Guidelines for Implementing Community TB Care Programmes

World Health Organization
Office for the African Region

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Acknowledgements

These guidelines are a direct result of the “Community TB Care in Africa Project” implemented between 1998 to 2000 in 8 urban and rural sites in 6 sub-Saharan African countries, namely: Botswana, Kenya, Malawi, Republic of South Africa, Uganda and Zambia. Subsequent to the pilot projects, countries have gone on to scale up activities and broadened the knowledge from the pilot projects further. The role of the National TB Control Programme Managers of these countries and all programme staff involved in the project and ongoing scale up in countries are particularly acknowledged.

Collaborating agencies for the project are recognized for their role in funding the activities and in providing technical assistance together with the World Health Organisation (WHO) to the implementation, monitoring and evaluation of the various country level projects. These include: United States Centers for Disease Control and Prevention (CDC), THE United States Agency for International Development (USAID), the International Union Against TB and Lung Diseases (IUATLD), the Royal Netherlands TB Association (KNCV) and the United Nations Joint Programme on HIV/AIDS (UNAIDS).

Lessons from other non-WHO funded experiences with Community TB Care such as in Togo, and from other disease control programmes have also contributed to the lessons upon which these guidelines will continue to evolve.

The authors and contributors to the “Community Contribution to TB Care: Practice and Policy” publication provided a synthesis of the experiences from the “Community TB Care in Africa Project” widely used in these guidelines.
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1. Introduction:

1.1: Community participation in health care delivery:

Community participation in health care is an age-old concept. In 1978, the joint WHO/UNICEF Conference at Alma Ata accepted Primary Health Care (PHC) as the strategic approach with which to reach the goal of “Health for All by the Year 2000” adopted a year earlier by the World Health Assembly (WHA).

The PHC principle recognizes that health services should be accessible, cost-effective, tailored to local needs, characterized by inter-sectoral co-operation and delivered with the participation of the people.

In TB Control, community involvement in the implementation of Program activities is also not new. The WHO Expert Committee on Tuberculosis in its ninth report (1974) observed thus,

“it is important that the community should be involved in the program, including leaders, such as village elders, tribal chieftains, or other influential persons, and the welfare organizations including the voluntary agencies and laity”.

Following that report, WHO has been promoting the integration of National TB Control Programmes (NTPs) within general health services in order to increase access to effective TB care and the internationally recommended TB DOTS strategy is now almost being implemented in all member states (see Figure 1) even though population coverage within countries and quality of services could be improved.

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1 Reference on “PHC”, 1978
While integration has gone a long way to increase access to TB services as expected, the generally limited coverage of public health services has continued to impede accelerated access to TB control services. This has partly been due to inadequate health service infrastructure, insufficient decentralization of both diagnostic and treatment services and inadequate human, material and financial resources. The recent phenomenal increase in the incidence and burden of tuberculosis in the Region, especially in Southern and Eastern sub-regions due to the direct impact of the HIV/AIDS epidemic, has greatly increased pressure on public TB services in many countries, renewing interest in alternative cost-effective approaches to delivering TB diagnostic and treatment services, such as community based TB Care initiatives\(^5\).

Recent experiences in the African Region and elsewhere in the world indicate that community participation has the potential to overcome some of the limitations of relying on the public health sector for the delivery of TB services, resulting in more widespread implementation of program activities, improved treatment outcomes and more efficient use of available resources\(^4\).


1.2: Community TB Care in the African Region.

Since the HIV fuelled TB epidemic emerged, the number of TB cases notified in the Region has increased exponentially and general health services and TB services in many countries have found it difficult to cope with the upsurge of cases. Figures 2, 3 and 4 below show the increasing trend of new smear positive cases since the mid nineties, notification rates for overall notifications for 2002 and the ever-increasing trend of new and overall notification rates between 1993 to 2002.

Figure 2: Trend of new smear positive cases. AFRO 1995-2002
Even though cases have continued to increase, case detection rates and treatment success rates in the region have remained below regional and global targets. This is shown in Figure 5 below.
With these trends in total reported cases and rates over the years, the search for complementary and alternative cost effective means to manage the cases has become unavoidable. A WHO coordinated mission in 1995 assessed TB care in community based organizations in several countries and recommended operational research to evaluate the potential of community contribution to the delivery of effective TB care as part of NTP activities.

1.2.1: The Community TB Care in Africa Project:

Between 1996 and 2000, WHO coordinated a multi-national project to evaluate community contribution to TB care in 8 sites in 6 sub-Saharan African countries: Francis town in Botswana, Machakos in Kenya, Lilongwe in Malawi, Kiboga and Kawempe in Uganda, Ndola in Zambia, and Guguletu and Hlabisa in South Africa. The aim of the project was to evaluate the effect on NTP performance of decentralizing the provision of TB Care beyond fixed health facilities up to community level. The main outcomes of interest were effectiveness, acceptability, affordability and cost-effectiveness and the key features of each study are summarized in Table 1.2.1 below.

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Table 1.2.1: KEY FEATURES OF THE COMMUNITY TB CARE PILOT PROJECTS

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<th>Project Site</th>
<th>Setting</th>
<th>Study design</th>
<th>Community organization</th>
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<td>South Africa</td>
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<td>Uganda</td>
<td>Kiboga</td>
<td>Rural</td>
<td>Historical case control study</td>
<td>Parish Development committee</td>
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<tr>
<td>Zambia</td>
<td>Ndola</td>
<td>Urban</td>
<td>Prospective controlled</td>
<td>Church NGO AIDS programme</td>
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1.2.2: Summary findings from the project

i): Francistown, Botswana.

The Botswana study was designed to determine the cost and cost-effectiveness of Home Based Care (HBC) of chronically ill HIV positive TB patients compared to hospital care. The study showed that patients under the conventional hospital based care scheme stayed in hospital longer than their counterparts and home based care was much cheaper than conventional hospital based care both to the health system and to care givers. Economic analysis showed that HBC was 42% more cost-effective than conventional hospital based care. The investigators concluded that it is more cost-effective to treat chronically ill HIV positive TB patients at home than in hospital.

ii): Machakos, Kenya:

The Machakos study assessed the cost-effectiveness of decentralized and community based DOTS compared to conventional hospital based DOTS. All newly registered TB patients were given the option of limited hospital admission followed by either facility based (hospital in-patient, hospital outpatient and health center) or community based care even during the intensive phase of treatment.

