

Community TB Care: a conceptual framework

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Overview

- ◆ What is Community TB Care
- ◆ Rationale for its inclusion in NTP strategy / GF proposal
- ◆ How it works and operational principles
- ◆ What it does
- ◆ Indicators
- ◆ Operational planning: introduction and scale-up
- ◆ New opportunities



What is Community TB Care (CTBC)

Operational partnership between the health services and civil society aimed at contributing to TB care.

Responsibility for TB control remains with the NTP.

- ◆ Support to patients (DOT) throughout treatment until cure
- ◆ Patient, family and community education
- ◆ Case detection (referral of pts with chronic cough)
- ◆ Advocacy for political commitment to TB control
- ◆ Increase accountability of local H.S. to communities



Rationale for CTBC initiatives

Concentration of health facilities in and around urban settings
poor accessibility (geographic and economic) for rural based population

Hospitalization of TB patients, often unnecessary, is costly for Health Services and imposes a further direct and indirect costs on patients and their families.

This prevents TB patients from attending regular follow-up visits at clinics when discharged from the hospital.

As a result, many TB patients are not cured and the disease spreads to other people.

CTBC addresses these constraints to improve pt's care



Specific objectives of CTBC

- ◆ To improve geographical access to TB diagnosis and treatment through community participation in patients' support and provision of DOT.
- ◆ To improve referral of TB suspects by communities to diagnostic services.
- ◆ To improve TB case management and adherence to treatment.
- ◆ To reduce financial burden for patients and their families, reducing duration of hospitalization and number of follow-up visits to health facilities.

