

# Rise in tuberculosis in Peru: A byproduct of the COVID-19 pandemic

Angelo Perera  
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In an article titled, “An Unexpected Pandemic Side Effect in Peru: A Comeback For TB,” NPR (National Public Radio) gives a sobering account of the rise of tuberculosis (TB) in Peru and much of the developing world because of the COVID-19 pandemic.

In Peru, in 2019, the nonprofit health care organization Partners in Health (PIH) began a screening program called TB Móvil, which brings TB testing to the community via two vans equipped with X-ray machines that use Artificial Intelligence (AI) software to diagnose TB quickly and accurately. The vans are operational in the three northernmost districts of Peru’s capital, Lima.

Martin Valencia Garcia, a community agent of TB Móvil, noticed that after the onset of COVID-19, patients likely stopped seeking further tests and treatment. Speaking of a 52-year-old patient who was in his care before COVID-19 but has since lost touch with him, Garcia remarked, “He could not do the exams, and since he couldn’t do the exams, he couldn’t be diagnosed, and he couldn’t receive treatment.”

Under disruptions caused by COVID-19, Luz Villa-Castillo, a study coordinator at Cayetano Heredia University in Lima, pointed to the masking of a rising tuberculosis caseload as fewer patients sought diagnostic testing and received inconsistent treatment. Villa-Castillo suspects many milder strains of TB may “have likely become resistant.”

At the onset of the coronavirus pandemic in March 2020, Peru, like most countries across the globe, went into partial lockdown with restrictions on movement and commerce. While lives were certainly saved, job losses were extensive, leading to more than six million people left unemployed by the second quarter of 2020, with many jobs permanently destroyed. With public transportation capacity cut by 50 percent, many younger workers who depended on these modes of commuting were unable to go to work and lost their jobs.

The stresses of economic devastation coupled with a lack of transportation also meant that many patients with multiple drug-resistant tuberculosis (MDR-TB) most likely stopped

seeking treatment and were lost to followup evaluation and care.

Worldwide, TB is one of the top 10 causes of death and the leading cause from a single infectious agent. The World Health Organization (WHO) states that a total of 1.4 million people died from TB in 2019 (including 208,000 people who also had HIV).

The infectious disease is caused by the bacterium *Mycobacterium tuberculosis*, which usually affects the lungs, causing the signature bloody coughs. Most infections, however, are described as latent TB, producing no symptoms, and the person is considered not contagious.

The primary risk is that about 10 percent of these individuals will go on to develop the active disease. The risk is as high as 5 percent in the first two years, climbing at a rate of 0.1 percent per year afterwards. The elderly or those with compromised immune systems, such as people living with HIV, malnutrition or diabetes, or people who use tobacco, have a higher risk of falling ill with active TB.

TB is considered a poor man’s disease, with 95 percent of cases and deaths appearing in developing countries. In 2019, out of the estimated 10 million people who fell ill with TB worldwide, 2.2 million cases were attributed to undernutrition. Another 1.4 million cases were attributable to alcohol use disorder and smoking, practices that continue to exist disproportionately in poorer sections of global communities.

Yet the disease is both preventable and curable. The WHO stated that, since 2000, an estimated 63 million lives were saved through early diagnosis and treatment of TB. For most who have access to treatment, a rigorous six-month course of four antimicrobial drugs, which need to be taken daily, can be curative. But without the support of health care workers and health infrastructure, patients may not be able to complete the full course, which can lead to the development of drug-resistant strains.

Multidrug-resistant tuberculosis (MDR-TB) is a form of TB caused by bacteria that do not respond to isoniazid and rifampicin, the two most effective first-line anti-TB drugs.

Extensively drug-resistant TB (XDR-TB) is also resistant to second-line medications, which are much more toxic and less effective than the first-line medications. Treatment schedules for MDR-TB are arduous, possibly lasting up to two years, with medicines that are both expensive and difficult to take due to their side effects. MDR-TB remains a public health crisis and a health security threat.

