resource setting is possible with government commitment, technical support and stakeholder engagement.

References


Acknowledgements

The Ministry of Health and Social Services acknowledges the support and contribution made by the following: United State Agency for International Development (USAID) through KNCV Tuberculosis Foundation; the Global Fund to fight AIDS, TB and Malaria (GFATM); the World Health Organisation (WHO); all the community based organisations and care providers in the field of TB and HIV; health care workers, and all our patients.