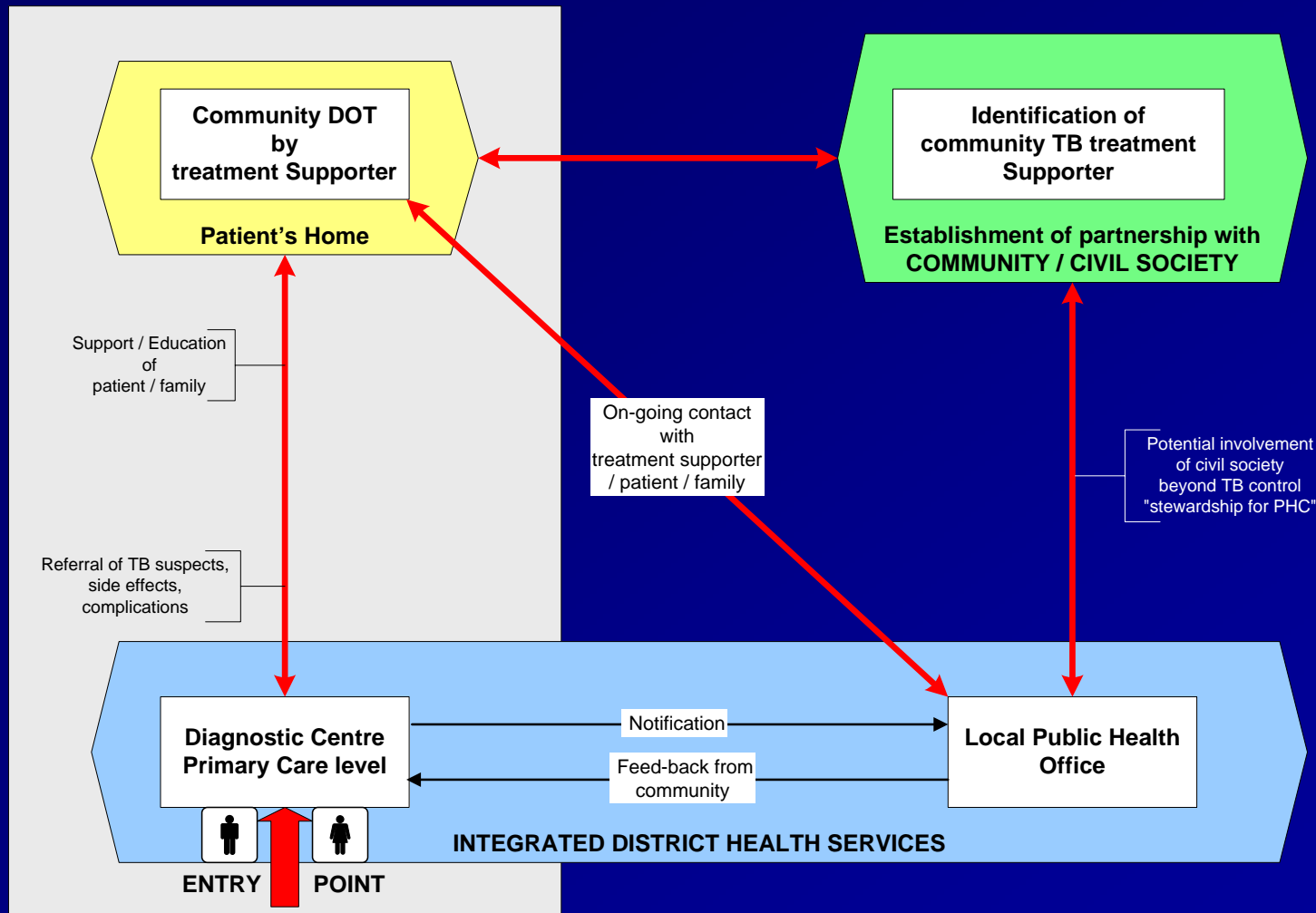


DOTS strategy and CTBC

- ◆ **Patient care** to cure and prevent TB is the ultimate goal of DOTS
- ◆ The foundation of DOTS is effective patient care which alleviates suffering, as well as controls and prevents TB in a community
- ◆ Advocate for (1) DOTS, as the recognised **public health strategy** for TB control, and (2) the importance of **individual patient care** within DOTS
- ◆ Accelerate **DOTS expansion** promoting community participation and action to increase (1) demand for proper care and (2) participation in patient's care
- ◆ Most people in need of treatment for TB and HIV live in resource-limited settings: scarce resources should be allocated to functions and components of care that are strictly “medical”, encouraging the **civil society** to take up, whenever possible, the responsibility to support patients.



Community-based (rural) and Home-based (urban) model of TB care



