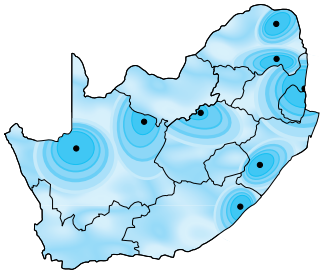
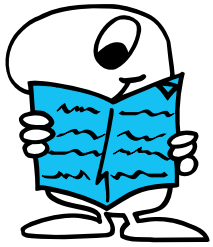


Initiative for Sub-District Support



Kwik-Skwiz #10

Tackling TB in Benede Oranje Region

File for quick reference

The Issue

TB has been identified as the most important health problem facing the Benede Oranje region/district in the Northern Cape province. In 1996 the district reported a staggeringly high incidence of 1 160 cases per 100 000 people compared to an estimated 340 cases per 100 000 people for the rest of the province (Tuberculosis Research Programme, MRC).

ISDS has been working with the district in an effort to reduce the incidence of TB. Although long-term solutions to the problem will depend on poverty reduction and improvements in living conditions, the district team believes that their first task is to ensure an efficient district level TB control programme.

Progress to date

Step 1: Establishing TB control as a priority

When questioned, almost all health care workers in the district identified TB as the biggest health problem facing them. They felt that their efforts to control TB were largely ineffective.

Analysis of the figures at one clinic confirmed the health care workers impressions. The clinic achieved a 30% cure rate despite access to laboratory and X-ray facilities and a reliable supply of drugs. More than half of all TB patients interrupted their treatment. Closer analysis showed that overdiagnosis was a problem - almost a third of adult patients probably did not have TB at all and staff were wasting valuable time and money in treating them!

Analysis of how the clinic worked showed that although health workers viewed TB as a priority, this was not always reflected in their work. There is clearly a need to ensure that TB receive the attention it deserves both at district and facility level.

Step 2: Identifying obstacles to effective TB control in the district

The major obstacles which were identified included the following:

- Poor co-ordination and communication between different service providers. For instance, hospital staff did not trust clinics to supervise patients and rather kept patients in hospital.
- Confusion surrounding treatment guidelines - clinics were using two different sets of treatment guidelines which were similar but slightly different. This resulted in a lot of confusion.
- Reliance on chest X-rays rather than on sputa results for the diagnosis of TB
- Delays in receiving sputa results.
- Absence of a system for community-based directly-observed treatment.
- Lack of involvement of NGOs and CBOs in the programme.

Step 3: Involving all role players

A District TB co-ordinator was appointed late in 1997. One of her first task was to establish a TB Co-ordinating Group. The group includes the district TB co-ordinator, the district manager, the provincial TB co-ordinator, the district TB Medical Officer, the PHC co-ordinator, a SANTA representative and representatives of the TB hospital and laboratory services.

Step 4: Developing a District TB Plan

The TB Co-ordinating group has developed a District TB plan for 1998. The plan includes time-frames as well as a clear definition of who is responsible for which actions.

ORGANISATION AND MANAGEMENT

- ✓ The Regional TB Co-ordinating Group will meet quarterly to review progress and to ensure co-ordination of services.
- ✓ Each facility will identify one professional nurse who will take overall responsibility for managing TB in that clinic.
- ✓ The Regional TB Co-ordinator will visit all clinics at least quarterly (problem clinics will be visited on a monthly basis).

TECHNICAL

- ✓ The National TB Control Programme guidelines have been accepted by the region. A circular outlining this has been sent to all health facilities and Local Authorities.

Diagnosis

- ✓ Diagnosis will be standardised in accordance with the National guidelines - this will result in far fewer X-rays needing to be done.

Laboratory Investigations

- ✓ An investigation will be undertaken to determine the reason for long sputum turnaround times and for no reports on some specimens.
- ✓ A specimen register will be established.

Drugs

- ✓ Combination drug preparations should be used in all hospitals.
- ✓ Rinah will be made available in the region.

Evaluation and monitoring

- ✓ A district TB register will be started.
- ✓ A minimum of one professional nurse from each facility will be trained in completion of the register.

TRAINING AND SUPPORT

- ✓ The district coordinator should attend a national course aimed at district co-ordinators.
- ✓ The district coordinator will visit the TB demonstration sites in the Western Cape.
- ✓ All nurses will be trained in the use of the National TB guidelines.
- ✓ At least one professional nurse per clinic will be trained in the use of the register.

COMMUNITY AWARENESS

- ✓ Formal health education sessions will be held in all sub-districts
- ✓ A play which will be performed throughout the region will be developed.
- ✓ Education of employers (particularly farmers) about TB and management of TB patients

COMMUNITY INVOLVEMENT

- ✓ Co-ordinate the programme between all the role players from the public sector and from NGOs and other institutions such as churches.
- ✓ Increase the number of patients who receive DOTS
- ✓ Investigate inviting TADSA to train treatment supporters

TREATMENT OF TB PATIENTS

- ✓ Develop a contract of compliance for new patients.
- ✓ Investigate ways of improving facilities at the TB Unit

Step 5: Implementing the plan

Already a number of successes have been achieved. The Co-ordinating team is meeting regularly to review progress and deal with any problems. Staff have been trained in use of the guidelines and clinics are visited by the TB co-ordinator on a regular basis.

The emphasis on using direct smears only for diagnosis has resulted in substantial reductions in laboratory costs and co-operation with the laboratory has improved the speed of service.

Step 6: Monitoring and evaluation

A district register has been introduced which will help to monitor progress. Initial reductions in the number of patients with TB will reflect improvements in diagnosis, but it is hoped that the district will soon be able to demonstrate improvements in case holding and cure rates.

This brief was written by Lesley Bamford, ISDS facilitator for the Northern Cape, attached to the Child Health Unit, University of Cape Town

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