

Shortfalls identified in the management of tuberculosis for Mozambican patients obtaining health care services in Malawi

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Summary

We report findings of a pilot qualitative study in which we aimed to determine management gaps among TB patients from Mozambique obtaining health care services in Malawi. The study was conducted between April and May 2002 involved twelve health workers and 4 Mozambican patients. Semi-structured questionnaires were used and responses were followed up with in-depth interviews. Several areas of management gaps were identified. These included; language

barrier if patients are formally referred with documents in Portuguese; lack of follow-up system in case of patients defaulting; no structured contact-tracing possibilities and no initiation of Isoniazid prophylaxis in the case of children living in households with a sputum smear positive adult case. We conclude that logistical management gaps exist in the management of TB patients from Mozambique obtaining care in Malawian health care facilities.

Introduction

The tuberculosis (TB) problem has increased over the past decade in sub-Saharan Africa mostly due to the HIV/AIDS pandemic^{1,3}. For instance, 20,630 new TB cases were notified to the Malawi National Tuberculosis Control Program (NTP) in 1996, a fourfold increase since 1986⁴. Malawi's TB treatment is now decentralized to health centers and community level using the directly observed therapy (DOTS)^{5,6}. This means that most administrative roles are carried out at the local level. Each treatment health facility has a TB Officer or TB Assistant (who may be a Health Surveillance Assistant) who reports to the District TB Officer (DTO). The DTO reports to the Zone Officer supervised by the NTP. The NTP acts as a policy formulating body, and conducts periodic supervisory visits and operational research.

In 2001, a network of researchers and civil society organizations formed the Malawi-Mozambique-Zambia International Diseases Surveillance (MMZ-IDS). The network was established in order to present a coordinated front towards cross-border diseases prevention and control and is headquartered in Lusaka, Zambia. As part of ongoing research activities, we conducted this pilot study to document management gaps pertaining to the care of Mozambican patients obtaining care in Malawian health facilities.

Methods

A qualitative study was conducted between April-May 2002 in Mulanje, Mwanza and at Blantyre Adventist Hospital (BAH). Twelve health care workers involved in the management of TB patients were interviewed and 4 Mozambican patients obtaining care in Malawi were also interviewed. Responses were followed up to obtain in-depth information. We aimed to obtain the following information; the language of communication used by Mozambicans in Malawi, the mode of referral, areas from which Mozambicans who come to Malawi for care come from and reasons why people come to Malawi for care. With particular reference to TB, the following information was sought; sources of TB

health education information, procedures for contact tracing and whether there was isoniazid prophylaxis provided to children of smear-positive Mozambican TB cases who obtain care in Malawi. Data were recorded and categorized based on themes.

Results

Mozambican TB patients obtain care in Malawi as outpatients and inpatients in Mulanje, Mwanza District Health Zones and at Blantyre Adventist Hospital, (BAH). Patients speak *Nyanja*, *Sena*, *Nyungwe* and Portuguese, with the three local languages being understood by most health workers on the Malawian side. Mozambicans attend Malawian health facilities either as their primary care level or as referrals, being both self-referrals and health worker referred. With regard to those individuals formally referral, their documents were in Portuguese, a language that all the health workers interviewed could not read nor write.

Patients reported preference towards Malawian health facilities because they believed that the nearest health care facilities in Mozambique are poorly resourced. Attendance at health centers in Mozambique is at a consultation is at a fee equivalent to US\$ 0.30 and drug costs. Obstetric, child, chronic illnesses and individuals who have certification from government that they are too poor to pay are exempted. Patients at BAH pay similar charges as would be required of a Malawian.

Mozambican patients are registered separately in Mwanza District but not in Mulanje and at BAH. This was due to the fact that in Mwanza, the TB program had been registering high default rates when both Malawian and Mozambican patients were in the same register. Health workers in Mwanza perceived Mozambican patients as likely to default than Malawians. However in Mulanje and at the BAH, health workers did not perceive Mozambican patients as different to Malawian with regard to adherence to treatment regimens.

