THE NEED FOR A MULTI-SECTORAL APPROACH IN TUBERCULOSIS CONTROL FOR ENHANCING COMMUNITY PARTICIPATION

ANSHU BANERJEE*

SUMMARY

This paper looks at reasons to treat Tuberculosis (TB) from an epidemiological, economical, and human rights point of view, explores issues such as stigma and poverty in relation to TB, and proceeds to look at National Tuberculosis Programme (NTP) strategies and issues in public health. It then identifies what can be done in the field by the different stake holders, such as the public health system, the private sector and the community. It describes a convergence model for delivery of TB services through the public health system, the private profit and non-profit health services and community participation.

It concludes, that if one wants a coordinated approach to cover whole districts and states, for organising the TB services activities and for their effective monitoring and supervision, a strong leadership, communication, planning, monitoring and supervision skills as well as an open mind to collaboration are needed, for the public health system to make it a success.

I. INTRODUCTION

Approximately one-third of the world’s population is infected with Mycobacterium tuberculosis. It was estimated that in a year some eight (8) million people will progress from tuberculosis (TB) infection to disease and an estimated 1.87 million will died). Of the estimated 8.8 million TB cases worldwide, more than 40% are in Southeast Asia. India has approximately 31% of all notified cases worldwide(2).

TB is the leading cause of death from an infectious agent, and in the developing world, accounts for 7% of all deaths and 26% of avoidable adult deaths(2,3).

TB is a disease which preferentially affects the most vulnerable and marginalized populations in all countries(4) and its direct and indirect costs can be devastating to individuals as well as to families. The cost to high TB burden countries is overwhelming. Worldwide, every year, TB related illness and deaths cause the loss of millions of potentially healthy and productive years of life. This is all in the face of an available, cost-effective cure.

This paper will look at why we need to treat TB, look at issues such as stigma and poverty in relation to TB, look at national TB programme (NTP) strategies and issues in public health. It will then look at what can be done in the field by the different stake holders such as the public health system, the private sector and the community, and conclude with some recommendations.

II. RATIONALE FOR TB CONTROL

A. Epidemiological

It is estimated that a smear positive patient infects 10 - 15 new people every year. Of these 10 %
will have a lifetime risk of getting TB. Unless smear positive patients are treated properly, the risk is that more smear positive patients survive, but do not get cured. They keep on infecting more people. A poorly functioning TB programme has thus the consequence that the number of TB cases increases. To control the TB epidemic by curing smear positive patients and reducing the burden of TB is therefore the main objective of a National TB Control Programme.

B. Poverty and health

It has been established that poverty leads to poor health and that poor health leads to poverty(5). This is particularly true for TB whereby, the stigma attached to the diseases and the poor delivery of public health services, has major socio-economic consequences for the patient and family. TB infection reduces the growth of the Gross Domestic Product by 0.7 %. A well functioning TB Control Programme reduces the infection in the community and should have a direct impact on the poverty of the community.

C. Right’s perspective

As mentioned earlier, TB is mainly a disease of the poor and the vulnerable. The principle of nondiscrimination is fundamental to public health and human rights thinking and practice. Overt or implicit discrimination violates one of the fundamental principles of human rights. It often lies at the root of poor health status and results in the lack of targeted policies and programmes and of access to services and other government structures relevant to health. Gender discrimination, for example, in addition to directly affecting vulnerability to TB and access to TB services, can deny girls and women access to education, information, and various forms of economic, social, and political participation that can increase health risk.

III. ISSUES IN TB CONTROL

A. TB and poverty

TB is clearly a disease of the less advantageous in life. Not only cultural perceptions but also social-political forces such as poverty, economic inequality, gender inequality, racism and political violence play a big role. This has been described as “structural violence”(6). The mere availability of a test to diagnose and drugs to cure TB does not insure its control in developing countries. The decline in TB in rich countries before the advent of effective tools for its control can be attributed to socio-economic improvement.