For both new and re-treatment smear positive patients, treatment success rates were similar between the two treatment groups and treatment completion was better in the CTBC group. For smear negative and extra pulmonary TB cases, treatment completion, default and transfer out rates were significantly improved in the CTBC group compared to the facility-based group. Death rate was similar between the two groups. Finally, both patients and family members preferred home to hospital care of TB patients. The study therefore concluded that Community TB care was a viable means of implementing DOTS as it served to remarkably decongest the hospital wards, was acceptable to patients and guardians, and was more cost-effective. The main challenges observed were the increased demand for supervision, training of community based care providers and the need to decentralize and maintain quality laboratory services.

iii): Hlabisa, South Africa:

The objective of the Hlabisa study was to assess the acceptability and effectiveness of Traditional Healers (THs) as supervisors of TB treatment compared to other types of treatment supervisors (clinics, Community Health Workers, shopkeepers and other lay persons). Results from the study showed that traditional healers were another potential group of DOTS supervisors. The THs had similar case holding rates as other types of supervisors, and patients were satisfied with the service they rendered. An earlier detailed economic analysis of the TB control program in the area that included a costing of the existing community-based DOTS program showed that community based DOTS was more cost effective than hospital care.
iv): Guguletu, South Africa:

The Guguletu study was designed to evaluate and compare program performance for both new and re-treatment smear positive pulmonary tuberculosis patients supervised at clinic, community and other supervision options over an 18-month’s period. Comparison data for economic analysis was collected in neighboring areas where the community option was not available.

The study findings showed that the community based TB care supervision option was more cost-effective than clinic and other options both for new and re-treatment TB patients. There was also a significant decrease in health system and patient related costs for new smear positive as well as re-treatment TB patients in the community group compared to the clinic based group. The investigators concluded that community based care of TB patients was both cost-effective and acceptable.

v): Lilongwe, Malawi:

The overall objective of the Lilongwe study was to compare treatment outcomes; cost and cost-effectiveness between decentralized TB care services and conventional centralized TB care services. Besides the main TB hospital, 21 new DOTS centers were established at urban health centers where patients could choose to receive their intensive phase of treatment supervised by health center staff or at home supervised by guardians of their choice. For the economic assessment component of the study, treatment outcomes in the two main hospitals in the study area were compared during and before the study in a before and after study design.

The study showed that overall cure rates were similar between the periods, while default and transfer out rates were lower during the period with community TB care option. Case fatality rate, however, was higher during the community based option time (perhaps due to more complete reporting of end term events due to closer supervision). Acceptability of community involvement was inferred from the willingness of community groups and guardians to participate in the provision of community based TB care. Decentralized care was also less costly for smear positive TB cases but introduced new costs for smear negative cases in the form of DOT visits and more expensive drug regimens. The investigators concluded that decentralization was more cost-effective for new smear-positive TB patients but less so for new smear negative cases.

vi): Kawempe, Uganda.

The study in Kawempe, an urban location in Kampala, was designed to assess the cost-effectiveness and acceptability of community based management of TB using a non-governmental (NGO) AIDS support organization, TASO. Conventionally, patients were admitted for the first 2 months of intensive phase of treatment followed by monthly reporting to Health Units to collect anti-TB drugs that are taken at home unsupervised. During the intervention, patients started treatment in the Health Unit for the first 2 weeks and then given a choice between community and Health Unit for DOTS supervision.
Intervention uptake and treatment success rates in this study were unexpectedly low even though treatment success rate for new patients was slightly better in the intervention group than in the control group. Community members as well as patients had reservations about community care of TB patients because of issues of stigma, cost, and distance to the health unit for those who chose that option. No economic analysis was undertaken in this study. The main conclusion was that it had not been possible to successfully implement a community-based approach for TB care in this urban setting in Kampala.

vii): Kiboga, Uganda:

The Kiboga study was designed to compare the cost-effectiveness of community care for TB and the conventional approach where patients are admitted for the first two months of treatment. Kiboga served as the intervention population and Masindi district nearby served as the control population. A before and after comparison for Kiboga was also made during the analysis.

The study found that patients in the intervention group were twice as likely to be treated successfully than those in the control group. There were also substantial reductions in cost and over 50% improvement in cost-effectiveness in the intervention group. The hospitals have as a consequence increased capacity to cope with rising number of patients and CB-DOTS has become highly acceptable to patients, health care workers and the community.

Because of the success of this project, CB-DOTS has been adopted as national policy for TB care in Uganda since January 2000. The current major challenge faced by the NTLP is to allocate adequate resources for successful implementation of the policy.

viii): Ndola, Zambia:

The Ndola study was designed to assess the effectiveness of community based TB care. The project identified Chipulukusu compound that has an established community based group serving chronically ill people with symptomatic HIV infection, as an intervention site and Twapia compound which did not have an established community based care program as a control. In the intervention population, treatment options included community based DOTS in the initial phase and if necessary in the continuation phase as well while in the control area, staff administered TB treatment to ambulatory patients at the health center daily or weekly.

The results showed that integration of TB care into the Home Based Care (HBC) program in Chipulukusu where trained and supervised volunteers were used to administer DOTS to patients is feasible and resulted in high cure and treatment success rates for sputum positive patients compared to the control area. Further, the default rate for all types of patients was zero in the intervention compound, which was significantly different from the control area. The approach was also highly acceptable to patients, volunteers and the wider community.
1.2.3: MAIN CONCLUSIONS AND POLICY RECOMMENDATIONS DRAWN FROM THE PILOT STUDIES:

1. Community based TB care is a feasible, acceptable, effective and cost-effective way to deliver TB DOTS services. However, it must be implemented within the guidelines, and preferably, as an integral component of a national TB Control Program. Countries where TB caseload is overwhelming currently available resources should seriously consider how they could increase community contribution to TB care.

2. While community DOTS is cheaper and more cost-effective than hospital based care, new resources are often required in its implementation. This if mainly for training of care providers, strengthening of health delivery systems such as laboratory, monitoring and evaluation services, and patient follow up.

3. Successful community contribution to TB care requires close collaboration between the national TB Control Program and the community in order to provide technical and other support to the community initiatives and ensure high quality services. It should therefore only be pursued where essential elements of a national control program are in place (even if the results of programme performance are below targets), and decentralization of health facility provision of TB services has been maximized.

4. Managerial expertise is essential in linking the TB program; general health services and community care providers. This facilitates efficient decentralization of logistics (e.g. drug supply, reporting outcomes) and effective co-ordination and leadership. Training of community care providers is essential and should focus on a limited number of activities. Supervision should be regular, frequent and supportive; and community TB care should be designed to complement and extend NTP capacity, not to replace it.

5. Sustainability of the program is very important and must be planned for from the start. A good situation analysis is necessary to identify area specific contexts and to identify appropriate community care providers. Appropriate community providers are more likely to be motivated individuals close to the patient or to belong to a well-established and experienced community group or organization as opposed to a recently established and inexperienced group. It is necessary to identify the context-specific motivation of community care providers and ensure ongoing motivation to sustain their activities.

6. Effective community contribution to TB care, especially Community based DOT, requires strong referral, recording and reporting systems, easy access to laboratory services, and a secure drug supply. These should therefore be developed as part of general health care delivery system strengthening in order to ensure smooth delivery of services and efficient support for activities at all levels.
2. **Why Regional Guidelines?**

The African region is the worst affected by the health sector impact of the increasing HIV-fuelled TB epidemic. And it is globally accepted that the TB fight will be won through judicious and widespread application of the DOTS strategy in all countries. Unfortunately, even though the Strategy was first grown on the African soil through IUATLD supported programs in Benin, Malawi, Mozambique and Tanzania before being adopted globally, most NTPs in the region are not yet achieving adequate coverage, case detection and treatment success rates to have a significant impact on the burden of the disease. Thus, it is necessary to adopt new ways to complement public health services in the provision of TB care in the region.

