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Independent observer of the Global Fund

First Shipment of Drugs to Treat MDR-TB in Somalia Expected to Arrive Soon, PR Says

Somalia has a major burden of multi-drug-resistant TB (MDR-TB), rivalling that of the most-affected countries in Asia. According to World Vision International Somalia (WVI-S), principal recipient (PR) for the Global Fund's TB grants in Somalia, the first shipment of medicines to treat MDR-TB is expected to arrive this month.

Among the cases of TB in Somalia that have not responded to treatment (and so became "retreatment" cases), 40.8% are reported as being MDR-TB. Among new cases, the rate is 5.2%. These rates translate into about 500 cases of MDR-TB a year among all TB cases. The real rate is certainly much higher. (In comparison, the MDR-TB retreatment rate in Kenya is estimated to be 10%.)

Somalia has been unstable for over 20 years, ever since the collapse of the central government following the overthrow of the late president Said Barre. One of the first institutional casualties of the instability was the collapse of the health system.

TB in Somalia is an old problem. Poverty, living in crowded family homesteads, the abundance of dust and smoke, and poor health care have all contributed to creating high TB prevalence. Many (if not most) families in Somalia have some experience of TB.

A sign of how ubiquitous and well known TB is in Somalia is how the TB programme was accepted by different warring factions, and patients were allowed to cross between zones controlled by different groups when the violence in Somalia was at its peak. Both sides knew relatives who needed treatment, so the patients were allowed to cross over.

An almost entirely unregulated private “health” sector in the south of Somalia has led to widespread mistreatment, poor treatment or non-treatment. It is very easy to set up a clinic or a pharmacy, and the government has few resources (a) to decide if someone has qualifications to run it; or (b) to check on the stock of medicines that are being handed out. However, this is likely to change in future as health authorities impose controls.

The MDR-TB has emerged from a long history of broken treatment regimens – caused by a combination of stocks out, slow diagnosis and poor adherence. These factors have been fuelled by a collapsed health care system in the 1990s, followed by the mushrooming of private and unregulated clinics in many parts of the country during the years of conflict.

The figure of 10.2% MDR-TB overall rate comes from a drug resistance study led by the World Health Organization (WHO) and WVI, published in March 2013. It appears that it was only after this study became available that the WHO’s Green Light Committee had the information it needed to approve MDR-TB medicines for Somalia.

According to Dr Vianney Rusagara, the Global Fund Programme Director at WVI-S, the details of known MDR-TB patients from the study and diagnoses of MDR-TB using GeneXpert are being mapped now, and new treatment targets are being set. Currently, little is known about where the TB and MDR-TB cases are. What is known is that the disease knows no regional boundaries, and is not primarily found in any one religious group or community. It is not known whether TB and MDR-TB is primarily a rural or an urban problem; the disease appears to be everywhere.

Dr Rusagara said that, initially, there will be sufficient resources to treat about 60 patients per year. However, he said, being able to treat more than 250 patients a year would have a much more significant impact on the epidemic. Treating a patient for MDR-TB requires a considerable investment, not only for the medicines, but also for adherence programmes and patient follow-up. The costs are even higher in an unstable environment like the one in Somalia.

Dr Rusagara said that WVI-S and the government authorities will be looking for more money for the TB programme for 2014. Preparation has begun for a Phase 2 application to Global Fund; the major focus will be on treating more MDR-TB patients. (Somalia has received Global Fund support for its TB programme from Round 3, 7 and 10.)

The funding proposals were all in the non-CCM category, as there is no CCM in Somalia. In the absence of a CCM, the Somalia Health Sector Committee provides oversight. The sub-recipients for the grants include 12 International NGOs, 10 local or regional NGOs and two UN agencies.

“World Vision works with other partners to implement the grant,” Dr Rusagara said. “They include the WHO, which provides TB training, storage of supplies and distribution; and Comitato Collaborazione Medica, an Italian NGO, which provides supervision and M&E services jointly with national TB programme staff who also provide links with the Ministry of Health.”

Dr Rusagara said that the TB grants from the Global Fund have enabled Somalia to make great progress in tackling TB. However, he added, there is still much more to do. “At the beginning of Round 3, there were 37 TB treatment facilities and now there are 64 facilities, ranging from TB management units to large TB hospitals,” Dr Rusagara said.

Dr Rusagara added that the average treatment success rate for TB in Somalia through the facilities funded by the Global Fund and other partners has been about 89% over the last seven years. This is considered excellent, particularly for a conflict area.

However, it is estimated that at least half of all people with active TB do not seek care in the public health sector clinics. These patients, who may self-diagnose, seek treatment at private clinics or pharmacies without having had a proper diagnosis. Some of the private clinics and pharmacies experience stock-outs, and many fail to educate their clients on treatment protocols. In some cases, their medicines are substandard. This may explain the high prevalence of MDR-TB in the retreatment cases. In one instance, it was also found that “the drugs sampled and tested from some of the open-market sites showed low bio-availability for both rifampicin and isoniazid. This certainly contributes to resistance,” Dr Rusagara said.

Because of the high prevalence of MDR-TB, plans have been drawn up to control the disease. Treatment protocols and guidelines have been developed, as have recording and reporting tools. Staff at facilities have been trained to manage MDR-TB.

“A total of 66 staff has now been trained or retrained on MDR-TB management,” Dr Rusagara said. “An admission ward in Hargeisa for MDR TB was renovated and plans for referral are in place, while patient follow-up plans are being finalised.”

In addition, a culture laboratory has been established in Hargeisa. Plans have been put in place to monitor MDR-TB – including through drug sensitivity testing to be conducted outside Somalia. External quality assurance for laboratories is being performed.

Other strategies are also being used to increase awareness of the need for people to seek treatment from the public health sector clinics. As well, there is considerable pressure on the Somali authorities to ban the sale of anti-TB medicines in private pharmacies. Somaliland and Puntland, two of the regions in Somalia, have formal bans in place, but enforcing them is a challenge. In addition, the TB programme is also working with the private sector to promote referrals to the public clinics.

“The response has picked some momentum, but it has a long way to go,” Dr Rusagara said.

This article was amended on 10 July to incorporate some clarifications received after the article was first posted.

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