Studies have only recently been undertaken to identify the socio-economic burden of illnesses, such as TB, but the linkage between TB and poverty has long been noted. Increased probability of getting infected and of developing active TB are both associated with malnutrition, crowding, poor air circulation, and poor sanitation—all factors associated with poverty. The significant decline in TB between the mid-19th and mid-20th centuries, before the advent of drug treatment, observed in developed countries, was largely brought about for example, by factors that had reduced transmission-improved working conditions and assured less overcrowding.

A series of studies in India have strongly correlated income with TB(7). In one district, those who earned less than US$ 7 per month had twice the prevalence of those earning more than US$ 20 per month. In urban areas, prevalence among those with no schooling was four times that of tertiary graduates. In the developed world as well, people living in poverty, experience conditions that are more conducive to TB, have little access to health care which delays diagnosis, and if they get treatment, it is more likely to be inconsistent or partial.

The socioeconomic burden of TB is particularly acute as it has its greatest impact on adults in their most economically active years. Three quarters of the new cases of TB each year are among men and women between the ages of 15 and 54. Three to four months of work time, the equivalent to 20-30 per cent of annual household income, are typically lost to TB. The cost is higher if patients have delayed seeking treatment and remain ill longer. Incurred debt, combined with lost income, may trigger sale of assets such as land or livestock, pushing the family deeper into poverty. If budgets become tight enough, both adults and children may begin to feel the effects of malnutrition, which can have a permanent impact on a child’s health. Children may be removed from school because there is no money for uniforms, or, fees or because they must begin work to help support the family. In India, upto one fifth of school children discontinued their studies(7).

B. TB, stigma and gender

TB is a stigmatising condition that elicits fear and avoidance rather than sympathy. Various cultures associate TB with socially and morally unacceptable behaviour, witchcraft, and curses. An attempt at patient isolation during treatment is the commonest approach by the community to deal with the risk of infection. There is also a perception that if one person is infected other members of the family too will be
infected soon and people might try to avoid the family(8,9,10). This may lead to family members terminating or denying relationships with the infected. Often it would lead to decreased chances of marriage for both the patient and family members. For women it could lead to divorce or the husband taking a second wife(8) or being sent back to their natal homes(ll). TB is also widely believed to be inherited, and people who have TB are sometimes considered unmarriageable. The fear of being blamed for spreading the disease to neighbours and relatives made several patients stay away from the community and sometimes from their family (self-stigmatisation)(12).

As a reaction, the sick will try to normalise their lives by not informing others about their illness and the fear of ostracism may lead to reality evasion and prevent them from seeking health care and social services(13,14,15). In India, people were reluctant to give sputum because of the association between sputum and TB. Hence private practitioners often put patients on TB treatment without informing them(12).

Reasons for dropping out of treatment are feeling symptom free (usually after one or two months of effective chemotherapy), unwillingness to accept the unpleasantness of the therapy, loss of faith in the therapy, the stigma attached to being a TB patient, inability to afford the medication or poor communication between the doctor and patient. In Bombay, fixed clinic days, inconvenient timings and lack of attention by staff resulted in drop-outs. Men dropped out because of pressures to return to work or alcohol or drug addiction, women from the pressure to keep the secret or questions about them going out on a regular basis. On the Indian sub-continent parents of marriageable girls may be reluctant to send their daughters to the clinic because of stigma(ll).

Underprivileged women are generally loaded with household chores and the care of young children and are less likely to seek care from health services far from home, unless their illness becomes very serious. Time constraints can also vary seasonally and are bigger during harvest times. Women tend to seek care for cough much later than men (49 versus 27 days)(16).

TB patients may avoid going to nearby health centres associated with TB diagnosis for fear of exposure, instead seeking diagnosis and treatment in a different community. This may afford more privacy, but it also makes travel, and thus completion of treatment, more difficult.

Children in households with TB may also be taken out of school or sent to work. Both situations deprive children of their right to education and put them in situations that may expose them to more prolonged contact with persons with active TB.