Following the successful piloting of the community TB Care approach in the 6 African countries as discussed in section 1 of this document, the regional office has included Community Based DOTS as one of the approaches to increase population access to DOTS services and improve programme performance. Since the pilot projects, a few countries are already implementing decentralized TB care including community-based supervision of DOTS services with satisfactory levels of performance. Further, for the medium to long term, AFRO will be promoting the approach to more countries in the region to help expand DOTS coverage and improve treatment outcomes. These guidelines are therefore meant to assist member states to systematically plan and implement community TB Care within their NTPs taking into consideration each country’s unique circumstances.

2.1: **Who are the Guidelines for?**

These guidelines are meant for TB Control Programme planners, managers and coordinators both in the public and private health sector to conceptualize, plan, organize, implement, monitor and implement community based TB control initiatives. They should find utility in translating TB Control decentralization policies into programmes at operational level. They should also be useful for general health care providers implementing the initiatives at peripheral levels where the participation of communities is critical. Community health agents of various types will also find the guidelines handy as they plan and implement control activities with beneficiary communities.

Due to the varied target groups, the guidelines have attempted to cater for a wide range of beneficiary audience. The crafting of terminology and content traverses the simple to the complex, the operational to the strategic. However, practical applicability in implementation of programmes underlies the main guiding principle. It is clear that these guidelines will complement other supportive documents that discuss specific topics in more detail.
3. **THE GUIDELINES**

3.1: **Purpose of the guidelines:**

These guidelines on the decentralization of TB services, including community TB care, are borne out of actual experiences from selected countries in the region and from general decentralization theory. Their importance lies not in their ability to describe accurately what should happen in practice in all countries, but in their clarification of key design issues that must be considered in developing decentralized TB control services and initiatives. They are meant to provide programme planners, managers and implementers at various levels of the health care delivery system with a framework for designing and implementing community based TB control activities as part of overall national TB Control Programmes.

3.2: **Motivation for decentralizing TB services**

The purpose of decentralizing TB services, including community TB care, should be to increase access to DOTS services and improve program performance, especially as it relates to case detection of new smear positive cases and treatment success rates. Many countries in the region are implementing DOTS based TB Control programmes that cover the whole country especially in the public sector. However, case detection and treatment success rates for new smear positive TB cases tend to be low. This is partly due to insufficient coverage of at risk populations in the context of limited general health service coverage.

It is now clear that involvement of communities and other players in the health sector beyond the public services has potential to increase coverage and improve access to health services in general, and TB diagnostic and treatment services in particular. Enhancing equity for hard to reach and vulnerable populations such as women, the poor, displaced persons and nomadic groups are also some of the reasons TB services may be decentralized. Recent experiences in countries that are implementing community TB care widely have shown that flagging treatment outcomes due to patient default and transfer outs can benefit significantly from community participation in the supervision of treatment programmes.

*Whatever the motivation for decentralization of TB services in any one country, it should not translate into abrogation of or mere offloading of responsibility from one level to another without due consideration for continuum of quality care for the individual TB patient. “Above all, do no harm”.*
3.3: Possible forms of decentralization.

When the decision to decentralize TB services has been arrived at, the next equally important step is to decide the form of decentralization to be adopted. This is important in order to assess the advantages and disadvantages of each type based on existing circumstances and contexts. The context may determine the type that is finally chosen even if it may not be the best among choices.

Based on general organizational theory, four standard forms of decentralization are recognized. These are discussed below as options to be considered in decentralizing TB services and each one assessed appropriately in the correct context.

3.3.1: Deconcentration:

As the word implies, this is “decongesting” of the system without losing technical control of the situation. Deconcentration involves the “giving” of authority over some (note, not all!) administrative decisions to locally based offices, such as district health offices, for the delivery of the particular service. However, authority for major policy decisions pertaining to that service still remains with the central technical office in the line ministry, such as the TB Central Unit. Under this arrangement, a local representative of the central level, such as the district medical officer, is given responsibility for all health functions in the geographical area, and TB program staff is responsible to him/her on a daily basis. However, the TB Central unit in the ministry headquarters maintains overall responsibility for technical monitoring and evaluation of program activities. The local representative essentially becomes answerable to the central unit with regard to performance indicators for the respective programme.

This approach is recommended when introducing community TB care activities for the first time in a national program or in a district / province in order to ensure systematic introduction and careful monitoring of the technical adequacy of activities. It also helps to ensure regulation of procedures and practice. However, once introduced, districts should be allowed to manage the activities and develop the necessary capacity to make local technical-administrative decisions with regard to implementation without compromising on the technical quality of services delivered. This sequence of events and progression is highly desirable and helps to develop an effective system for accountability and sustainability.
3.3.2: Devolution:

Devolution is the next natural step in the hierarchy of decision-making. It involves the creation or strengthening of sub-national levels of government that have considerable decision-making authority with respect to a defined set of functions but also share some power with central authorities in relation to these functions. This form of decentralization implies a much more radical restructuring for the health sector and ensures political accountability to the local electorate. Traditionally, these are geo-political entities such as District Assemblies or provinces established by legislation, each with an elected assembly and a governor and with the power to make laws either by themselves or, as in the case of health, in conjunction with the central level (Thomason et al. 1991).

Devolution is becoming common in the region through local government decentralization initiatives and invariably affects the delivery of general health services and TB services in particular. Under this arrangement, provision of health services provision, including TB services, rests with the local assembly but line ministries still have technical advisory roles. In the case of TB, the onus then rests with NTPs to take every opportunity to promote the introduction of particular TB interventions including community TB Care within the health development plans of the assembly and play an active advisory and technical supportive role in the implementation of such programs including the provision of National Manuals, Guidelines and tools. Central units should also facilitate supportive legislation to regulate practice; and where necessary, enter into contractual agreements with the assemblies for the performance of specific program tasks. Commonly, this is achieved through the local health representative in the assembly who more often has supervisory links to the central health office.

3.3.3: Delegation:

This is a step further in terms of control than devolution. Under this arrangement, managerial responsibility for a defined set of functions is transferred to organizations outside the government structure such as non-governmental organizations and Hospital Boards. Whilst central government retains authority over some services and delegated agencies are accountable to central government, the delegated body is only indirectly controlled by government. Boards at district or hospital level, for example, composed of representatives both of government and broader civil society might be seen as delegated authorities for activities. The contractual element and its positive performance implications makes this one of the attractive options for introducing new health initiatives such as Community TB Care services (as it ensures commitment by the delegated authority to deliver agreed outputs). However, just like any others, it has pitfalls too that will be discussed later.
3.4: Which form of decentralization to pursue for community TB care?