A global total of 206,030 people with multidrug- or rifampicin-resistant TB (MDR/RR-TB) were detected and notified in 2019, a 10 percent increase from 186,883 in 2018. Globally, only 57 percent of patients with MDR-TB have been successfully treated. About 3 percent of new cases and 18 percent of existing ones are drug-resistant.

Around the world, TB health care facilities and personnel have been diverted to handle the COVID-19 pandemic. A survey by the Stop TB Partnership, an international organization fighting to eradicate TB, noted that of the top 20 high-burden TB countries, which represent 54 percent of all TB cases in the world, staff, isolation wards, and specialists had frequently been redirected to provide COVID-19 care, with many TB laboratories and research teams essentially shut down. TB diagnostic supplies and drug shipments have been drastically disrupted, leaving infected patients without medical recourse.

To place the impact of the pandemic on the burden of drug-resistant TB into its dire context, as the NPR report stated, even before COVID-19, in 2018, of the nearly 500,000 new MDR-TB cases, only a third were given an effective treatment. Peru has the highest estimated RR/MDR-TB burden of the Americas, with 9 percent of TB cases being drug-resistant, according to 2017 data.

A Stop TB Partnership study conducted in India, Kenya and Ukraine estimated that second-line treatments for drug-resistant TB will drop to as low as 25 percent in those countries due to coronavirus-related disruptions.

In October 2020, the WHO warned that the pandemic is threatening to reverse the global progress against TB. TB notifications in three of the highest-burden countries—India, Indonesia and the Philippines—fell by 25 to 30 percent from January to June of 2020, compared with the same period in 2019. The agency estimated that roughly 85 percent of people who are diagnosed with TB and notified could be successfully treated. However, according to their modeling estimates, if the number of TB patients detected and notified globally falls by 25 to 50 percent over a three-month period due to disruptions in TB services, deaths related to the disease could reach as high as 400,000 just for 2020.

A 2015 report published by Oxfam titled, “Inequality in Peru: Reality and Risks,” paints a devastating portrait of the deplorable conditions caused by extreme poverty and substandard infrastructure in the country. The report found

that more than half a million households had no electricity. An estimated 1 million households are not connected to the public water network, 2.5 million lack sewage, 7 million do not yet have access to safe drinking water, and in rural areas, less than 5 percent of households drink chlorinated water. The pandemic has only exacerbated these grim statistics.

Peru’s ruling class has for decades conducted a concerted assault on the working class. Perhaps this has been best personified by the “Wall of Shame” that separates the slum dwellers of Lima from the wealthier neighborhood called Casuarinas.

Korey Finn of Lehigh University depicts in his paper, “The Informal Economy in Peru: a blueprint for systemic reform,” a deplorable picture of misery sustained by an informal economy that collapsed under the pressures of COVID-19. Finn describes the shantytown in the outskirts of Lima in the following passage. “The Peruvians here are seldom able to travel into the city for income opportunities, finding whatever work they can within their neighborhoods to provide for themselves and their families. One woman described making a living by selling milk, bread, and other essentials in the neighborhood mini mart, earning less than \$2 a day. These Peruvians have one thing in common—they operate in the pervasive informal economy, which disproportionately affects Peruvian workers.”

Where an informal Peruvian worker could make as little as \$2 a day, Wikipedia lists seven billionaires in the country who collectively hold \$11.9 billion. This level of inequality is not sustainable, and Peru, having gone through three presidents in a week last November, is poised for a social explosion. The health care crisis exemplified by the resurgence of TB under these squalid conditions ripe for the spread of the bacterium only confirms the complete indifference of the ruling class towards much of the population.

The independent action of Peruvian workers, linking arms with the working class of the Americas, can prepare for such a social explosion, and direct it to the formation of a socialist state, which would be the only solution for reversing the disastrous health care crisis in the region.



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