IV. OBJECTIVES AND CHALLENGES FOR THE TB CONTROL PROGRAMMES

The objective of an NTP is to reduce mortality, morbidity and disease transmission and further, to prevent the development of drug resistance by providing standardised short-course chemotherapy under direct observation(17).

Early passive case detection and adherence to treatment are key factors for a successful TB control programme (complete treatment is minimal 6-8 months). Early diagnosis is often uncommon due to several months of patient and health services delay. Patients are usually diagnosed as a consequence of the interaction between their active efforts in seeking health and the passive case-finding activities of health care workers in health centres. Among patients with active disease, who do not adhere to treatment sputum conversion to smear-negative could be delayed, relapse rates could be 5-6 times higher and drug resistance may develop.

In 1992 TB was declared a global emergency and the World Health Organization formulated the DOTS strategy (Directly Observed Treatment Short Course Chemotherapy; Box 1) to improve TB care and control. The elements of the DOTS strategy have been incorporated into the Revised National TB Control Programme (RNTCP) in India.

Box 1: The DOTS strategy

The success of the DOTS strategy depends on the implementation of a five-point package(17).

1. Government commitment to a NTP
2. Case detection through case-finding by sputum smear microscopy examination of TB suspects in general health services
3. Standardised short-course chemotherapy to, at least, all smear-positive cases under proper case management conditions.
4. Regular, uninterrupted supply of all essential anti-TB drugs.
5. Monitoring system for programme supervision and evaluation.

Directly observed treatment (DOT) is one of the elements of the DOTS strategy. DOT means that a
supervisor watches the patient swallowing the tablets. This ensures that a TB patient takes the right drugs, in the right does, at the right intervals. In many countries, supervisors have observed patients’ treatment in in-patient settings in hospitals or in sanatoria. Supervisors have also directly observed treatment in out-patient settings. Over the years, the definition of a DOT provider/supervisor has been relaxed in order to make the treatment more accessible to the patient A health worker or even a trained and supervised community member may now be DOT provider. However, there must be a clearly defined line of accountability from the NTP staff to general health services staff and the supervisor who directly observes treatment.

V. ROLE OF HEALTH SECTOR

Traditionally most health services, including TB services, are delivered through the public health system. There is a perception at the moment that the public health services are not meeting the demands of the population. Therefore, in view of changes in health policy, the role for the public health sector is about to change. The public health authority is seen more and more as a regulator with the overall responsibility of ensuring that basic health services reach the needy through service delivery in the public sector and by contracting out services to other players in the health field, the so called stewardship role (see Box 2).

Health policies have to take the political, administrative and logistical considerations into account and should be sustainable. Non-hospital interventions are more cost efficient when dealing with prevalent health conditions. If necessary it is better to spend on district hospitals than on tertiary hospitals. However, as most of the budget is often spent on personnel, leaving none for drugs etc., there will be a low turnover at the peripheral centres and hospitals. Patients even go for minor ailments to tertiary hospitals that are supposed to cater for specialised care. Box 3 describes how money is spent in Andhra Pradesh on health care and Box 4 how money could be reallocated to make services more equitable(18).

<table>
<thead>
<tr>
<th>Box 3: Impact Expenditure Review Andhra Pradesh</th>
</tr>
</thead>
<tbody>
<tr>
<td>An Impact Expenditure Review carried out for the health sector in Andhra Pradesh showed that:</td>
</tr>
<tr>
<td>- Of total health care expenditure only 13.4% is public</td>
</tr>
<tr>
<td>- 85% of out patient contacts and 72% of hospitalizations are with the private sector</td>
</tr>
<tr>
<td>- Large share of public expenditure goes to secondary and tertiary care</td>
</tr>
<tr>
<td>- Higher income groups make far more use of public hospitals than the poor despite the fact that user fees are primarily paid by the better off, ie:</td>
</tr>
<tr>
<td>* top quintile are hospitalised 7 times more frequently than the lowest quintile (10 times more in rural areas)</td>
</tr>
<tr>
<td>* top quintile accounts for 40% of in-patient days in public hospitals, the bottom quintile 10% (exception is child birth)</td>
</tr>
</tbody>
</table>

Hence, public health subsidies in total benefit the better off more than the poor.

