



## Interview with Saidi M. Egwaga about the fight against tuberculosis in Tanzania

**Dr. Egwaga, what do the «National Tuberculosis and Leprosy Programme» and you personally as its responsible leading officer expect from the latest tuberculosis information campaign?**

Egwaga: Firstly, we expect that people will be aware of the symptoms of tuberculosis and that we could motivate them to come early to the health facility for diagnosis and for treatment, where possible. The second part is to make people aware that the new services are available and that the new services free of charge. And lastly, our health workers must be prepared to receive an additional number of patients.

**How many more? Only one out of two cases of tuberculosis is diagnosed in Tanzania; WHO expected 70 percent back in 2005.**

It is difficult to predict. Maybe we will get 20 percent additional new cases reporting to the clinics.

**Meaning that the situation will improve in three districts only?**

Initially, yes, because the campaign is starting

in three districts. This is where we are gaining experience and observing the effect of social marketing methods. If we are successful, we plan to extend the campaign as far as our financial and human resources allow.

**Why do so many TB-patients remain undiagnosed and untreated? Is it lack of awareness, inaccessibility of diagnosis services or other reasons?**

A number of reasons: We know for instance that our health workers don't suspect tuberculosis at times. Sometimes patients may come up to five times before the right diagnosis is made. A second reason is lack of laboratory capacity to diagnose. We are using smear microscopy, which detects only 60 percent of the cases. The third point is that, unfortunately, half of our patients are infected by HIV. Immunodeficiency affects the symptoms of TB. Sufferers do not have a cough, for example, there is no sputum to examine in the microscope. This is from the health facilities' side...

**...and what about the patients?**

From the patients' point of view: Not all of them understand the symptoms. And sometimes when they have night sweats or a

persistent cough they don't come straight to the health facility, instead they go to the traditional healer, and there they get lost. Or when they come, it's just too late to help them.

### **What can be done to improve the health workers' commitment to TB treatment?**

First of all we have to give them the appropriate knowledge to know that TB is a big problem. We are already giving them refresher courses. The second part is to change their mindset, the way they must direct their patients. This is difficult.

Traditionally it has been: «I know, and you, as my patient, give me information.» Now it's supposed to be a dialogue, so that the patient can understand the duration of the long treatment. Because if he doesn't adhere to treatment there is a possibility of raising resistance - not only to TB but also to HIV drugs. And that is a big problem. We're all scared of that. Finally, I think we need to recognize the health workers' important role, by awarding them certificates of recognition. This will improve their spirits.

**In the past, Tanzania's tuberculosis program was perceived worldwide as exemplary. Now, it would appear, HIV/Aids have put paid to all that. It is surprising, therefore, that the fight against these so-called 'twin diseases' is not better coordinated.**

I must admit, until recently everybody was doing his business alone. Only some years ago we realised that we have two diseases but one patient. What we are now working on is called «TB/HIV collaborative activities». TB-patients who are in TB-clinics are screened for HIV after having agreed to be tested. If they are positive we are starting to provide all the treatment for HIV within the TB-clinic for the first six months. Then we transfer these patients to the HIV-clinics. We are also working with the HIV-group to change our documentation. We have columns for the patients' status and the HIV-treatment the patient is receiving.

### **How far does this approach reach?**

We started two years ago; two districts are already putting together the package I'm describing. We are now working on the additional districts to empower them to do that. I must also say, the process of setting up this type of TB- and HIV-service in one spot is a long one, in terms of first-hand knowledge and capacity-building, but even the infrastructure. Our TB-clinics were never designed to deal with all the issues around confidentiality, or issues around storage and security of the drugs, so we need to refurbish them. This is a long process, and within the government bureaucracy it takes time!

### **And the HIV-clinics? Are they ready to receive TB-patients?**

Yes, we are making sure that the HIV-clinics are able to screen for TB-patients, and do you know why? If you have a TB-patient who is positive in an HIV-clinic, he may infect all these patients, and because they are immunocompromised they can easily develop tuberculosis. In order to separate these patients who are, in a way, dangerous to the others, we take them back to the TB-clinic for treatment. But in the long run we want to use the same system at the community level to supervise these patients. If they have problems within the community they can be taken care of by the community-based care systems. We are setting up a national framework, what we call TB-HIV-National policy. I think, soon we're able to present a document, which will be the guiding star for all people, partners, government and the public who are going to implement TB and HIV-activities. I think we are moving, slowly but surely towards a collaborative activity.

