



# TB and Poverty Network Newsletter

July 2005

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Do you have photos that show your organization's programs in action and TB events that you would like to share with other Network members? Then send us those photos or text describing such activities and we will publish them in our subsequent newsletters or even on our website!

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**Remember to circulate this Newsletter widely by email or simply print several copies. If you have further ideas and suggestions on how we can do better with this Newsletter, please let us know!**

## EDITORIAL

Welcome to our July Newsletter.

The focus of this newsletter is on key lessons learnt from case studies on making DOTS pro-poor in South Africa, Kenya, Uganda and Malawi. We hope that you will find them useful. We look forward to your comments and feedback, and we also request that you share with us your experiences in efforts to make DOTS pro-poor. In Malawi we believe that '*Lende nkukankhana*', which means that "we can't do things alone, but together."

**Dr. Felix Salaniponi**  
Director, EQUI-TB Knowledge Programme & Head of Network Secretariat

## 36<sup>th</sup> Union World Conference on Lung Health, Paris, France



Will be held at the Palais des Congrès in Paris, France, from 18 to 22 October 2005.

The theme of the Conference this year is "**Scaling up and Sustaining Effective Tuberculosis, HIV and Asthma Prevention and Control**".

There will be a symposium on TB and Poverty for the Network of the Secretariat for Action on TB and Poverty. Presentation will range from country-level experiences in addressing the needs of the poor through scaling up activities in DOTS Expansion, TB/HIV, Advocacy, Communication and Social Mobilisation, and MDR-TB. You are invited to attend!

For more information, please visit the conference website at:

<http://www.worldlunghealth.org/Conf2005/index.php>

## ADDRESSING POVERTY IN TUBERCULOSIS CONTROL IN AFRICA: Country Specific Examples

Tuberculosis (TB) and poverty are inextricably linked. Poverty increases individuals and communities' vulnerability to TB; whilst having TB means that individuals and their families are more likely to become poor, due to related financial and opportunity costs (Nhlema et al., 2003; WHO, 2005). The global TB control targets are to successfully treat 85 % of detected smear positive cases and to detect 70 % of all such cases. Less than half of all TB cases worldwide are diagnosed, and approximately 60 % of the diagnosed cases are cured. The major causes of this situation include the restricted access of poor people to TB services. Making DOTS pro-poor is justified on epidemiological, economic, sustainability and equity grounds and will significantly contribute to the achievement of the global targets.

The following write-up synthesizes 3 key lessons learnt in making DOTS pro-poor from specific experiences from Kenya, Uganda and South Africa which were presented at the launch of the TB Poverty Secretariat in Paris, France in October, 2004. These key lessons are complemented by insights from Malawi, where the TB Poverty Secretariat is hosted.

### **1. Flexible and patient centered Community Based DOTS**

*'Strengthening of Community Based DOTS is one of the strategies for the acceleration of action' (Dr. Lindiwe Mvusi, Director South African NTP, July, 2004)*

Management of TB patients in many countries where the majority of the population resides in rural areas with poor geographical access to health facilities has often included mandatory hospital admission during the initial intensive phase of treatment as one way to ensure direct observation of drug taking until the patient is considered non infectious. This practice is expensive and cumbersome both for the health system and for patients. It presents a severe access barrier especially for the urban poor and

often leads to interruption of treatment due to financial constraints. Therefore, there is an acute need to further decentralize the provision of TB services beyond health facilities to increase geographical access and to foster people's participation into patients' support, in order to improve access and increase the likelihood of successful treatment.

In Uganda CB-DOTS was launched in 1997, and roll out began in 1999. By 2004 CB-DOTS was adopted as national policy and implemented in 48/56 districts (Adatu-Engwau, 2004). Since 1997, benefits related to programme performance impact, community impact, and benefits related to the health system have been observed.

Decentralizing DOTs to the community level has also been central to Malawi's approach to addressing poverty in TB Control. As with the Ugandan experience this is believed to have reduced the patients' financial and opportunity costs as well as having positive repercussions for the health system (Floyd et al, 2003). What is unknown however, is the implication of this role for the observer, and if there are any challenges to the sustainability of this pro-poor approach from the observers perspective. This is the subject of a forthcoming study in Malawi.

