Getting serious: Romania and tuberculosis
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omania’s current tuberculosis (TB) problems illustrate the consequence of what happens when the challenges of such a disease are, for many years, met with lethargy rather than action. The country currently has about one-quarter of all TB cases in the EU and European Economic Area, even though it has just under 4% of the area’s total population. Efforts to fight tuberculosis in general—following a long period of slow, halting implementation—peaked about a decade ago and are now bearing fruit. The same cannot be said, however, of the multidrug-resistant version of the disease (MDR TB). A joint World Health Organisation (WHO)-European Centre for Disease Prevention and Control (ECDC) report calls drug-resistant tuberculosis “one of [Romania’s] major public health challenges.”

**Significant progress on the easier part of the problem**

Romania was initially slow to take action against TB. It adopted DOTS (directly observed treatment, short-course)—the then WHO strategy for addressing the disease, which includes observation of treatment as well as various political, financial, and public health commitments—in 1997, around the same time as many other European countries. Rollout, however, was far from rapid. Six years later, TB clinics with directly observed therapy existed in just 54% of the country. Although ostensibly coverage has been complete since 2005, in practice “many patients do not receive DOTS-supervised treatment,” especially in rural areas, says Silvia Asandi, general manager of the Romanian Angel Appeal, a non-governmental organisation (NGO) that co-ordinates TB expenditure in the country provided by the Global Fund to Fight AIDS, tuberculosis and malaria.

![Romanian TB incidence](chart1.png)

**Chart 1**

**Romanian TB incidence**

(per 100,000 people)

Although far from ideal, these efforts have yielded some marked, positive effects. This is especially true for new cases of drug-susceptible TB, which equate to 76% of all cases in the country. The case-finding rate (the number of diagnoses as a proportion of the estimated disease burden) was just 55% in 1996, but since 2002 has hovered around 80%. More striking, the cure rate for new cases of drug-susceptible TB more than doubled, from 41% in 1996 to 85% in 2005, a level from which it has

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2 Ibid.


4 Unless otherwise noted, TB prevalence, incidence, treatment outcome, and mortality data are all taken directly from, or derived from figures in, the WHO Global Tuberculosis Database.
not varied significantly since. Over time this has led to substantial declines in overall TB incidence, prevalence and mortality. As the above charts show, each of these measures of the epidemic peaked as the TB programme took hold and then began to drop steadily. By 2013, the most recent year for which figures are available, prevalence and mortality were down by 49% from 2002 and incidence had fallen by 48%.

The remaining TB burden is still very high by European standards: incidence and mortality are well over two and a half times that in nearby Bulgaria and prevalence and incidence about 20 times that in...
Greece. Nevertheless, things are undeniably moving in the right direction. As Victor Olsavsky, head of the WHO’s Romania office, notes, “we can now see the success” of efforts dating back a decade and a half against TB. Ms Asandi adds, “we are doing well in treating and finding non-resistant TB.”

This progress is welcome, but it is against the simplest challenge posed by the disease. Other parts of the TB picture are of far greater concern.

**MDR TB: A problem long ignored**

Both Dr Olsavsky and Ms Asandi list drug resistance among the top TB-related challenges facing Romania. On the surface, however, the data seem reassuring: between 2008 and 2013 the number of diagnosed MDR TB cases dropped steadily. The figures and the trend that they purport to show are problematic, though, because the Romanian health system over these years did not try very hard to identify cases of drug resistance. Only 40% of newly diagnosed TB patients and 54% of previously treated ones were tested for MDR TB in 2012. Such lack of testing leaves a gaping hole: based on WHO figures for the estimated burden of MDR TB, Romania found just 62% of cases.5

Even for those diagnosed, however, the quality of care has been extremely poor. Formally, most individuals diagnosed with MDR TB have been enrolled in treatment. In practice, however, says Dr Olsavsky, “the Ministry of Health could support the treatment of only around 300 patients [of 1,500 with MDR TB].”