<table>
<thead>
<tr>
<th>Box 4: Reallocation of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reallocation of resources should be away from budget lines which benefit the better off to those which primarily benefit the poor</td>
</tr>
<tr>
<td>- From secondary and tertiary to primary health care, from hospitals to Primary Health Centres</td>
</tr>
<tr>
<td>- Reorient spending within existing budget lines towards the need of the poor</td>
</tr>
<tr>
<td>- Encourage the better off to seek health care somewhere else</td>
</tr>
<tr>
<td>- Trade off between cost-effectiveness and equity</td>
</tr>
<tr>
<td>- Public subsidies should be focused on interventions which have externalities and on cost-effective interventions which the poor would.</td>
</tr>
</tbody>
</table>
Therefore, to provide equitable services, and make the services more available to the poor and marginalized, there is a need to change the way how health services should be targeted. In view of this, freedom from discrimination will be a key principle and has been interpreted in international human rights law, in regard to the right to health, as prohibiting “any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.”(19)

What does this mean for TB services that have to deliver through a poorly functioning public health service? On the one hand, there is the DOTS strategy aiming at treating as many patients as quickly as possible to reduce mortality due to TB and reduce transmission of TB. Under this, one is not willing to wait for health reforms to strengthen the health systems in general, which at present are weak in many countries. On the other hand, there are those who argue that strengthening the health systems and making them more equitable will automatically improve TB care. They would rather support the integration of vertical programmes into the health system. They look upon the DOTS strategy as a vertical programme. Thus, it is clear that new approaches are needed to strengthen the health systems and TB control.

VI. MULTI-SECTORAL COLLABORATION

A. Public health service delivery :

With a limited amount of finances available, the public health system will have to prioritize such of the services, as would require public funding. It should improve the quality and accessibility of those services, it wishes to provide by decentralization of powers to district level and should establish strong accountability mechanisms. This will have an impact on the delivery of TB services as well and will need strong managerial, planning and supervisory capacities at both the State TB Office as well as at the District TB Office level. Investment in infrastructure, for example to improve communication between health facilities, will have a major impact on logistics, verification of addresses of patients, defaulter tracing etc. The health department will take on a more facilitatory and regulatory role and will have to develop those skills.

B. Public Private Mix (PPM) DOTS

As mentioned earlier, most out-patient contacts take place in the private sector. In many high burden countries, suspected TB cases also first approach and are managed by private practitioners. In India alone, the private sector is believed to manage half of the TB cases accounting for a sixth of the global burden of TB. Similarly, as for other public health problems treated in the private sector, it would make sense to collaborate with the private sector in order to increase the coverage of providing TB services to the general population. In most countries, the private sector has still remained alienated from DOTS implementation. As a result, reported case detection rates have remained low in many of these countries. Productive collaboration with private practitioners could go a long way in achieving rapid DOTS expansion and controlling TB.

C. Problems with TB control in the private sector are(20):

1. Not using smear microscopy as the main tool for diagnosis and therefore not identifying the smear positive patients
2. Not using standardised regimens but prescribing according to perceived seriousness of the disease and the patients ability to procure treatment
3. No standardised follow up and monitoring of patients, increasing the risk for development of multi-drug resistance.

That collaboration with private practitioners is possible has been demonstrated in the Sivananda-Mahavir project in Hyderabad, Andhra Pradesh, whereby all private practitioners in an area covering 5,00,000 people were contacted and asked to collaborate with RNTCP with the Mahavir hospital as the referral centre. This has resulted in 70% case detection and 85% cure rates in the area covered(21).

