



Decentralization of Programmatic Management of Drug-Resistant Tuberculosis (PMDT) Services in Nigeria: Lessons learnt

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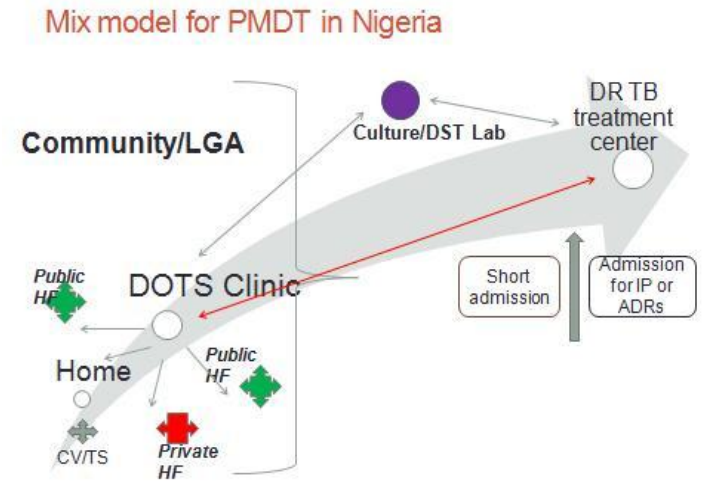
Background

With a MDR-TB prevalence of 2.9% among new TB cases and 14.3% among previously treated TB cases; Nigeria is among the high drug-resistant TB (DR-TB) burden countries. The introduction of GeneXpert MTB Rif testing has led to an increase in the number of rifampicin-resistant TB cases requiring treatment for DR-TB. There are only 10 DR-TB treatment sites with less than 300-bed capacity resulting in waiting list and patient's refusal for admissions in facilities outside their states. The objective of the study is to describe the lessons learnt and challenges from decentralization of PMDT to community.

Methodology

The national PMDT guideline was revised to adapt a mixed model of care with clear criteria for: 1) A 3-month hospitalization during the intensive phase; 2) Enrolment on treatment within the community; 3) An 8-month hospitalization throughout the intensive phase. Capacity building for state teams on all the 3 models was done in 8 selected states for phased implementation.



Results

A total of 91 health care providers were trained from the 8 states. 72 DR-TB patients were admitted under the mixed model for a shorter duration of 3 months during the intensive phase (M:51; F: 21) in 2 batches of 47 and 25 patients respectively. 61.6% of the patients were in the age group 25-44 years; 87.7% had documented HIV status, of which 78.6 % were HIV negative. All 47 in the first batch where discharged after 3 months of the intensive phase with negative sputum smear results & the 25 patients are awaiting discharge. Currently, 24 patients have been enrolled primarily for treatment in the community.

Challenges: Delay in completion of all the base-line investigations for patients primarily enrolled at community level; documentation of follow-up lab results especially culture; lack of effective monitoring and treatment f Adverse Drug Reactionss.

Conclusion

Ambulatory/community PMDT is feasible. Capacity building, logistic support for patient's daily transport for DOT, quality supervision and patient review by consilium, and sample transport/result retrieval from culture DST labs are all important for success.