Operational Principles - 1

- **Curative services**

- focus on drug procurement, lab services, Dx based on microscopy, standard regimens, good M & E
- no new structure or function created

- **Public health services**

- dealing with TB as a public health problem in the context of other routine activities
- empowerment and sustainability
- no new structure or function created

**Establishment of a strong referral system
between curative services and public health services.**



Operational Principles - 2

- **Community**

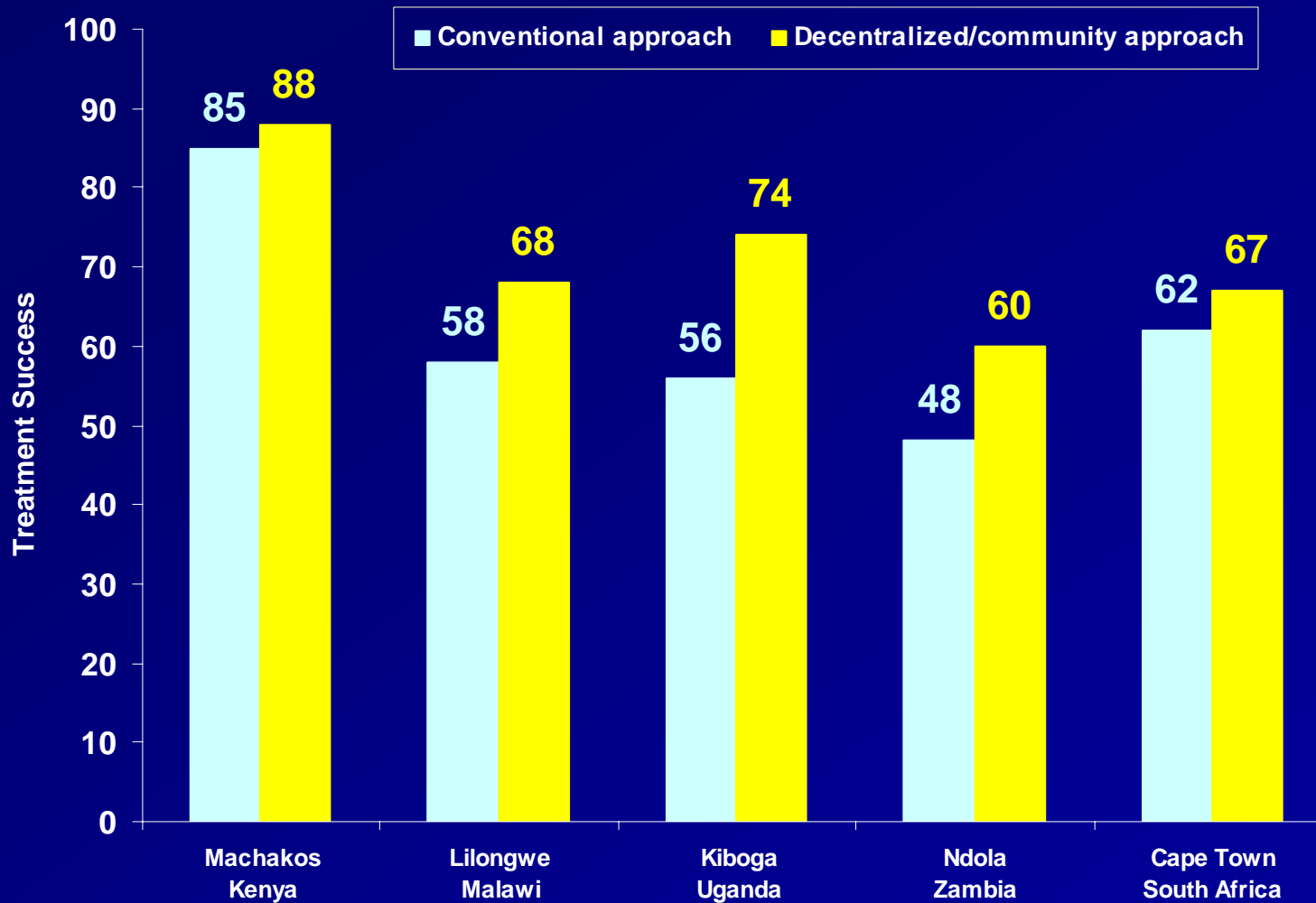
- partnership vs. mere geographical extension of services
- identifying and training a Treatment Supporter only when a TB case occurs within the community: efficient, effective and sustainable approach
- PHC: difference between CHWs/TBAs and CVs
- incentives and/or ownership (e.g. eradication vs. long term control)
- creation of “capacity / responsibility” as a positive externality