In order to involve the private sector, a preliminary policy framework has been developed (20):

1. There should be an assessment of the extent and nature of private sector involvement in TB care, the opportunities afforded by the private health sector, and any ongoing dialogue or collaboration.
2. Collaboration with the private health sector within the DOTS framework.
3. Emphasis on the 'public health' aspects of the control of TB and other communicable diseases in the
medical curricula. Medical students should be encouraged to spend some time working with the NTP and other communicable disease control programmes as part of their training.

4. Involve representatives of private health care providers in planning of TB control activities and policies on private sector involvement and maintain dialogue with private providers.

The private sector includes both the formal and informal sector as well as the not-for-profit sector: Non-Governmental Organizations (NGOs), charities, etc. There are different dynamics in setting up collaboration with these different sectors. However, the main drawback seems to be the attitudes of both sectors, whereby the public sector accuses the private sector of trying to make as much money as possible out of the patient and the private sector accuses the public sector of not providing any services at all. To start a dialogue, these differences should be set aside, and each sector should understand the constraints faced by the other and identify how both can collaborate.

If, after an initial assessment, it is thought that the private sector will be able to contribute to TB control the following steps need be taken:

1. Sensitization of possible partners such as NGOs, trust hospitals, private hospitals, medical colleges, diagnostic centers, and private practitioners on TB and their possible role in TB control

2. An assessment of the capacity of the partner, an agreement of the roles of the TB control programme and the partner by signing a memorandum of understanding and training of their staff.

3. Monitoring of the activities carried out by the partner and feedback, including corrective action, if needed.

Participation with the TB control programme will depend on the relationship and the level of trust established between the TB control programme and the private sector. For those willing to collaborate with the programme, training of the for-profit-providers will have to take a different shape from the training of the public sector providers. Because of time constraints to leave their practice, the training material will have to be covered over a number of sessions. Also, monitoring of the performance of individual private providers will have to be adjusted. Though many TB patients initially visit a private provider (PP), because of the large number of providers, each of them might diagnose and provide treatment for only a few patients. In case of the Sivananda-Mahavir project in Hyderabad, even though it has taken a number of years to involve the PPs in the area covered, the project had an advantage in establishing a relationship with the PPs. This has been possible, as it is a private trust hospital which offers tertiary care diagnostic facilities for those referred (PPs are not referring their patients to a public hospital. They might not have been inclined to do so, because of the poor perception of the public health services). However, not all PPs are referring patients to the project and some are not referring all their TB patients to the project (they prefer to treat some themselves). The number of supervisors in the project area is also much higher than that available with the public sector, resulting in better cure rates because of more intense follow up. Supervision occurs through review of the treatment cards used by the RNTCP.

For those, involved in TB care but not willing to participate with the TB control programme as they are not willing to report their cases to the programme, it will still be important for the programme to interact with them, to improve their diagnostic skills, to try to influence the prescription of treatment regimens in order to use RNTCP regimens and to emphasis the need for follow up of the patient. This requires frequent interaction with the providers and is time-consuming.

As long as the government does not have a stronger policy on mandatory notification of TB patients, on enforcement of quality of care and the fee to be charged by the private sector for services delivered by them, participation of the PPs will depend on their goodwill based on the trust created between the TB control programme and the PPs. The possibility to influence PPs to adhere to TB control programme policies should therefore not be overestimated.

Collaboration with NGOs and hospitals that will act as a microscopy center (MC), can follow routine programme monitoring procedures.

To conclude, PPM is about relationships. Just as patients initially go to PPs because of perceptions, past experience and an established relationship, so does the inclusion of PPs/NGOs depend on the establishment of a relationship with them. Setting up PPM can take a long time, even after the initial agreement, as willingness does not always translate into immediate action. This means, recurrent efforts and frequent interaction are needed. This is time intensive and, assuming 40% of patients are treated
in the private sector, justifies a separate person focussing on PPM in urban districts with a high PP population.