In the event that a patient does not present to the health facility for further treatment, health workers reported non-uniform treatment between Malawian and Mozambican patients. Generally, there was no systematic follow-up of patients in their

communities for Mozambicans. Exceptions were however when the patient was a well-known government official working for the uniformed services (immigration, customs and police). Such patients could be followed up without difficulties with the immigration authorities. For other patients, there is no follow-up system in place.

Health workers also reported that in some cases, they only learn that a particular patient was from Mozambique after s/he defaults. The patient may have registered as a Malawian, giving his or her address as a village in Malawi. Upon default and follow-up instituted, that is when it is realized that the address was false. Health workers reported that it was possible some patients from Mozambique could give a Malawian village as their home for thinking that by doing so would entitle them to better care. With regard to contact tracing of regular close contacts of sputum smear positive patients, health workers reported no contact tracing in case of Mozambican patients. Malawian patients should benefit from contact, notably children under the age of five years who were household contacts of adult smear positive cases. The main reason given for the differences in care was that Malawian health workers had no jurisdiction over TB treatment and surveillance activities in Mozambique.

Discussion

This study indicates that Mozambicans obtaining care in Malawi are managed differently from Malawians by virtue of the fact that they stay across the border. Inadequacies in TB management could result in an increase of multi-drug resistant TB 7-10 and adverse patient outcomes, such as prolonged morbidity and increased deaths. There is therefore a need to 'break down' the barriers so that proper care of TB patients is facilitated between Malawi and Mozambique. We suggest that in order to provide better TB care facilities, there is need for confidential language interpretation services other than just using any available interpreter; provision of border (immigration) passes for Malawian health workers following-up patients or rather cooperation arrangements with fellow TB health workers in Mozambique to whom patients can be referred. Malawian and Mozambican health workers in border districts could hold joint professional education sessions in order to be appraised on harmonized TB treatment regimens.

The Southern Africa Development Community (SADC) and Common Market for Eastern and Southern Africa (COMESA) are possible fora at which these issues could be discussed. Policy makers at all levels need to know that territorial boundaries are posing an obstacle in the proper care of Mozambican TB patients obtaining care in Malawian health care facilities.

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Reply from National TB Control Programme

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We welcome the paper by Muula et al on shortfalls in the management of TB for Mozambican patients who obtain health care in Malawi. The main problem with the paper is the small number of patients (4) who were interviewed, which makes generalisation of the results somewhat difficult. However, interesting aspects arise from this study.

The Malawi National TB Programme (NTP) has been interested for some time in the number of non-Malawian nationals from neighbouring countries who are registered and started on anti-TB treatment. The NTP is currently collecting data on the magnitude of the problem. In many border districts, a separate register is kept of these patients. However, the case numbers and the treatment outcomes are not included and do not appear in any Malawian national data sets. Furthermore, Malawi does not send this data to the appropriate TB programmes of the neighbouring countries. These patients are therefore "missing cases" when it comes to global TB case finding, and this may contribute to the low case detection rates reported globally by the World Health Organization.

What are the solutions? Muula et al suggest cross-border TB-follow up activities with provision of immigration passes for Malawi health care workers. This suggestion is probably unrealistic. NTP staff are stretched at the best of times to follow up Malawian nationals on anti-TB treatment without having to cross over to neighbouring countries to follow up non-Malawian nationals. The legislation required for such immigration passages might also take years to sort out. There is a body called the "Southern African TB Control Initiative (SATCI)", which meets once a year to explore regional tuberculosis issues. Cross-border notifications and follow-up of patients has recently been an important item for the agenda in the SATCI meetings. In the next meeting to take place in Maputo, Mozambique, in February 2003, the issue of cross-border notifications and follow-up of patients will be one of the leading topics of the agenda.