- **Family / Patient / Volunteer**

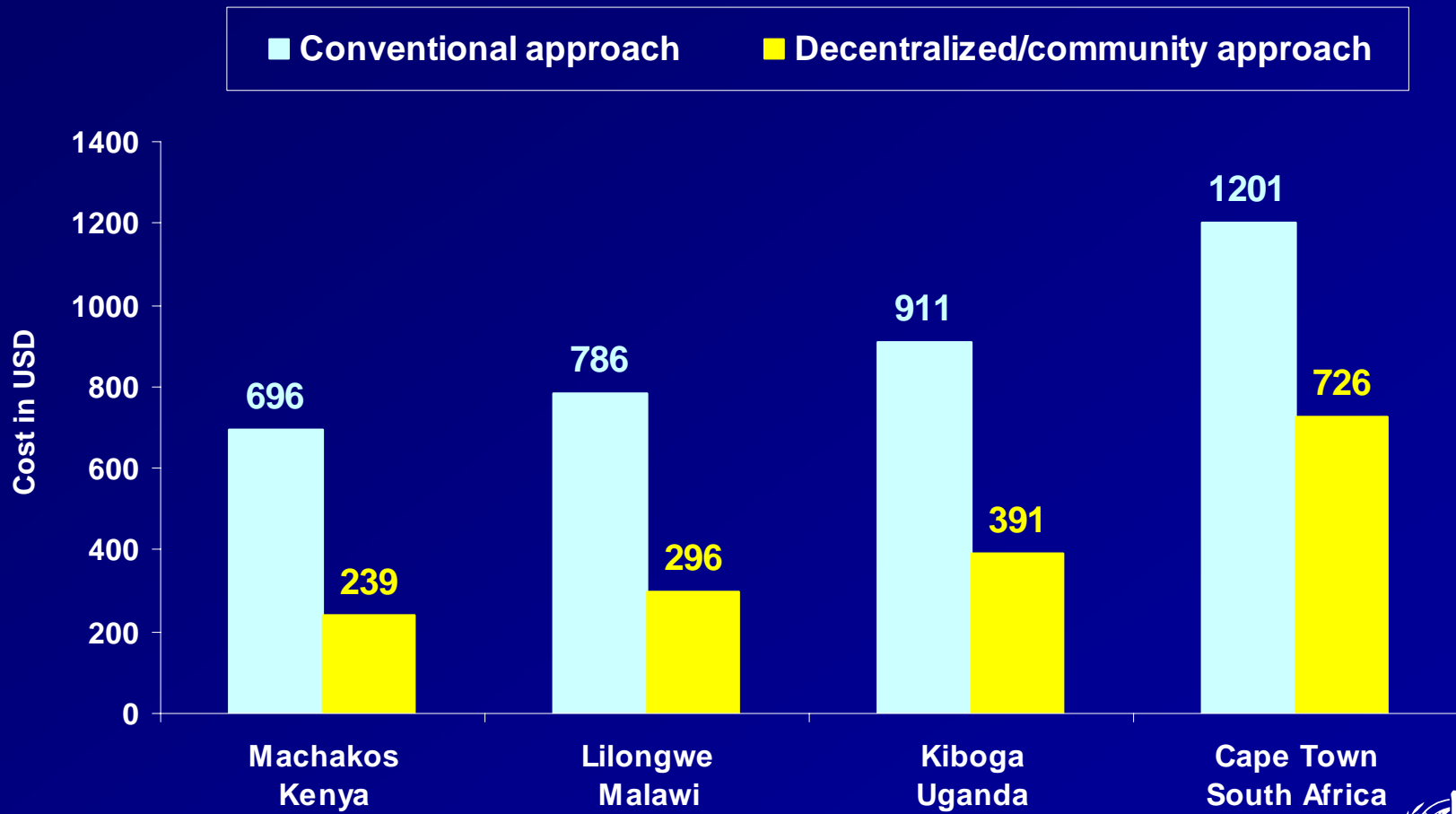
- DOT accepted as support to the patient
- simple functions, nobody is “medicalized”
- avoiding peer pressure (choice of neighbor vs relative)