Since decentralization and centralization of health services are more usefully viewed as movements between two poles, all the four forms of decentralization discussed above, singly or in combination, are applicable in the region depending on the socio-political set up of a country. However, available information indicates that central unit planning and oversight is necessary for successful implementation of CTBC activities, especially in the initial stages. This argues strongly for forms that allow for close central unit involvement in the planning, implementation and monitoring of activities. While advocating for close central unit involvement, the application of it must take into consideration the service needs of the particular community and the resource constraints of the local administration. This should include consideration for two broad objectives:

a) **Ideological objectives**: such as:
   - Enhancing civic consciousness of the problem of TB in the society.
   - Bringing about community participation and local self-reliance;
   - Promoting the accountability of the health delivery system to the population

b) **Pragmatic objectives**: such as:
   - Overcoming the institutional, physical and administrative constraints to provision of TB care services (such as more effectively meeting local needs)
   - Reducing congestion at health facilities;
   - Improving access to administrative services/ agencies;
   - Mobilizing support for development plans.
Everything considered, privatization arrangements are the least amenable to central unit control and may not favour the introduction of new initiatives about which more information needs to be collected for expansion purposes. Overtime, each of the different types becomes applicable and possible, perhaps graduating from deconcentration to the more independent arrangements. Where an independent system already exists, the best arrangement to maximize on programme performance should be applied. In any case, the support role of the central level technical unit is indispensable.

Whatever approach (or combination of approaches) is adopted, sufficient flexibility should be allowed for decentralized decision-making on how best to use available resources to meet the TB care needs of the local population (“the basic needs approach”).

However, decentralized expenditure responsibility must be accompanied by appropriate mechanisms for ensuring accountability for the use of resources.

4: Milestones in decentralizing TB services

There are key undertakings in the process of decentralizing TB services to communities and other players. These include the tasks to be decentralized and who to decentralize the tasks to. In general, TB activities will be associated with case finding and or management after diagnosis is made. They also include advocacy, treatment supervision and patient follow up. Each of these will now be discussed, not in any chronological order of importance.

4.1: Determine the community to whom TB services will be decentralized

As intimated above, one of the key design issues in planning community TB Care services is “to whom” to decentralize the services. Delivery of TB services in general and community TB services in particular can be decentralized to groups of “communities/organizations” for management purposes. While civil society as communities of groups of people living in a circumscribed geographical area participate in the actual implementation or are beneficiaries of the services to be delivered, responsibility for planning, implementation, monitoring and evaluation has to rest with some administrative entity. These are fourfold:

4.1.1: Locally based offices of central government ministries: In this case, this can be the District or Provincial office of the Ministry of health. In this scenario, the line of accountability for implementation of the community initiatives tends to be towards central line ministries, rather than to the local community.

4.1.2: Sub-national levels of government e.g. assigning health functions to devolved local government levels.
4.1.3: Organizations outside of government (e.g. autonomous hospitals and executive agencies);

4.1.4: Private for-profit or not-for-profit organizations (e.g. through contracting out the provision of these services).

4.1.5: Civil society (e.g. villagers or members of interest groups)

On a more broader level, communities to decentralize TB services to can be defined as “a group of people who have something in common and will act together in their common interest.” Many people belong to a number of different communities (such as people in the place where they live, people they work with, or people they pray with in their religious groupings). All these community groups are potential “organizations” to decentralize TB care to.

The decision of who to decentralize TB services to is an important one and should be made before introducing community TB care activities in an area. And it is very important that the community chosen must have or be assisted to build the requisite capacity and skills to undertake the tasks for which they will be responsible. The wisdom of choosing “organizations” that include members with skills relevant to the tasks being decentralized must be stressed.

4.2: Determine the tasks to be decentralized to communities

Another key design issue in decentralizing TB care services is that of the functions or tasks to be decentralized. Having carefully decided on the communities or groups of communities who can be given responsibility to deliver or participate in the delivery of services, it is critical to even more carefully decide on the tasks to be carried out by the respective communities.

As a general rule, even under the most extensive form of decentralization, the decentralized unit should never be entirely responsible for all tasks. In particular, functions that are critical to the attainment of central-level goals such as broad policy development, resource allocation, quality assurance and monitoring and evaluation of program performance should in principle not be completely transferred. Depending on the type and capacity of the particular community, typical TB control tasks that should be considered for decentralization include, but are not limited to the following:

- Advocacy and initiatives to increase community awareness on TB and TB services
- Referral of suspects and or cases
- Case detection and prescription of treatment
- Drug administration and treatment monitoring
- Registration and reporting
- Direct observation of treatment
- Documentation of progress and outcomes
- Patient follow-up
- Community mobilization
Underlying the design questions raised above are two key issues that must receive adequate consideration.

- Firstly, that it is critical to achieve the right balance between central and local authority in decentralizing TB care services. Central levels should be more focused on policy formulation and analysis than on implementation, while the decentralized levels, including the community level, should focus more on implementation of activities in line with the central level policy; in this case, implementation of the DOTS strategy.

- Secondly, the nature of resource mobilization, allocation and control should be in favor of the unit being decentralized to as decentralized units can be effectively powerless if they do not have control over financial and other resources for carrying out designated tasks. This is the “financing should follow function” principle (Lubanga 1995).

4.3: Determine community needs for TB Care services

In considering introduction of community TB care initiatives for the first time, as well as for maintenance of programmes; certain pieces of information are useful to ensure equity and effectiveness in the delivery of services. A situation analysis is mandatory (unless relevant information already exists) in order to appreciate what exists and what the gaps are.

Useful information to be collected before or at the stage of introducing services in a particular area should include the following:

4.3.1: Demographic data:

- The size of the population in the area (where there is a large private sector, it would be more appropriate to use the population mostly dependent on publicly-financed health services);

- The demographic composition of the population (as certain demographic groups have a greater ‘need’ for TB services, such as the young adults and persons living with HIV/AIDS).

- The population density in the area (given that the costs of providing health services in sparsely populated areas are generally greater than in densely populated areas).
4.3.2: Social-economic data

- The socio-economic status of the population in the area;
- The profile of vulnerable and underserved difficult to reach groups
- Prevalence of welfare programmes and interventions
- Prevalence of health services and other health related social programmes

4.3.3: Disease burden and programme related data:

- Profile of communicable diseases including HIV/AIDS, and major health indices
- The relative burden of TB in the area (usually based on mortality and/or morbidity data)
- Existing set up for the delivery of health services in general and TB services in particular
- Current programme performance based on national targets for case finding and treatment outcomes (especially case detection and treatment success rates for smear positive TB cases)

4.4: Identity key determinants for current programme performance

One of the expected outcomes from decentralized services is to correct sub-optimal programme performance on key indicators. This entails documenting baseline information on the targeted indicators. A root cause analysis of the current performance is critical to designing programmes capable of improving them. Key attributes associated with programme performance include:

4.4.1: Worker skills and knowledge: The level of knowledge and skills of workers charged with responsibility for certain tasks determine in part how successfully the tasks are performed. Identifying strengths and weaknesses of workers in this area will help to quantify and modify these attributes.