VII. COMMUNITY SERVICES

Equity of services necessitates a cross-sectoral approach, and increasing synergy amongst the various sectors relevant to health and development should be promoted?. The interdependence of human rights-i.e. the right to nondiscrimination and the right to information as integral to achieving the right to health-and the need for all levels of society to be mobilized around the core principles of human rights, call for a social mobilization approach. Human rights emphasizes empowerment, participation, and nondiscrimination. The rights of individuals and groups to active, free and meaningful participation in setting priorities, making decisions, planning, implementing and evaluating programmes, that may affect their development, is an integral component of a rights-based approach.

Convenient and accessible TB treatment and care are essential. As access to health care is difficult in many places and there is a lack of health workers, there is a need to look at approaches outside the clinic and hospital setting. Community participation in primary health care (PHC) is not a new idea. The challenge is to do this in ways that contribute to community development and that are effective, acceptable and affordable. Two important lessons that TB control can learn from the experience of community participation in other aspects of PHC are(22):

- Community health workers can play an important role, provided that they receive adequate support, motivation and incentives
- It is better to work through existing community organizations than to create new ones

In general, successful community approaches have been the result of:

- Good collaboration between general health services, the TB control programme and the community
- Good education of the TB patient, his or her family and the community
- Good training for community supporters as well as health workers
- Good systems of supervision of community supporters by TB programme staff
- Improved access to anti-TB drugs

Community approaches to TB care have shown high rates of success in a variety of settings. One approach used successfully in South Africa(23), for example, is for community members to act as DOTS supporters. In Thailand(24,25), Indonesia(26) and Malawi(27), family members have been used to observe treatment, resulting in high cure rates. Another approach is peer and community support for TB patients as tried in one district in Ethiopia through establishing TB clubs(28,29). Partners in India can range from Panchayati Raj Institutions (PRIs), NGOs and Community Based Organizations (CBOs) to Self Help Groups, Thrift groups, Watershed groups, or any other group involved in poverty reduction programmes.

Activities that can be taken up at community level and proposed by the NGO guidelines of the RNTCP are:

1. Information Education Communication (IEC)

No health programme can be successful if those who could potentially benefit from it, lack the information they need. Misinformation about what causes TB, how it is transmitted, and whether it can be cured is linked to the stigmatization of TB and of people with TB. In India, more than half of surveyed households knew that government-run primary health centres existed, but only 15 per cent knew that free TB treatment was available there(7). Also, individuals' socioeconomic status has been found to determine their access to information about TB as well as the treatment available. Other study found that people who are illiterate have the most misconceptions about TB and that many physicians who treat TB themselves lack knowledge. Mass media campaigns might reach mainly the urban target groups but other strategies such as interpersonal communication (IPC) will have greater impact in rural areas. Using women groups, self help groups, PRIs and Anganwadi workers to educate the community is important. An example is the TB club formed by groups of TB patients in Ethiopia, who live in the same administrative area of a district, and who met while attending out-patient appointments. Each club, which has between three and 10 members, elects a leader. The leader ensures that all members attend the TB clinic and arranges weekly club meetings, where members can support each other and share problems. Anyone, who is failing to make good progress or who is experiencing drug side effects, is referred to the local health facility by the club leader. Attendance at TB clinics has improved significantly and treatment success rates are higher than in other parts of the country. With help from community elders, religious leaders, community health agents and local
health workers, the TB clubs have also identified people in the community with suspected TB, encouraged them to seek diagnosis and treatment, and helped to promote adherence to treatment and to trace defaulters. Using educational materials provided by the Ministry of Health, TB club members have also helped to educate the community about tuberculosis, in collaboration with health workers and community health agents. Of people, suspected as suffering from TB and referred for investigation, two-thirds were diagnosed as TB cases. They identified 69% of all TB patients and 76% of new sputum smear-positive pulmonary TB patients with smear-positive sputum diagnosed in the district. TB clubs have helped to increase community awareness of the symptoms of TB and the need for treatment(28,29).