Adding to the difficulties for patients, TB treatment in Romania is, because of specific incentives within the health system, excessively hospital-centred. Ms Asandi explains that ambulatory TB care is poorly developed, with insufficient support for patients to maintain their treatment outside hospital. Making matters worse, Dr Olsavsky explains, “care takes place in general hospitals, allowing TB to spread”. Moreover, being in such an institution for, in the case of MDR TB, up to two years, leads to unemployment. Unfortunately, adds Ms Asandi, “those who suffer economically do not receive adequate social support.” Collectively these conditions increase the tendency to abandon treatment early.

The results of poor provision for MDR TB patients have led to, as one recent analysis described it, a “minimal”6 medical impact of treatment. Over the last six years, the cure rate for MDR TB in Romania has varied between 16% and 26%, about half the global average and not that different from the historical spontaneous cure rate for TB (ie, of those receiving no treatment at all).7

Given the problems with official figures, it is impossible to say for certain that drug resistance is increasing. On the other hand, with such poor results from treating those affected, there is no reason to suppose that MDR TB is in decline in Romania.

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A lack of political will and of funding

The weaknesses of the Romanian response to drug resistance have been visible for some time. As early as 2005, for example, a report from WHO Europe noted a lack of patient oversight. Impeding action, however, has been a leadership vacuum at the top. For many years, notes Ms Asandi, “the political will was actually lacking, not in terms of words—the minister always says that TB is a priority—but in terms of doing anything.” Dr Olsavsky adds that, ironically, success against drug-susceptible TB made the issue less of a priority, a situation that has only recently changed as data have raised concerns about increasing levels of drug resistance.

Making matters worse has been administrative weakness in the Ministry of Health. Dr Olsavsky explains that one reason why “healthcare reform [of all kinds] has been patchy in the past 25 years is because, looking back, the average life expectancy of a minister of health is no more than one year.” Exacerbating this “chaos,” to use Ms Asandi’s term, has been the lack of institutional memory and policy continuity within the ministry. “You have a new team. They are energetic and have a new agenda. Then, next year, they are gone and you have new people who have a different agenda,” she adds.

The net result has been a lack of focus on implementing vital policies, not necessarily because of poor policies on paper, but due to chronic underfunding. In 2013 the national TB programme’s domestic budget was supposed to be €10m, but the government eventually allocated just €4 m. Similarly, in the same year, its €5.75m annual commitment under a three-year plan to address MDR TB went completely unfunded. This lack of funding helps to explain the poor coverage of drug resistance testing: necessary equipment simply was not available. Moreover, little if any money has been available even to think about improving case-finding rates. Worst of all, though, was the message that these minimal budget allocations sent. As Ms Asandi says, they “showed that the political will [to address the issue] was missing.”

A new beginning?

A sea change, however, appears to have taken place. It began in 2014, as the government engaged in extensive discussions with the WHO, ECDC, and the Global Fund about Romania’s TB burden. Officials took some immediate steps, such as buying rapid-diagnosis machines for laboratories in the capital, Bucharest, and Cluj-Napoca, a major regional centre. The clearest sign of progress, however, is the government’s release in October 2014, and full approval in February 2015, of a new National Strategic Plan for Tuberculosis Control 2015-20: Stopping the wave of multi-drug resistant TB. This scheme includes various important, if not especially taxing, goals, such as raising the cure rate for people with newly diagnosed, drug-susceptible TB from around 85% to 90% in five years, and cutting the mortality rate from 5.3 per 100,000 to under 5.0.

The plan is far more ambitious when it comes to MDR TB. Here, it aims to provide universal rapid MDR testing by 2020, to increase the proportion of people diagnosed with resistance who go on to receive appropriate treatment to at least 90%, and to raise the MDR TB treatment success rate from 20% to 70%.