4.4.2: Work environment and tools: The work environment is an important contributor to the performance of any task. The performance of even knowledgeable and skilled workers can be affected by the quantity and quality of tools they have to work with.

4.4.3: Job expectations: Everybody wants to be associated with the best. However, job expectations need to be realistic and based on feasible options. Tasks that depend on other parties and are not directly under the control of a particular worker should not be critical elements for the attainment of key programme performance indicators.
4.4.4: **Organizational support:** Every level of service in TB control is an extension of several other levels directly or indirectly. For maximum impact, all the levels need to complement each other effectively. Supportive supervision of peripheral levels by higher levels, and information sharing by peripheral levels with those above them is all important input into a successful programme. Both should be planned for and monitored.

4.4.5: **Worker motivation:** Worker motivation is known to improve performance by giving reason for investing into an activity. Motivation gives hope and meaning to life. Lack of it discourages workers and removes incentive for investing effort into an activity.

4.4.6: **Performance feedback:** Positive or negative feedback is an important management tool for performance improvement. It facilitates confidence building and opens doors for on the job training.

4.5: **Building community capacity for implementation of CTBC services**

Having profiled the targeted community on all relevant variables through a baseline situation and root cause analysis, capacity building at the level to which tasks are decentralized is mandatory. Lack of capacity weakens the ability to implement the initiative. Therefore when tasks and responsibilities are transferred from one level to another, the capacity to perform these tasks must exist at that other level. Thus, structural and systemic changes in the delivery of TB services are essential if community participation is to have some degree of success.

Capacity building for CTBC must be viewed beyond the availability of people with requisite mix of skills required to fulfill allocated tasks. It must include creation of capacities within systems and institutions. It must aim at empowering communities to perform appropriate tasks effectively, efficiently and sustainably. Specific system capacity building initiatives include creation of microscopy centers or development of mechanisms for facilitating access to laboratory services at peripheral levels for diagnosis and patient follow up. The communities must also be helped to have the technical capability and legal mandate to perform their tasks within the context of the existing health delivery system.
Of necessity, key elements for capacity building include actions necessary to achieve national TB program goals. Such elements should include the following dimensions:

4.5.1: Building the capacity of the task network:

This is the range of individuals and/or organizations which are jointly involved in accomplishing the task of delivering DOTS services to TB patients in the particular geo-political area. This is relevant because the following capacity related issues have been shown to be some of the key constraints to successful implementation of decentralized TB care services:

- Limited capacity within an individual “organization”, e.g. the public district health system
- Lack of effective interaction and communication between “organizations” e.g. central level and district level, and district level and peripheral level.
- Limited decentralization of decision-making power, especially for managerial tasks
- Failure to identify and involve other “organizations” e.g. community structures and organizations that play critical roles in service delivery or service utilization within the task network.

Experience from the pilot initiatives in countries has shown that trained personnel will only be effectively utilized in organizational settings with certain capabilities. Core providers of TB services at decentralized levels need to work together to achieve common goals, and also need to be given the required resources, supervised and motivated.

4.5.2: Addressing structural barriers to service delivery:

Structural barriers have been identified as one of the major contributory factors to capacity weaknesses in decentralizing TB services to community levels. These include issues around the delegation of power from the center to the local level and the relationship between the technical, administrative and political actors in the delivery system. At the implementation level, there is need to make sure that systems for monitoring and evaluating community TB care services is built into their design. All too often, health reforms such as community TB Care are implemented with little consideration for assessing their impact or success.
In the case of human resource training, insufficient number and range of people trained, the type of methods used for training and limited room and opportunity for trained personnel at the local level to make decisions can all have a bearing on how well services are delivered.

Programs considering introducing community TB Care services should therefore pay attention to these structural and related training issues. In addition, it is vital that implementation of the decentralization process is monitored (to identify and address problems that arise) and evaluated (to determine whether the initiative is achieving its stated goals).

4.5.3: Creating an enabling environment:

Performance is enhanced by creation of an enabling and supportive institutional framework. From the pilot community TB Care areas in the region, some of the environmental attributes associated with good program performance include:

- Ensuring the availability of policy to support Community TB Care
- A clear mission and set of goals, which are accepted and understood by all members of staff at the respective levels
- Recruitment of people with the skills required to implement the defined tasks within the particular community
- Effective management information systems, particularly activity outcome and resource-related information systems
- Satisfactory levels and types of physical resources useful in the provision of services.

Poorly maintained equipment and buildings have themselves been found to undermine the quality of services and community satisfaction with those services. These also contribute to poor staff morale. In addition, the lack of key resources for each level, such as drugs or sputum containers for health center levels, can undermine the technical efficiency of a programme. It is thus important that NTPs set clear missions and goals for decentralized TB services and ensure availability of critical human, infrastructural and logistical resources to enhance attainment of program objectives. This should be supported by hierarchical decision-making, transparent procedures for “recruitment”, recognition of care providers, and existence of up to date management information systems.
4.6: **Design a monitoring and evaluation plan for Community TB care services.**

Monitoring and evaluation systems are invaluable in designing decentralized TB care services including community TB care activities. Developing a plan at the beginning of the programme ensures that implementation is guided by expected outcomes. Therefore indicators for success should be defined before implementation begins. The plan should be designed to:

- Measure progress toward national programme objectives
- Identify bottlenecks and the need for further interventions
- Improve the policy and planning capacity of the national program, both at central and local levels
- Understand why things go wrong and remedy the situation

Key attributes to consider when evaluating decentralized TB services should include:

**4.6.1: Equity:**
- Has decentralization of TB care encouraged greater access to TB services, especially for the vulnerable?
- Has decentralization of TB services increased inequity between areas in a district?
- Are particular forms of decentralization (devolution, deconcentration, delegation, privatization) or levels (region, district, municipality, facility, community) more able to promote equity than others?

**4.6.2: Efficiency:**
- Is decentralized TB care a more efficient user of resources than centralized systems?

**4.6.3: Efficacy and appropriateness of services:**
- Are decentralized TB services able to provide effective and appropriate types of services for TB care?
These questions underline critical considerations about monitoring and evaluation of services in general.

- Firstly, that it is as important to assess the technical aspects of the designed health care package, as it is to assess the elements of the process followed in the formulation and implementation of the package. Evaluation of community TB care services should focus on both what has been done and how it has been done.

- Secondly, that while it may be difficult to establish causality or to isolate the direct impact of the decentralized TB care approach from other system changes that may influence output and outcome indicators, an attempt must be made to link the decentralized delivery of services to some specific outcomes (Bossert 1996, Bossert 1996; Collins 1996).

