Swaziland Community Model
Community Cadres

Rural Health Motivators (RHM) (approximately 5000) – know homesteads very well, given a stipend – have the authority to visit the HH – community picks someone that they know- trained for 3 weeks on a comprehensive package (TB, HIV, NCD, first aid)- every month they get additional training on a topic chosen through chiefdoms – higher level than Active Case Finder– responsible for 30 homestead
TB Community Cadres

TB declared an emergency in Swaziland so started a project with 4 new TB-specific community cadres:

1. Adherence Officers – based at district hospital - move around to smaller clinics and work with CHWs attached to that clinic – have a motorcycle (Harley Davidson)

2. Active Case Finder (369) – 6 year project – visit homesteads to contacts of index cases, not going to be sustained – report and work with RHM – they have bicycles and tend to be young men – if ACF finds a presumptive TB they inform the RHM to collect sputum – go weekly to clinic to get index cases and then visit homesteads of index cases – visit every homestead monthly

3. Community Treatment Supporters (850) – different from Adherence Officers – support only MDRTB patients who are ambulatory (one supporter for one patient) – patient comes with treatment supporters

4. Cough Officers (60) (note that these are facility-based) – can accept community referrals
Community Cadres

• There are TB HCW who need to be capacitated on CRD

• Other cadres who are not TB oriented need to be capacitated on TB
  • Diabetes Support groups
  • Epilepsy support groups
  • AMICCAL groups
  • Diabetics Mentors who provide education to patients.

• There is need to develop a curriculum on other CRD diseases with simple signs and symptoms
• CHW should visit the homestead regularly e.g. monthly
• Family centred approach should be used
• Community based health facility staff needs (nurses, cough officers) to be sensitised on the strategy so that they are aware
• Community based facility should be able to refer cases beyond their scope for further management.
Integrated Activities – Education and awareness

• Coughing is not normal and needs to be investigated
• Causes of cough: environmental toxin (smoke, silent smoking dust), allergies (pollen, animals), disease (TB, asthma, COPD, heart failure), medications (medications that may cause cough as side effect eg, ACE inhibitors as anti-hypertensives).
• Smoking increases risk of lung cancer, TB, other lung disease
• Symptoms of TB (cough, fever, night sweats, weight loss, coughing blood)
Prevention

• IPC - Cover cough
• Open windows (improve ventilation)
• Stop smoking
• Decrease internal smoke (kerosene stoves)
• Sleep in separate room if coughing from infectious cause (eg, TB, flu, pneumonia)
Screening and diagnosis

• Active case finding in home of index case - screen for TB symptoms (cough, fever, night sweats, weight loss),
• Screen for shortness of breath (what triggers it)
• Ask what medicines client is taking
• Is client adhering to treatment
• Diagnosis - collect sputum and send to clinic
Referral

• If specimen is positive then refer to facility for TB treatment
• If negative and still coughing then refer to clinic
• Referral form sent to clinic and nurse sends feedback
Adherence support

- Provide adherence support for TB treatment
- Educate asthma patients on how to use anti-asthmatics, proper use of inhalers and spacers
- Provide adherence support for other chronic medications
- DOTs centres focused for TB patients and need to expand to NCD.
WAYFORWARD

• There are TB HCW who need to be capacitated on CRD
• Other cadres who are not TB oriented need to be capacitated on TB
• There is need to develop a curriculum on other CRD diseases with simple signs and symptoms
• There is need to map all community cadres
• Streamlining community package and harmonise/synchronise the activities
• There is need to develop a standardised curriculum on other CRD diseases with simple signs and symptoms
• Mhealth for monitoring and evaluation.