8 WHO Europe, “First Review of the National Tuberculosis Programme in Romania, 4-15 April 2005,” 2006.
9 Bruce Warwick et al., “Bridging the gap, How the European Union can address the funding crisis for TB and HIV programmes in Eastern Europe and Central Asia,” 2013.
"Planul Strategic Naţional de Control al Tuberculoi bei în România, 2015-2020 Stoparea valului de rezistenţă TB multiderog rezistentă (TB MDR), October 2014."
The form of the plan—adopted by the whole government and signed by the prime minister rather than simply being a health ministry policy—shows the political weight behind it. Most importantly, the numbers are more than pious aspirations. Although the plan will receive substantial financial backing from the EU, the Norwegian government and the Global Fund, the Romanian state has also funded its portion of the costs. This has meant roughly doubling the previous TB budget.

The events of the last year have brought a noticeable sense of hope that a corner has been turned. Dr Olsavsky calls the changes “big progress,” and Ms Asandi believes that “we have lots of reasons to believe that things will change,” describing the plan itself as “a great step forwards.”

Two elements appear to have driven the government’s change of heart. The first, says Dr Olsavsky, is that such data as was available on the possible increase in MDR TB concerned officials, especially given the low rates of treatment and treatment success. This is clear in the ambitious MDR TB-related goals and the relatively modest other ones. “The alarm was over MDR TB, not the general incidence. Although Romania can do better, normal TB is treated well,” he explains. The other major driver has been international pressure. This included not just various foreign actors voicing concerns in the discussions on TB with the Romanian government, it also involved the power of the purse. Both the European Commission and the Global Fund, says Ms Asandi, made a renewal of the country’s TB programme contingent on the creation of a coherent, adequately funded plan of action.

**Other barriers still exist, however**

Although effective national government leadership is an essential part of addressing Romania’s MDR TB challenge, it is not sufficient. Other barriers to progress need to be overcome. Some are practical. For example, Dr Olsavsky points out that, although general practitioners (GPs) could play an important role in case findings and overseeing treatment, the pay they receive from the health system for this, about US$3 per patient, is “ridiculous.” Reaching patients in vulnerable populations is another common difficulty in addressing TB worldwide, and an area in which Romania needs to improve.

Other issues are attitudinal. Dr Olsavsky reports that “based on some of our small studies, stigma is everywhere.” Ms Asandi adds that “most patients experience stigma in their community or in the workplace; the poorer they are, the more they are stigmatised.” Consequent fear of being found to have TB leads to late diagnosis —giving the disease more opportunity to spread—as well as compounding the difficulties of reaching the more vulnerable sections of the population.

Just as big a potential problem for progress, however, is apathy. Ms Asandi notes that in the past the lack of political will at local government level has been as extensive as that at national level. Moreover, addressing TB is a question that does not resonate greatly with the public. To date, she explains, there has been “an inertia at the political level and in the general population, and civil society has not been strong enough in articulating the issues” surrounding TB. Indeed, one possible danger in future is that the current government action, driven in part by international pressure, may not have the domestic support needed to maintain momentum.
On the other hand, Romanian society provides a potentially useful asset in the fight against TB. As a result of her experience in co-ordinating Global Fund spending, Ms Asandi has found that many local NGOs are experienced, reliable partners in this field. Their help will also be essential if the new plan is to succeed. “No matter how well conceived the health ministry programmes are,” she says, “they will never reach members of vulnerable groups and those in remote areas without the help of local NGOs.”

Overall, then, the story of TB control in Romania in recent decades is a mixed one. A poorly funded programme without strong government support took several years to be established, but is now steadily reducing instances of drug-susceptible TB. The weaknesses in this effort, though, have allowed a worrying level of MDR TB to emerge. Now, however, the government seems genuinely ready to address the problem. Accordingly, as Dr Olsavsky puts it, “the next two or three years will be crucial for implementation. They might be the best chance we have to solve the MDR challenge.” On the other hand, the ability of the new plan to overcome other barriers to progress, or even how long the newfound commitment of the authorities will last, is far from certain. Ms Asandi believes that “we have to maintain vigilance, not just be happy and wait.”
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