- Finally, that the process of conducting monitoring and evaluation is itself an important data collection and analysis exercise, which should be transparent and involve key stakeholders wherever possible. This will facilitate acceptance of findings and promote the successful implementation of revised approaches that may arise from monitoring and evaluation efforts.
5: INTRODUCING COMMUNITY TB CARE SERVICES: A STEP BY STEP APPROACH

There are many strategies to implementing decentralized health services, including TB services. One suggested approach starts with policy formulation (as do most other approaches) then progresses through the following steps:

- Consensus building
- Identification of policy implementation agents and administrative units for implementation,
- Development of a regulatory framework and administrative guidelines
- Piloting and phasing
- Restructuring for decentralized service delivery
- Capacity building.

5.1: Consensus building:

Consensus building, including during the early stages of policy development, provides a strong foundation for later implementation of programs. Consensus building is itself also an important aspect of program implementation. Failure to gain national consensus around the value of proposed changes often leads to limited implementation of the proposed initiatives. It is therefore strongly recommended that the concept of community contribution to TB care benefit from a wider consensus from key stakeholders including the community members themselves.

5.2: Identification of Policy Champions and Implementation Units:

The use of key actors and opinion leaders who act as policy champions can facilitate the development and successful implementation of TB service decentralization efforts. These may be individuals or technical units charged with the responsibility of overseeing and pushing forward the proposed changes to service delivery. Without other responsibilities, such units can both plan ahead and deal with the range of day-to-day problems associated with decentralizing TB services, ensuring that the initiatives are nurtured and supported over time.
They can also play critical roles in training those to whom new TB treatment functions are decentralized. The effectiveness of this arrangement depends on the location of the unit and what clout it enjoys within the wider policy system. These two aspects should therefore be maximized in the planning stage.

**Establishing Interagency Collaboration:** Decentralization of TB services should be accompanied by improved integration and coordination of public and private service delivery at the local level. Unlike at higher levels where operations tend to be competitive, inter-sectoral contacts at local level tend to be less formal and so complementary. A supportive administrative environment is usually more conducive to collaboration and realization of economies of scale in service delivery. NTPs should encourage local levels to take advantage of this potential in the course of planning and executing decentralized services.

5.3: **Establishment of Regulatory Framework and Development of technical and administrative Guidelines**

Policy change is greatly supported by the presence of a legislative framework that provides a legal mandate for pushing forward change. Often, regulatory frameworks and administrative guidelines are both required in transferring authority between institutions, especially when each belongs to a separate geopolitical entity.

While legislation may be necessary, it is usually not sufficient for the implementation of decentralized health services. It must be supported by technical policies and guidelines. The NTP must therefore ensure that the latter are developed and made available to actual and potential users. Owing to the heterogeneity of care providers at the community level, technically sound but simple to follow materials are important.

5.4: **Re-Structuring of service delivery system:**

Decentralizing TB services just like decentralizing other health programs represents an organizational re-structuring. For community TB Care, this mainly involves revising the allocation of responsibilities and authority between one higher level and various lower levels. The responsibilities will depend on the package of services the lower level will be expected to undertake and should be clearly and unambiguously specified. The authority of each level should be clarified and the tools to enable each level carry out their assigned activities smoothly and effectively should also be provided. To be effective, the new ways of working should be understood by, and accepted by those involved. An integrated set up with the national TB Control Programme with referral links between the levels as outlined in Figure 6.8 below is recommended; at least during the initial phases when the approach is being consolidated.
Figure 6.8: Model of integrated community-based TB care
5.5: Capacity Building:

Lack of capacity can undermine decentralization initiatives. And for capacity building to succeed, it must cover two important areas:

5.5.1: Capacity of care providers at all levels to undertake their new responsibilities:

This is both in terms of numbers and skills mix to undertake the decentralized activities. It should involve capacity at the particular site as well as capacity of the technical Network of the area.

5.5.2: Development of management and support systems:

This is to enable the new players/levels to respond effectively to the new requirements. New requirements for recording and reporting for example become necessary at the lower levels, and the guidelines and tools to do this become part of implementation.

Box 5.5 below highlights some of the most critical issues that must be taken into account when planning for decentralization of services as well as some of the key enabling factors for enhancing success.

---


- **Planning for successful decentralization**
  - Assess country specific motivating factors for decentralization
  - Establish realistic goals, objectives, and expected outcomes
  - Define decentralization for each context of the delivery system
  - Modify the legal and regulatory framework if necessary
  - Design new management systems, processes and linkages
  - Estimate the financial and human resource costs
  - Phase in decentralization
  - Train management staff at all levels
  - Keep people informed
  - Monitor, evaluate and refine the decentralized system

- **Enabling factors for successful decentralization**
  - Find and support committed leaders of the process at each level
  - Take risks
  - Develop a critical mass of committed core care providers
  - Base program management on available relevant information
  - Foster and facilitate political goodwill across the board
5.6: Piloting interventions

The first few countries that effected decentralized TB care arrangements including community based DOTS utilized the pilot approach. Piloting has the advantage of allowing lessons to be learned and valuable experiences to be assessed for possible nation-wide implementation.

However, piloting can also undermine successful implementation of the program, especially when it is associated with particular key players such as donor entities. Also, by focusing resources at an unsustainable level in a pilot district, the analysis and implications drawn for nation-wide use may well be discredited or lose national support. This has to do with the inescapable consideration of the credibility and power of key actors in such a project. For these reasons, piloting (as opposed to phasing) is not recommended in the decentralization of TB services.

5.7: Phased implementation of interventions

Ultimately, programmes should plan to decentralize TB services to the whole country or geo-political jurisdiction. However, it is recommended to phase implementation in terms of geographical coverage and scope of interventions to be implemented. Just like piloting, phasing allows lessons to be learned in the implementation process and sufficient capacity to be developed at the district and lower level. More importantly however, it tends to avoid the major criticisms associated with piloting. Kenya, Malawi and Uganda, the first three countries to embark on scaling up community TB Care initiatives are finding this approach efficient. This has helped them to break down what can be a complex reform process into simple manageable stages.

From general health service decentralization experiences (Rondinelli (1983) and Mills et al (1990)), the following points are worth considering in phasing the interventions:

- Keep the reforms and reorganizations small in scope, at least initially.
- Allow a sufficiently long period for any changes to be adopted and to prove themselves.
- Transfer management responsibility and authority gradually and incrementally.
Another implementation issue that is closely associated phasing, is the need for ongoing monitoring and periodic evaluation. Monitoring and evaluation will allow for refinement of the decentralization policy and to enhance its chances of successful implementation. Data should be collected as interventions are being implemented and used to identify and address bottlenecks.

5.8: Control and supervision:

Experiences from the initial regional initiatives to decentralize TB service delivery have clearly shown that the decentralization of responsibility and authority for the delivery of TB services requires a matching system of control and supervision to ensure that the authority is being used responsibly. Means of control and supervision of implementation should include:

- Enacting legislation concerning new functions for various levels of service delivery
- Issuing of program directives
- Providing program guidelines
- Defining major planning and implementation procedures
- Earmarking resources for specific purposes
- Making certain types of practices and decisions, such as policy change, subject to approval from higher policy levels
- Requiring certain information flows, such as regular reporting of activities
- Monitoring regularly certain indicators of performance, e.g. treatment outcomes for specified cohorts
- Holding face to face meetings with implementers at various levels

When little discretion is allowed to the local implementers according to the type of decentralization chosen, supervisory practices should be a matter of ensuring that they abide by established rules.