How to enhance the sustainability and appropriateness of CB-DOTS are central concerns of the TB Alliance DOTS Support Organisation (TADSA) in South Africa. TADSA is a national NGO that has been working in partnership with the South African NTP for over ten years to facilitate effective community based DOTS (Smith, 2004). WHO recommends that health facilities should be providing the basic elements of the DOTS Strategy before CB-DOTS is introduced (ibid.). In recognition of this, TADSA assess the readiness of individual health facilities to the introduction of CB-DOTS. Once a facility has been assessed as 'ready', a service agreement is signed between TADSA, the district and provincial TB

control programs. Appropriate personnel for CB-DOTS are identified and trained based on available resources in the district. A system to monitor and improve quality is introduced and tailored to the district and a feedback system between the community, health facility and district is developed. TADSA's experience has been that to ensure sustainability, there is a need to develop ownership of the intervention through training and supervision, comprehensive monitoring and evaluation and feedback systems need to be in place to ensure that any problems or challenges are identified early and addressed.

## **2. Working hand in hand with HIV initiatives**

*'TB is the Number One killer of our clients and this is a shame' The AIDS Support Organisation in Uganda (TASO) Director*

The HIV epidemic in Africa has brought new challenges to National TB Control Programmes. HIV/TB co-infection has meant significant increases in TB prevalence. In Malawi it is reported that 77% of smear positive TB patients are HIV positive (Kang'ombe et al, 2004). From a pro-poor perspective there is an urgent need for TB and HIV policy makers and practitioners to work hand in hand to ensure services are available to co-infected people (who are often poor) and to increase referral from HIV services to TB services and vice versa. This has been recognized in a number of different contexts. In Uganda efforts are underway to integrate TB screening and care in Voluntary Counseling and Testing centers through the Ugandan application to the Global Fund Against TB and Malaria (Adatu-Engwau, 2004). HIV and AIDS strategies being integrated within a CB DOTS approach have been identified by TADSA as an indicator of effective implementation of CB-DOTS in South Africa (Smith, 2004).

The Malawi National TB programme has a post for a TB/HIV Officer whose responsibilities include integrating TB and

HIV services. Routine counseling and testing is offered to all TB patients, and those who are HIV + are offered Cotrimoxazole. In sites where ART is available, TB patients are referred for ART services, where appropriate. For example in the first year of ART scale up 11% of ART clients nationwide in 2004 were initiated on ART through diagnosis with TB (MoH, 2005).

## **3. PPM, New Partnerships and coordinated action to meet the needs of the poor**

*"Most of the people that come to buy these cough medicines for more than two weeks are advised to go to health facilities for TB diagnosis"* Storekeeper from Malawi

The term "PPM DOTS" has evolved to represent a comprehensive approach to involve all relevant health care providers in DOTS and ensure that they apply international standard of TB care, while taking on DOTS tasks according to their capacity. PPM DOTS targets a wide range of public as well as private health care providers not yet sufficiently linked to NTP. Depending on setting, this may include medical colleges, general hospitals, health services under specific insurance schemes, prison health systems, army health services, NGO health facilities, corporate health facilities, private specialists and GPs, private pharmacies, and the informal private health care sector.

In Kenya, TB is increasingly becoming a disease of the urban poor (Chakaya, 2004). For example, Nairobi with only 10% of the national population has more than 20% of the TB cases notified to the National TB Control Programme (ibid.). Most of the urban TB cases in Kenya come from slum areas, which are unplanned housing settlements with no amenities (such as running water, toilets and roads). Challenges faced in the provision of TB services in Kenyan slums include inadequate or non-existing public health infrastructure (ibid.). There are a

number of private health care providers and community based and non-governmental organisations offering health care in the slums. There are data to indicate that utilization of private health care providers in the slum is high primarily because the local community considers

these providers to be accessible, affordable and conveniently located (ibid.).

#### **Working together to provide TB services for the poor in Nairobi slums**

The National TB Control Programme has developed a programme for linking these private health providers, including private drug shops/pharmacies with public providers in order to improve access to TB services. There are also NGO based projects that in addition provide community mobilisation campaigns. The various stakeholders working in the slums have been coordinated through an urban TB control committee that meets regularly to review progress and explore innovative ways of improving TB care in the slums. Multiple partners are involved in this effort with stewardship being provided by the National TB Control Programme.

The implementation of this initiative began in Nairobi's Kibera slum and is being extended to other slums in Nairobi and Mombassa. A focal person has been appointed within the National TB Control Programme to coordinate initiatives for control of TB in urban slums with the aim of scaling up lessons learnt to all slums in Kenya. The major constraints and challenges faced in these activities include: Human resource limitations in carrying out regular support supervision; differing training needs of providers in the slums; vandalism of medical equipment and security of personnel. Source Chakaya, 2004

A similar initiative – Extending Services to Communities – is underway in Malawi. This involves collaboration between community leaders, storekeepers and the National TB Control Programme so that storekeepers can refer patients for TB screening and provide necessary

information and health promotion. The project was inspired by qualitative research findings which highlighted that the first port of call for many poor women and men with symptoms indicative of TB was the local small grocery store shop.

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