Swaziland and Lesotho Community Models
Community Cadres
Swaziland – Rural Health Motivators
Lesotho – Village Health Workers
TB Community Cadres (Swaziland)

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
• CHW should visit the homestead regularly e.g. monthly
• Family centred approach should be used
• Community based health facility staff (nurses, cough officers) need 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
• Need for community-based supportive supervision
• M&E systems are required to monitor community activities (mHealth)
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),

• Add these questions:
  • Screen for shortness of breath (what triggers it
  • Coughing blood
  • Smoking
  • Shortness of breath and what causes 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