As the permitted degree of discretion increases, supervision should shift to the monitoring of performance. Setting targets and monitoring their achievement by decentralized levels requires dialogue, consensus building, and flows of appropriate information.

Face to face meetings between levels can be a very effective way of exercising influence without higher levels being seen as dictatorial.
6: Ensuring Quality in Community Tuberculosis Care services

The World Health Organization (WHO) defines quality as consisting of the proper performance, according to standards, of interventions that are known to be safe, that are affordable to the community in question, and that have the ability to produce an impact on mortality, morbidity, disability and malnutrition.

A critical consideration as provision of care is decentralized to the community is to ensure that the quality of the services being offered is not compromised. In order for the quality of tuberculosis prevention, care and support services being offered at community level to be assured, quality practices must be introduced and sustained as an integral part of the services. In these guidelines, the focus is on institutionalizing quality in community TB DOTS using the Performance Improvement (PI) framework.

6.1: The Performance Improvement (PI) concept

Performance can be defined as the way people do their jobs and the results of their work. As already stated, some of the factors that influence performance include:

- Clear job expectations
- Clear and immediate performance feedback
- Knowledge and skills required to do the job
- Motivation and incentives to perform as expected
- Organizational support: strategic direction, job roles and responsibilities, supportive supervision systems
- Work environment: adequate and proper tools, supplies and work space

PI as part of community TB Care services should proceed by asking the following key questions:

- What performance is wanted?
- What performance exists now?
- What are the causes of the performance gap?
- Which solutions give the greatest return on investments?
6.2: Institutionalizing Quality:

6.2.1: Setting standards:

Intrinsic in the WHO definition of quality is the need to set standards by which performance can be measured. A standard is a statement of expected quality for a specific service or system and provides a basis of measurement against which performance can be compared and assessed i.e. it can be used to measure the achievement of the goal that has been set.

There are managerial as well as clinical standards of interest to provision of services. These apply to community TB Care services as well. They can be sub grouped into input, process and outcome standards as shown in table 7.2.1 below.

### Table 6.2.1: Standards for provision of care

<table>
<thead>
<tr>
<th>Clinical standards</th>
<th>Input standards</th>
<th>Process standards</th>
<th>Outcome standards</th>
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<tr>
<td></td>
<td>Job descriptions</td>
<td>Clinical practice guidelines</td>
<td>Patient health outcomes</td>
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<td>Specifications</td>
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<table>
<thead>
<tr>
<th>Managerial standards</th>
<th>Input standards</th>
<th>Output standards</th>
<th>Outcome standards</th>
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<td></td>
<td>Administrative policies</td>
<td>Standard operating procedures</td>
<td>Expected results</td>
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<td>Qualifications</td>
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A good standard must be

- **Valid:** “Able to measure what it is supposed to measure” and should be based on sound scientific evidence or other acceptable experience

- **Reliable:** Repeatable, that is “it will lead to the same result each time it is applied”

- **Clear:** “Lack of ambiguity”, that is, it should be understood in the same way by everyone and should not be subject to misinterpretation

- **Realistic:** “achievable”, - one should be able to achieve the standard with existing resources

**Standards must be explicit and communicated to all health providers. In order to identify and express in a measurable way the gap between the current level of quality and the expected one, a monitoring system must be instituted. This system will entail the collection of data on performance against standards.**
6.2.2: Identifying indicators:

An indicator is a measurable variable that can be used to determine the degree of adherence to a standard. It translates a qualitative statement to a quantitative one to express the quality gap. For example, in 7.2.1 above, one of the clinical input indicators given was stated, as “Each clinic must have at least one health provider trained in tuberculosis case management”. The corresponding indicator could be “The proportion of clinics that have at least one health provider trained in tuberculosis case management”. It is useful to classify input, process and outcome indicators. Indicators are easier to develop when a standard exists. Below are some examples of clinical standards to be used:

*Input standard*: Each clinic must have at least one health provider trained in tuberculosis case management

*Process standard*: Whenever tuberculosis is suspected, three sputum specimens must be collected for smear microscopy

*Outcome standard*: The treatment success rate for smear positive pulmonary tuberculosis must be at least 85%

6.3: Applying the Performance Improvement Approach (PIA)

The performance improvement Approach (PIA) is not a new intervention and it does not compete with successful interventions or programs such as the Maximizing Access and Quality initiative (MAQ), Quality Assurance Programme (QAP), Situation Analysis, Client-Oriented Provider-efficient (COPE) services or Whole Site Training rather it is a systematic methodology for improving access and quality. The PIA is a how-to set of tools to reach these access and quality goals, not a new set of goals. The PIA is a highly participatory approach resulting in larger capacity increases that are sustainable over time.


6.3.1: The Performance Improvement Framework (PIF)

The Performance Improvement Framework (PIF) outlines the essential steps in the institutionalization of quality. The Framework outlines five essential stages as shown (See figure 1 below) with sub-steps as follows:
i): Institutional Context Analysis

Community TB Care services is never implemented in a vacuum. It is therefore important to understand the institutional context within which the performance improvement is expected to take place. The goals, mission, and strategies of the larger TB Control Programme must be known and a consistent direction maintained when defining performance targets. The PI practitioner and the stakeholders must know the goals of the Ministry of Health of that country as they relate to TB prevention and control, the National TB Prevention and Control Program and possibly the goals of the HIV/AIDS Control program as well, given the relationship between TB and HIV/AIDS.
Another important dimension in this stage-setting phase is knowledge of the culture of the community being served, as there may be interventions that may not be compatible with the culture and community to be served. Social mobilization/education activities will need to precede the implementation of interventions. It is also vital to take into consideration the client and community perspectives as well as gender issues. Further, it is also important to understand what kinds of interventions have been undertaken in the past so as not duplicate and/or contradict worthwhile past efforts.

ii): Obtaining and Maintaining Stakeholder Agreement

The objective of this step is to get stakeholders to work towards the same goal. Solving performance problems or planning new health services requires that those with an interest in what occurs (the stakeholders) have a common understanding of what is to be achieved. Stakeholders can be staff, community members and leaders, government and non-governmental organization representatives, donor representatives. It is critical to obtain stakeholder involvement right from the start and to maintain this throughout the process.

iii): Defining the Desired Performance/Describing the Actual Performance/Defining the Gap

Desired performance is defined by asking what the individual/group/system/organization is expected to do and how well in terms of quality. This will require input from policies and standards and as much stakeholder involvement as possible (minimally to include providers, supervisors, managers and clients).