District TB Programme Performance before and after Introduction of decentralized/Community Approach, 1997-2000



Cost-effectiveness of Conventional vs Community Approach (Cost per new smear-positive TB Patient successfully treated), 1997-2000



What it does (and opportunities)

- ◆ Initial emphasis on improving **treatment outcomes** (low cure rate settings).
- ◆ Not only “**DOT**”, but peer support to the patient.
- ◆ More gains in: **affordability, acceptability and cost-effectiveness**.
- ◆ In settings achieving high treatment success rates: explore how CTBC can also extend to helping **identify TB suspects**.
- ◆ **Positive externalities (K,A,B)** attached to the CB-model pave the way for community contribution to case-finding.
- ◆ Possible role in: referring TB suspects for diagnosis, delivering sputum specimens to health care facilities, collecting results, ARV delivery.

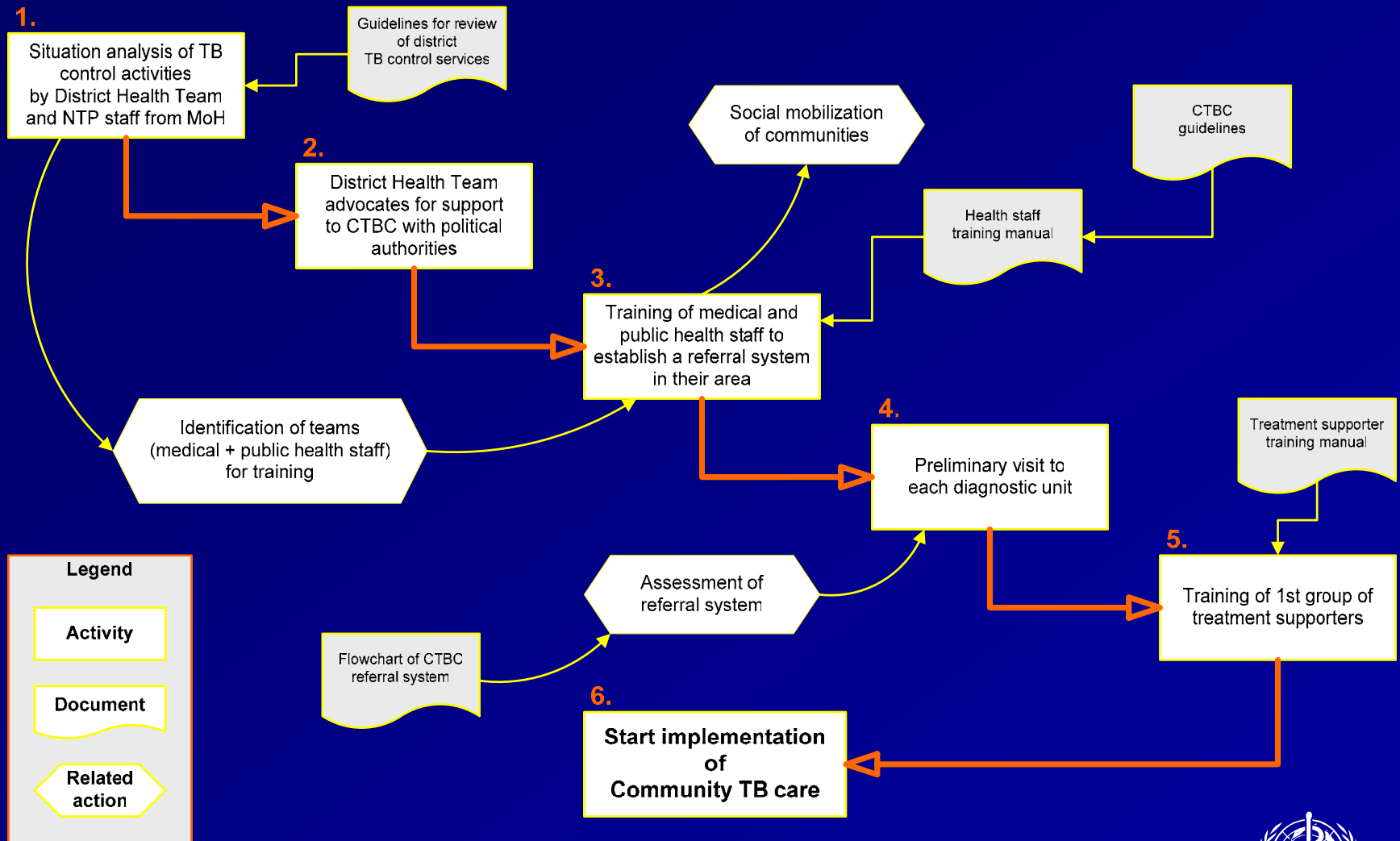


CTBC: specific indicators

- ◆ Proportion of new smear positive, smear negative and extra-pulmonary TB patients receiving DOT through CTBC.
- ◆ Change in case detection in area implementing CTBC one year after compared to one year before the introduction of CTBC.
- ◆ Treatment outcome for new smear positive, smear negative and extra-pulmonary cases, treated under conventional strategy or CTBC



Preparation for Community TB Care at district level



Preparation for Community-based TB Care at District Level

Activity	1st Month			2nd Month			3rd Month			
	1	2	3	1	2	3	1	2	3	
Contact with District Health Team - agree on situation analysis exercise	█									
Preparation of documents and data for situation analysis	█	█								
Situation analysis (with Central Unit resource person)			█							
Identification of clinical/public health staff for training			█							
Printing of all relevant training documents				█	█					
Presentation to District political and health authorities					█	█				
Training of all Health Staff (with Central Unit resource person)					█	█				
Social mobilization of community / leaders							█	█	█	█
Evaluation of referral system in all diagnostic units (with C.U. person)								█	█	█
Training 1 st group of Treatment Supporters (with C.U. person)									█	█

Remarks:

District political and health authorities should possibly be involved in a briefing before the situation analysis exercise and in a debriefing on relevant findings.

The Manager of the District Health Services and the District Health Team should actively participate in the review.

Please, allow enough time between activities for follow-up and action.

After the 1st group of Treatment Supporters has been trained, the introduction of CTBC starts officially.

Afterwards, whenever new patients are diagnosed, the clinical staff of the health facility will notify the new case to the public health staff, who establishes contact with the community asking its leaders to identify a treatment supporter, who is then trained individually by the public health staff.

According to this implementation timeline, the NTP resource person would pay 3-4 visits to the District over a period of 3 months.



Principles for a partnership with the community

- ◆ **Responsibility**: need for individual citizens and social groups, in exercising their rights, to have regard for the rights of others and seek the common good of all.
- ◆ **Solidarity**: expression by citizens of the need to be united, to share the needs and problems of others and to recognize and defend the dignity of each individual.
- ◆ **Subsidiarity**: a higher institution (e.g. government) should give over to the community what the community can accomplish by its own enterprise.



Making TB treatment (and ART) accessible: a social pact beyond the health systems?

- ◆ The value of this partnership between government services and the community goes beyond its operational returns (technical, administrative, economic, health, etc).
- ◆ It is a “social pact”, which strengthens both partners.
- ◆ Need to move beyond the biomedical concept of DOT and treatment adherence and integrate these in a new paradigm of solidarity and support to the patient.
- ◆ Can health services cope with continued monitoring of adherence of millions of people on ART for life?



21 Countries implementing CTBC in Africa

- Countries with **demonstration initiatives**: Côte d'Ivoire, Guinea, Mozambique, Namibia, Swaziland, Tanzania.
- Countries with an **implementation plan**: Botswana, Burkina Faso, Ethiopia, Nigeria, Rwanda, Senegal, Sierra Leone, Togo, Zambia, Zimbabwe.
- Countries **scaling-up demonstration initiatives**: Congo DR, Ghana, Kenya.
- Countries **adopting CTBC as national policy** and completing scaling-up: Malawi, Uganda.

