

Eyes and ears: Community and TB care

By Kakaire Kirunda, Uganda
HDN Key Correspondent Team

9 November 2007

African countries have some of the highest tuberculosis (TB) prevalence rates in the world, ranging from 100 to more than 700 per 100,000 people.

This has been attributed to several factors, including population increases, an unfavourable socioeconomic climate, the displacement of people due to conflict and the spread of HIV.

Since TB was declared a global emergency by WHO in 1993, the Africa Union has taken active measures to promote the implementation of the recommended directly observed treatment – short course (DOTS) strategy for TB control among the member states.

Why then has the number of cases continued to rise? In a presentation on community and TB care at the 16th Union Africa Conference ahead of the 38th Union World Conference on Lung Health, the Programme Manager of Uganda's National TB and Leprosy Programme Dr Francis Adatu Engwau, outlined sentiments on the issue shared by countries in sub-Saharan Africa. Ugandan journalist Kakaire Ayub Kirunda reports:

“What I have come to share with you is really sentiments as regards community TB care, and intervention we have been trying to implement in Uganda since 1998. The quality is still wanting; I want to expressly say this. However, it is true where all the facets have been followed, the results are wonderful. So you will find district by district variation in the attainment of results, which encourages me to say we probably need to push on. The system being dynamic, other factors come into play. One of them is HIV. This ‘one patient, two diseases’ has changed the ball game.

“We adopted the DOTs strategy in 1995. We piloted the community-based TB care, the application of the DOTs in 1998. This was proven to be effective, it was proven to be 63% and was found in a study it was acceptable to both the clients, the health workers and the community served. Then we embarked on expanding the programme and we were able to achieve national coverage by April 2005.

“In 2005, we also participated in the Global Plan to Stop TB and one of the six verses in there is operationalizing TB and HIV collaborative activities. Uganda has put on the ground a policy in this regard, printed and distributed it. It is now a reference document for all our interventions. We put together a communications strategy. We put together a training guide and we are as going on the M and E [Monitoring and Evaluation] in this regard. I am also happy to report that the training guide has been modularized. It is now being used for all that are trying to expand TB-HIV collaborative activities.

“It is important to note for all those who may want to try community-based TB care you must note the kind delivery health system you are in. We are having a decentralized health care delivery system. The district implements while the central government's Ministry of Health sets health policy, standards, resource mobilization, and technical support supervision as their fundamental goals.

“As if that is not enough, there is something called restructuring. I don't know when it will end but this is an ongoing exercise which determines what and where the relevant human resources are placed. So the system is dynamic and might be responsible for some of the undesirable results we find there in.

Challenges:

"I have presented many times on community-based TB care. I imagine many of you in here know the model I am taking about. But I think challenge number one, just like I have mentioned in a meeting going on in another hall on human resources is the human resources regarding the management capacity, regarding the necessary skills in, regarding actual numbers, the health delivery system we run in a decentralized system is greatly affecting our belief in implementing community-based TB care. Where as it was meant to decongest the burden in the health units, it was meant to engage more peripheral health workers to ensure that the quality of supervision and actual DOTS is done.

"There are challenges around logistic management information systems. We are now in a system where we are saying we get the drugs and supplies based on actual consumption. This is the system commonly dubbed as 'pull down'. People at the periphery might not be too cooperative to try and fill the dispensing roles, and that way the National Health Information Management Systems will have a problem. The quality of data, completeness of reporting, accuracy in reporting, and the utilization of this data at the collection points – the health unit themselves still remains wanting. Because you are running a decentralized system, you find you are now faced with a large number of people trained, retrained and reoriented; many times getting new ones and many times losing the old ones to greener pastures.

"So we ask the question, are we implementing common plans and common missions? As programme manager, they want you in the senior staff meeting, they also want you to meet somebody from WHO, then somebody from this group has arrived, another person from USAID is waiting in the corridor and the minister says we are flying out this evening. So this coordination is beginning to make me greyer than usually I am.

