



## Tuberculosis and Leprosy Control Policy in Nigeria, 1985-2015

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### ABSTRACT

Nigeria ranked first in Africa and fourth in the world among tuberculosis (TB) endemic countries. An estimated 460,000 cases of tuberculosis and 5000 cases of leprosy occur in Nigeria annually. TB prevalence among Human Immune Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) patients rose up to 27% due to increased association of TB with HIV/AIDS. This study described the dynamics of Tuberculosis and Leprosy Control Policy in Nigeria. Many Non Governmental Organizations (NGOs) and private partners compliment the effort of the federal government in combating this scourge. The federal government has continually reviewed her policy framework to reposition her to combat the scourge. Some progress has been made, but more effort is required to scale up operations. Proper budgetary allocation for health in line with international best practice, improved funding, monitoring and evaluation of TB and leprosy control programmes are invaluable in the actualization of this noble course.

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### Introduction

Policy is a set of principles guiding decision-making. It provides a framework against which proposals or activities are tested, measures progress and clearly delineate the short and long-term goals to be achieved, the priorities to be addressed, and the strategies to be adopted. Policy evaluation is very vital and ideally, it should be revised every 5-6 years. The World Health Organization in 1985 reported 5.4 million registered cases of leprosy and an estimated 10-12 million, a combination of registered and unregistered cases worldwide. This figure reduced to 680,000 registered cases and an estimated 1.6 million total cases worldwide by the year 2000. In 1989, Nigeria recorded 193,715 registered cases of tuberculosis, which occurred predominantly in the northern part of Nigeria. [1,25]

The National TB and Leprosy Control Programme (NTBLCP) reported that over 600,000 new cases of tuberculosis have occurred in Nigeria, according to the survey conducted in 2014, with 91,354 cases placed on treatment. The World Health Organization (WHO) ranked Nigeria as the 3rd among the 22 highest prevalence of TB burden countries in the world and noted that directly observed treatment short course (DOTS) services are currently provided in about 6000 health facilities in the country and diagnosis are obtainable in 1,515 microscopy laboratories across the nation in 2014. [1,2,3] The main health policy targets in Nigeria focused on the Millennium Development Goals (MDGs) which include, "to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases". The major diseases here include tuberculosis and leprosy. [1,4,25] This article described the dynamics of Tuberculosis and Leprosy Control Policy in Nigeria.

#### Perspective and operations of the policy

The overall policy objective of the policy hinges on the provision of effective, accessible, and affordable quality healthcare that will improve the health status of Nigerians. The primary health care is fundamentally based on practical, social and scientifically sound and acceptable methods and technologies widely acceptable to people at the grass roots. It is

the key to actualizing the health policy at the grass roots, to enhance the socioeconomic development of the people. [5] In order to achieve the much-desired goal of good health for all Nigerians in this millennium, the policy targeted disease burdens and health problems that contribute greatly to the poor health indices of Nigerians. Key health interventions were mounted to combat Tuberculosis and Leprosy (TBL). The goal of the TBL control programme was, "To reduce the prevalence of Tuberculosis and Leprosy to a level in which it will no longer constitute a public health problem in Nigeria". This was meant to be achieved through provision of effective treatment for all tuberculosis patients in Nigeria using the Directly Observed Treatment using Short Course Chemotherapy. (DOTS) recommended by the World Health Organization (WHO), and the International Union against Tuberculosis and Lung Diseases (IUATLD). Other measures include detection of all cases and particularly all the infectious cases in the early stages of the disease and to treat them effectively. This is a way to reduce the bacterial load and interrupt transmission of the disease through combination of other acceptable methods in the communities, and reducing the mortality and complications associated with them. The objective of the policy also covers reduction or elimination of the social and psychological stress and the social stigma associated with tuberculosis and leprosy and to achieve 100% DOTS coverage by 2005 and to implement new Tuberculosis Initiatives like the TB/HIV Joint Action, Public Private Mix (PPM) DOTS, Community DOTS, Control of Multi-Drug Resistant (MDR) Tuberculosis, etc. [6,7,8]

Tuberculosis and leprosy have remained diseases of public health concern after over two decades of TBLCP in Nigeria. The key players in the TBLCP in Nigeria are WHO, Global Fund to fight HIV/AIDS, Tuberculosis, and Malaria (GFATM), Centre for Disease Control (CDC), Canadian International Development Agency (CIDA), and Global Drug Facility (GDF), German Leprosy and TB Relief Association (GLRA), Christian Health Association of Nigeria (CHAN), Netherlands Leprosy Relief (NLR), Tuberculosis Control Assistance Program

(TBCAP), United State Agency for International Development (USAID), TB & Leprosy Mission Nigeria (TLMN), International Union against TB and Lung Diseases (IUATLD), and Damien Foundation, Belgium (DFB). Others are the Institute of Human Virology of Nigeria (IHVN) and all voluntary or Non-Profit Organizations working for control of Tuberculosis, HIV, and Leprosy in Nigeria. [2, 5, 9]