Subsequent to defining the desired performance information should then be collected about the actual performance using the same indicators used to define desired performance. Once actual performance levels are known, the gaps between desired and actual performance can be described.

iv): Root Cause Analysis (identifying the underlying cause)

Having described the gap, the next step is to conduct a root cause analysis that asks why a performance gap exists. Root cause analysis should take place immediately following the review of the performance gaps with the same stakeholder group that defined the desired performance. This is one of the most critical steps of the PI process since a good root cause analysis increases the likelihood that the interventions identified would have the
This step requires that information be gathered from as many stakeholders as possible. Before analysis and data collection, review the problem statement as developed during the previous stage (defining the gap) in the light of available information. The problem statement should give information on:

- Who is involved
- Where the problem occurs
- How widespread the problem is
- When the problem occurs
- What happens when the problem occurs

Most problems or quality deficiencies relate to the way work is done. It is therefore important that when one is doing a root cause analysis one understands the process in terms of performance factors outlined earlier, namely:

- Clear job expectations
- Clear and immediate performance feedback
- Adequate physical environment, tools and organized processes
- Motivation and incentives to perform as expected
- Skills and knowledge required for the job
- Organizational support, including access to leaders and resources

Anchoring root causes to these performance factors has two main advantages:

- Interventions become clear and more focused
- The root causes closest to the performer and his or her work environment are identified - this means that the performer can participate in addressing the root causes thereby facilitating sustainability

**Example of tools for root cause analysis:**

Given the complexity of health service delivery, clearly identifying root causes needs a systematic in-depth analysis using tools such as flow charts, systems modeling and cause and effect analytical tools. For the purpose of these guidelines, the focus is on two cause and effect tools that can enable one to generate hypotheses on the root causes. These hypotheses would have to be validated by further data collection and statistical analysis. Here we will look at two commonly used cause and effect tools namely: The Fishbone Diagram and The why-tree process.
The Fishbone Diagram: The health providers problem might be for instance that health workers are performing unnecessary repeat laboratory tests and it is important to know why. The “Effect box” will then be labeled as shown in Figures 2(a) & (b) below. On the periphery of the diagram are the six performance factors cited above. So as the stakeholders brainstorm possible causes of the problem, each root cause agreed upon will be tallied to a performance factor so that the final outcome will look something like Figure 3.

**Fig. 2 (a): ROOT CAUSE ANALYSIS – FISHBONE TECHNIQUE**
The why-tree process: The process starts with the effect and proceeds to ask why this is the case on relevant areas until possible reasons are listed and subsequently analyzed. See Figure 3 below.
As Figures 2 & 3 show, it is not unusual to find more causes that can be addressed. This means that there is a need to narrow down possible causes to the most probable causes and prioritize these by engaging expert opinion, voting or using prioritization matrices. Once a root cause has been identified, this should be tagged to the relevant performance factor. For example if the root cause of the performance deficit is “Written guidelines are not available” then the corresponding performance factor is “job expectations”

v): Selection of Interventions

Having systematically and collectively defined the performance problems and their root causes, the next task is to select an appropriate intervention to overcome the performance deficit. This process should involve all stakeholders and especially those whose performance is to be improved. In determining the appropriateness of an intervention, the following factors should be taken into consideration:

- Is the selected intervention actually going to solve the problem?
- Is it cost-effective; will it give the best results for the least resources?
- Is it feasible? That is, can it actually be implemented?
- Is the intervention acceptable to the clients, community and the staff who are expected to carry it out?
- Is the proposed solution sustainable?

These are general guidelines. Specific circumstances will dictate what is actually put in place. For example, some criteria such as inflexible funding or time limit may become impeding factors. It is advisable that solutions that can be carried out quickly without outside assistance be carried out even if they are low-ranked solutions. The quick results show the value of the PI process, show that change is possible and motivate staff members to improve their performance and attempt seemingly more complex problems.

vi): Implementing Interventions

Having identified the priority interventions to correct a performance gap, it is time to implement the interventions. Carrying out performance improvement interventions requires good management skills – planning, scheduling, budgeting, coordinating and keeping people informed. Expertise from out of the facility may be sought if the situation warrants it. Implementers must plan for the evaluation of the interventions and take steps to initiate and sustain these interventions.
vii): Monitoring and Evaluation

This is a key, continuous component of the PI process. The putting in place of solutions must be monitored to ensure that they are executed as scheduled (process evaluation) and the results of these activities must be assessed for impact (impact evaluation). The evaluation must answer the question “Did the intervention bring about the desired change?”. As earlier stated, this process requires that standards (desired performance) and indicators to measure performance be in place.

7: MAKING COMMUNITY TB CARE WORK: THE ROAD MAP TO IMPLEMENTATION

These guidelines have highlighted the complexity of decentralizing TB care services. There is a range of possible reasons for introducing decentralization and there are many different forms that a decentralized system can take. Decentralization should not merely involve “technical” changes in organizational structures; but should also ensure that there is:

- Focus on context, scope, process and actors relating to the chosen form of decentralization;
- Identification of levels or organizations to decentralize to
- Identification of tasks to be decentralized to the chosen level(s) or organization(s)
- Building of necessary policy, regulatory, technical and managerial capacity at relevant levels to facilitate implementation of the decentralization process and tasks, e.g. introduction of wholly oral drug regimens for use at community level.
- Phasing of implementation of decentralization to allow for necessary capacity development and to identify key lessons from initial implementation experience; and
- Routine monitoring and evaluation to identify and overcome implementation obstacles and to determine whether objectives are being met.

Policy makers and sector managers should not only focus on “what must be done” but also on “how it should be done”, in order to increase the likelihood of successful implementation of decentralized TB services. This calls for development or revision of necessary supportive program manuals and guidelines.
At local level, critical steps to be taken when planning to increase community contribution to TB care should include but not be limited to:

1. Conducting a situation analysis to identify available TB services, including existing community contributions to health care in general and TB care in particular

2. Identifying relevant players that might play a role in enabling community contribution to TB care [mapping the technical response network]

3. Specifying the roles and functions of each player in the delivery system

4. Establishing relationships between players and functions in the context of the existing health delivery system

5. Building upon and develop current systems before seeking to develop new ones.

6. Developing a training plan to cater for all players and functions

7. Designing and producing relevant tools necessary for the implementation of quality TB prevention and control (technical and operational manuals, guidelines, training curricula and manuals, etc) tailored to the roles of various tasks and players.

8. Preparing for and conducting trainings

9. Monitoring and evaluating program implementation

On balance, decentralization of TB services as currently practiced in selected countries has many potential advantages: it focuses on the community, may promote community participation, may encourage more equitable access to DOTS services, may improve the motivation of local staff, may speed up the implementation of national and local control program activities, and may promote inter-sectoral collaboration.

However, decentralization needs to be carefully planned and monitored, as for each potential advantage, a corresponding disadvantage is possible. A decentralized system is likely to be more inequitable; may make it more difficult to promote national policies, priorities and standards; may intensify existing shortages of trained human resource, and may be less efficient.

Continuous review of adopted policies and practices is therefore necessary to ensure that services are provided efficiently and cost-effectively at all times, and scarce resources are maximized.
8: **Selected References**