### **What about sharing information?**

This is the last stage. We have computerized tuberculosis information. They are also working on the computerizing of the HIV information. The issue is, how can we link information from the tuberculosis to the HIV side, so that patients who have got both infections can be captured, and to avoid duplicating this information.

### **But this doesn't exist yet?**

It's something we're working towards.

### **There is likely to be an increase of resistance against the medication, which is in use these days. Are you prepared?**

Yes, indeed. We have resistance to anti-TB drugs on the horizon. Poor programs create this resistance. If you don't have a good program on the ground and patients are not properly supervised when they're taking their drugs, then you can create resistance. In response, we are strengthening the monitoring component of the treatment by introducing the patient-centered approach. It helps the patient to be supervised by a family member, and will, hopefully, increase compliance. The second point is that we've changed the type of drugs. We were using loose tablets, and the patients had to take up to twelve tablets every day. Now we have brought in fixed-dose combination drugs (FDCs), where we reduced the doses from twelve tablets to four tablets a day.

### **Is that all you can do?**

By and large, we're also strengthening our laboratories. We have weak laboratories; if there is resistance, we don't know. But I must rush to say that resistance in Tanzania is still low - less than one percent. We have done a nationwide survey on drug resistance, and we are now collaborating with institutions outside and inside the country to check for MDR-TB (Multidrug Resistant TB) and what we call Extremely Drug Resistant TB (XDR TB). We have engaged WHO and other partners to train people in management of MDR TB and we hope to bring second-line drugs into the country.

### **Why?**

Until now we have had only one line, we don't have second lines. So we are working at a package, strengthening laboratories, strengthening management, and finally we are trying to see if we can work with partners to improve what we call infection con-

trol. We need to protect our health workers through proper infection control, separating those who are infectious from those who are not infectious and making our patients aware. We must also screen for HIV among health workers, so that the HIV positives don't have to work in a TB ward. That is the direction we're taking.

**All these projects, not least the information campaigns, staff training, and the renovation of hospitals and laboratories, cost a lot of money. Up to 80 percent of your program, which deals with the fight against tuberculosis and leprosy as well as the HIV/Aids program, is funded by external sponsors.**

This is true, unfortunately. Money is a big problem. No question: we are reliant on outside help. At the same time, we must admit that the government is financing the overhead costs of our program, including the diagnosis and treatment of tuberculosis. When I started working for the NTLP ten years ago, we received just 7,000 dollars a year from the government. By now this figure has risen to two million. Although this still isn't enough, it must not be forgotten that other health problems exist, including malaria and Aids, for example. These are even bigger killers than tuberculosis.

**Nevertheless, this dependence on sponsors, who always cultivate their own interests, must be difficult to swallow over the longer term.**

Absolutely. But at the moment we cannot do without them. Contributions from international organizations, aid agencies and NGOs give us well-needed breathing space. The donation of state-of-the-art tuberculosis medication by Novartis, set initially for a period of five years, will allow us to secure the treatment of several hundred thousand patients and give them the choice of being treated where they would like. We are very grateful for this.

**However, project-based support is losing favor. Under the motto of good governance,**

**donors are switching to budget aid.  
Governments shall decide independently  
how they deploy their funds effectively.**

This is also the case with us, which is why we've started to add up the total amount spent on fighting tuberculosis. With a view to drafting a medium-term financial plan, we want to be able to show the government exactly what our needs are. No doubt the government will continue with its commitment, which has already proved to be successful in the past.

*Interview: Jürg Bürgi*

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Saidi M. Egwaga, 54, is head of the National Tuberculosis and Leprosy Programme in Tanzania. After completing his medical training, Mr. Egwaga has developed a career as an expert in public health. After holding a position as a district physician, he went on to manage a regional Aids program before being appointed regional coordinator. At the end of the 1980s he returned to university and completed a doctorate in epidemiology with a pioneer project concerning the integrated management of childhood illness (IMCI).