2. DOT Provision

Ideally, TB treatment should be as close to the patient as possible. Even if the present public health infrastructure in India would function optimally, to be receiving DOT from a health worker would, for many patients, be either too far away or not convenient. Even a community based worker, such as an Auxiliary Nurse Midwife (ANM), has to cover a number of villages and not all villages are covered by Anganwadi workers. Performance of other type of providers has been evaluated in other countries, ranging from shopkeepers to family members. With the right education and supervision these have all been successful. The main problem in identifying non-health staff as DOT providers, is the little accountability the provider has towards the health services. Therefore there is a need to create accountability to the community. Also, the issue around appropriate incentives is still highly debated, with some insisting on monetary incentives and others feeling that it should be totally voluntary.

For certain groups, such as migrant workers, it might be worth piloting “family based DOTS” for the period that they are out of their district or while travelling to their place of work.

3. Lab services

Many primary health centres that should function as Microscopy Centres for sputum diagnosis do not have Lab Technicians. In Orissa, DANTB has trained other PHC staff to do smear microscopy as well as community volunteers, depending on the willingness of the individual (personal communication).

Lepra India has established Sputum Collection Centres in Koraput district in Orissa to facilitate sputum collection in areas as far as 50 kms away from a Microscopy Centre. TB suspects identified in the community leave 3 samples with the Anganwadi worker. The samples are collected by a Lepra field worker and transported to the Microscopy Centre and the results are taken back to the Anganwadi worker the following day. In case of smear positivity, the patient is asked to go to the nearest PHC to start treatment (personal communication).

4. HIV

The relatively high prevalence of HIV in the general population in some states necessitates strong collaboration between the two programmes to have a synergistic impact. The TB control programme can, in particular, benefit from the network of NGOs and other collaborating partners of the State AIDS Control Societies in the prevention and care of HIV.

5. Monitoring and supervision

As can be seen from the above interventions, the health staff will have to take on a wider role than just provision of services. Working with the private sector, communities, community leaders, and community groups and stimulating their involvement in planning and carrying out services requires skills and trust. These are not always present at the state and district level and need to be developed. Support can be provided by NGOs that have experience in this area. In Andhra Pradesh, NGOs who work in leprosy control (Damian Foundation India Trust, German Leprosy Relief Association, Lepra India) and assist the government in monitoring and supervision of the leprosy control programme at district level through Technical Support Teams, are providing the same support to the TB programme as well in a number of districts. A team of a doctor and one or two supervisors equivalent to a Senior Treatment Supervisor, assist the District TB Officer in monitoring the quality of the programme, identify gaps that need addressing, assist in training programmes and in reviewing the programme.

VIII. CONCLUSION

This article has tried to explore issues in TB control and to describe a convergence model for delivery of TB services through the public health system, the private profit and non-profit health services and community participation with a stewardship role for the programme officers. It has looked at possible future changes within the role of the public health system and the fact that the private sector is widely used. However, coordinating these activities and the monitoring and supervision of these activities and
reporting the results to the Central TB Division, Ministry of Health, will remain with the public health system. At the same time, information on tuberculosis and that on availability of services need to be available in the community.

The reason for the inclusion of other partners in TB care delivery is that the public health system does not reach all patients, and those reached are often at a delayed stage. At the same time, from the side of the public sector, there are prejudices to involve the private sector as well (PPs, NGOs and CBOs). When pilots are tried out, they often work, despite the poor public health system, because they are tried out in a small area with additional inputs. However, if one wants a coordinated approach to cover whole districts and states with several forms of collaboration, strong leadership, communication, planning, monitoring and supervision skills as well as an open mind to collaboration are needed for the public health system to make it a success. Action is however required as soon as possible, and, therefore the different activities to make the convergence model successful should be introduced parallel to each other.

REFERENCES


22. www.who.int/gtb/policyrd/CommCare.htm


25. Pungrassami P, Johnsen SP, Chongsuvivatwong V, Olsen J, Sorensen HT. Practice of directly observed treatment (DOT) for tuberculosis in southern Thailand: comparison between different types of DOT observers. *Int J Tuberc Lung Dis* 2002 Mar;6(5):389-95