"Then there is the whole ball game of financing. Our budget has continued to be very low. Allocation to TB has continued to go down. Three years ago I was given 50 million shillings (approx. \$29,411) to run the TB programme, last year I was given 40 million (\$23,529), this year I was given 25 million (\$14,707). I must be a very intelligent man if I am to run a TB programme on 25 million shillings. So the issues of health financing and sustainability are a very big problem. We are grateful to efforts by the Global Fund. But I want to assure you that Global Fund is a performance-based grant. It does not quite take care of the other two important resources; the human resource on the ground and the 52 weeks in a year which we don't have very much control on. So these affect the implementation of community-based TB care activities. The monies are big and good but the monies are not also easily utilizable considering the quarterly reporting you have to make. But all the same, we want to thank the world for coming together to put something called Global Fund, which has mobilized resources for TB control.

"Then we are facing other challenges and this worries me as public health worker – other emerging priorities. For example if Uganda decided to buy insulin for diabetics, it would take the whole Ministry of Health Drug bill. And when they see a WHO vehicle parked outside our offices they think we are funded. This has an impact on funding for TB. Non-communicable illnesses may soon overtake us before we even have a hold on these infectious diseases we are battling with.

"Sustainability at three levels is also an issue; at community, at government and at a partner level. Community; I have publicly said this before; TB programmes are generally weak at advocacy, communication and social mobilization (ACSM). So we are trying to sell a product to customers who have not been empowered to make a rational choice. So there needs to be investment in the area of advocacy and social mobilization so that communities including their leaders come to own and appreciate that TB is their problem and needs to be addressed by them.

"Central Government and District Governments are also a problem. When I left yesterday, Uganda had 80 districts, when I go back I am not sure what the number will be. I will have to ask. So with that kind of situation, it gets very difficult for you to plan. With CBDOTs [community-based DOTS], item number one is political commitment. So every time there is a new district there is a line of new

administrators and leaders. You must invest time in going to orient this, and at that time their priorities might be different – they are trying to take charge and get known in their districts.

“Then partners with all their attendant problems: different reporting formats, different fiscal years, different objectives, one programme manager. So those are problems.

Remedies:

“The need to involve all key stakeholders in planning, implementation and monitoring levels is important. I think the private health-care providers need to be engaged, and engaged quickly. ACSM, as I alluded to earlier, programmes don’t have the expertise to plan budget and sustain this implementation. I have attended many workshops on how, but the interest in TB to attract people to do ACSM for TB has not been forthcoming. Not even among people living with HIV who are affected by TB.

“Then integration of the approach with in the general health system has an advantage but it means you must agree to move slowly and be able to go through the bumps and humps you will meet on the way.

“Financing and implementation: If we could be using one health plan which incorporates community-based TB care or CBDOTS, that would be very good because we would be making some strides forward.

“Then ensuring regular review of progress by all partners, and this must be incorporated as part and parcel of the national monitoring and evaluation plan. This would get us going forward. It looks like everybody is needed. There should be one national response to TB.

Key lessons:

“The first one is actually community-based DOTS work because the five districts that have sustained and achieved these results are highly human resource dependent. If you have a lazy district coordinator, he will give you excuses. And if you have a network of peripheral health workers not committed, they will give you excuses. From my own experience I have found if the head of district health services, the district health officer is committed and is able to convince the district leadership, it works and works wonders. But human resource is a vital prerequisite to the success of CBDOTS.

Shared goal and mission:

“Knowing what the burden of TB is and agreeing as a whole district to do something about it – this is fundamental. I have seen this in districts, in which we have managed to convince to put only 10% of the primary health-care fund as a conditional grant from the central government to the districts. Just 10% has been able to create differences with in a very short time.

“It takes time and it is worth investing in DOTS. But we must be so flexible enough so that other effects that come, we are able to quell them quickly and that is where we need advocacy, communication and social mobilization. The other thing which I must take note of is partnerships. The Uganda Stop TB Partnership was launched in December 2004, it now has a membership of 27 and these people have been wonderful in making sure some more funds are available, some technical guidance is given and actual implementation in form of support supervision. This has demonstrated a difference.

Health & Development Networks (HDN) 2007

Website: www.TheCorrespondent.org

Email: info@thecorrespondent.org