The National Tuberculosis and Leprosy Control Programme (NTBLCP) was launched in Nigeria in 1991. Multi resistant Drug Treatment started nation-wide in Nigeria in 1991 with the support of International Leprosy (ILEP) organizations for treating leprosy patients, while DOT started in 14 German Leprosy and Tuberculosis Relief Association supported states in 1993. In 1995, the MDT national coverage for leprosy patients recorded 100% nationwide, while the WHO elimination benchmark of less than 1 leprosy case per 10,000 population by 2000 kicked off in 1998. The first TB Strategic Plan for 2001 to 2005 commenced in 2001 while the Second Strategic Plan was launched in 2006, to run until 2010. In 2002, expansion of DOTS to 17 Northern States commenced with assistance from CIDA and USAID while DOTS implementation spread to all States of Nigeria in 2004. DOTS coverage subsequently rose to 65% of all the 774 Local Government Areas in Nigeria in 2005. Case Detection Rate (CDR) of new smear positive TB cases improved from 4% to 30% in 1994 and then to 15% in 2002 while in 2006, TB treatment success rate reached 75%. In 2007, there was enhancement of the TB control activities in Nigeria with grant of first phase of Global Fund Round 5 to fill in the gaps. The inauguration of the WHO "STOP TB" strategy adopted by the Federal Government of Nigeria through the Federal Ministry of Health (FMOH) and other agencies kicked off in 2008. [9, 10, 11]

The first strategic plan for leprosy control in Nigeria took place from 2007 to 2011 to reduce the diseases prevalence to the barest minimum where they will no longer be public health problems. The TB arm sought to successfully detect 70% of estimated new sputum smears and successfully treat 85% while the Leprosy arm sought to improve early detection of cases and stem grade 2 disabilities in new patients to less than 5%. It is expected to maintain a Multi Drug Resistant Treatment (MDT) completion rate of a minimum of 85% for Pauci-bacillary and multi bacillary. [12,13] In line with the commitment to providing equitable access to the diagnosis and treatment of multi drug resistant TB in Nigeria, the NTBLCP and National Agency for the Control of Aids (NACA) in collaboration with donor agencies and partners, have scaled up capacity for the diagnosis of TB among persons living with HIV (PLHIV) and drugs-resistant TB. This was achieved by installing 98 GeneXpert MTB/RIF machines across the 36 states and the Federal Capital Territory (FCT) in 2014.

Integration of Care and Control of TB (ICCTB) into the General Health Care Services Scheme based on the Primary Health Care System in Nigeria was introduced to effectively cover the grassroots. The Nigerian health care system is grossly under-staffed. With a teeming population of 170 million people, poor health indices and wide margin of health care professionals to patient ratio coupled with constant brain drain to foreign countries, the health care delivery system need comprehensive overhauling. Primary Health Care (PHC) embraces the provision of basic health needs of the people. It embraces the prevention and control of locally endemic and epidemic communicable diseases, immunization against the major infectious diseases, family planning, maternal and child health. Other components of primary health care include basic sanitation and provision of

portable water, health education, and mobilization, provision of good food and nutrition, and supply of essential drugs. These were tailored to management, administration, monitoring and evaluation, and the activities of governmental and non-governmental agencies that drive the process in collaboration with the government through the Federal Ministry of Health. Vaccination with Bacille Calmette-Guerin (BCG), was introduced into the Expanded Programme on Immunization (EPI), and is given at birth to newborn infants. In addition to prevention of TB, it gives some level of protection against the *Mycobacterium laprae*. Chemoprophylaxis with isoniazid for six months is given to under five children with positive tuberculin test and to those who have not been vaccinated, and have not manifested the clinical symptoms. This is in addition to health promotion on good housing, good personal hygiene, avoidance of overcrowding and proper ventilation. Strict adherence to the WHO recommendations for the management of TB co-infection with HIV/AIDS is strictly promoted at all levels of care. This is coupled with the administration of prophylactic dapsone in addition to control of contact. However, even though dapsone prophylaxis reduces the risk of contracting leprosy, it is generally unaccepted due to the risk of development of resistance. Hence, it is considered under strict medical supervision. [14, 15, 16, 17] This is carried out with inter-sectorial collaborations and community participation at all levels.

The Federal Government through the Federal Ministry of Health (FMOH) undertook comprehensive upgrade of existing TB control work by provision of guidelines, training, and retraining of staff involved in TB management at all levels and improved supervision of their operations. State Ministries of Health have been encouraged to provide periodic training for those who need them while others participate in managerial research, development, and training in collaboration with institutions in their domains in areas of health development, and better ways of disease management. National Hospital Service Agency (NHSA) was established and is saddled with the responsibility of development of standard treatment guidelines (STG), hospital administration, and health system management, distribution of hospital services, monitoring and evaluation, and provision of guidelines on health services especially at the tertiary level. This was in addition to provision of DOTS to all people living with active tuberculosis. A new supportive strategic plan was adopted from 2010 to 2015. The key objectives of this strategic plan was to pursue high quality DOTS expansion and enhancement, improve key indicators in TB and MDR-TB management through quality assurance bacteriology, improvement of the management of TB/HIV co-infection, control of MDR-TB, and provision of laboratories and quality assurance services. Others include integration of all health care providers, increased and sustained funding, and community mobilization. The Federal Ministry of Health facilitates research and development with national and international institutions to facilitate capacity building, utilization and local content development in the disease management [17, 18, 19,] Health care workers manual for TB and leprosy management were made available and reviewed periodically to keep pace with global best practices. It helps to maintain uniformity of care at all levels. The 5th edition of the training manual was launched in April 2010. [11] Standardized Management Information Systems (MIS) have been put in place for proper and efficient data capture at all levels of leprosy and TB care. This facilitates timely capture, dissemination, and use of data at all levels of the value chain while enhancing efficiency

