Consultation meeting on finding missing TB cases through integrated community-based TB service delivery-11-13 April 2018, Addis Ababa, Ethiopia

Meeting report

Summary

A global consultation meeting on finding missing TB cases through integrated community-based TB service delivery was organized by the Global TB Programme (GTB) of the World Health Organization (WHO) in the context of the catalytic role of WHO in the Global Fund Strategic Initiative to find Missing Persons with TB. The event took place on 11-13 April 2018 in Addis Ababa, Ethiopia. Participant countries included Democratic Republic of Congo, Indonesia, Kenya, Mozambique, Myanmar, Nigeria, and United Republic of Tanzania. The purpose was to share country best practices and implementation strategies, identify programme gaps and opportunities and develop country specific roadmaps to improve existing plans including technical assistance needs to find missing TB cases. The meeting enabled diverse and extensive sharing of experience and best practices between the countries and laid out key ingredients for nationwide scale up of quality integrated community-based TB activities.

Monitoring and evaluation was highlighted as a major challenge that requires innovative solutions like digital technologies. Other key challenges included non-standard implementation tools and strategies, limited integration of TB into other community-based interventions and weak coordination between NTP and other stakeholders. Country specific roadmaps to ensure quality implementation and nationwide scale up of integrated community-based TB activities were developed.

Process and background

As a part of preparations for the meeting, desk reviews were conducted. These reviews helped to define key areas to be covered during the meeting. The meeting was conducted in variety of ways including plenary presentations, thematic group work and country specific group works. Participants included National TB Programme (NTP) managers, NTP community focal points, Global Fund Principal Recipients with budgets for community-based activities, Challenge TB, Stop TB Partnership, USAID, CDC, Global Fund, WHO from country-, regional- and headquarters level. The following were the key issues discussed in the meeting:

Policy and programmatic framework: The WHO ENGAGE-TB approach, that provides tools for systematic programming, standard definitions for community health workers and volunteers, community-based TB activities and core indicators for monitoring and evaluation offers opportunities to find missing TB cases. Large numbers of countries have adopted the ENGAGE-TB approach and report data on community contributions to TB outcomes to WHO (51 countries in 2017). However, ensuring systematic quality of implemented activities as well as national wide coverage remain a challenge. Integration of community-based TB activities with other community interventions (health or development) is one of the ways to achieve scale up. The Global Fund strategic initiative to find missing TB cases using the matching funding in country grants provides resources and technical assistance to support country efforts.

Country experience at the centre: The meeting format encouraged sharing of best practices and experiences. Country presentations in plenary session were peer reviewed by another paired country. The Community, Rights and Gender (CRG) assessment tools developed by the Stop TB Partnership were
presented and discussion conducted on how to enhance their take-up at country level to be able to develop interventions to ensure specific populations are reached with appropriate TB services. Meeting participants undertook SWOT analysis and defined key ingredients for nationwide scale up of community-based TB activities. Finally countries developed roadmaps and shared in plenary session.

Current status and challenges

**Strategies, tools and implementation arrangements:** Community-based TB activities are part of national TB strategic plans in all participating countries. Some countries (Kenya, Tanzania and DRC) also have national integrated community health strategies. In cases where these are part of the GF grants, they are usually budgeted within Resilient and Sustainable Systems for Health (RSSH) grants with careful linkages with disease components. Most commonly, inadequate resources are allocated for nationwide implementation of these strategies. The implementation tools vary widely (e.g. varied national guidelines for community-based TB activities, training modules for community health workers, referral tools and forms for referrals from CHWs/volunteers, and tools to provide TB treatment support in community settings). Implementation arrangements also vary. DRC, Kenya and Tanzania have focal person to coordinate community-based TB activities in the NTP. There are often multiple cadres of CHWs and CVs at the community level with different scope of work based on donor funding or NGO affiliation. Further challenges include poor working relationships between the health facility staff and the CHWs/ CVs and low levels of motivation of CHWs. Retention and capacity building of CHWs and CVs is a major challenge due to lack of harmonized training plans across different implementers, outdated training material, lack of material in local language and high drop-out rates. All countries highlighted domestic resource constraints and dependence on external funding. CHWs generally receive a small stipend or incentives rather than remuneration. Incentives across different community programs and projects are not harmonized. The absorption of CHW and CV into public health system (e.g. as in Kenya and Tanzania) is key for addressing such challenges.

**Monitoring and evaluation:** Key challenges for M&E include lack of national M&E plan (DRC), availability of multiple and non-standard community data recording and reporting tools and too many reporting indicators by multiple partners with different reporting requirements (DRC, Kenya, Mozambique). Further, the NTPs and community stakeholders collect large amount of data, with limited utilization to guide programme management. This affects data quality and causes incomplete reporting and lower motivation of the CHW and CV (Indonesia, Kenya). At health facilities, the staff does not systematically document referrals from community considering it as additional burden. Some countries have dedicated human resources for monitoring and evaluation (DRC, Nigeria) and established supervisory structure for CHWs (Kenya). Although some countries undertake quarterly data validation at district and community level to address the quality issue (DRC, Mozambique, Tanzania, Kenya), overall the supportive supervision is weak. Following were specific observations on indicators and recording and reporting:

**Indicators:** The two core indicators recommended under the ENGAGE TB approach are part of national monitoring and evaluation systems in all participating countries. In Kenya and Tanzania these indicators are incorporated into national electronic data system and TB registries up to sub-district levels. However understanding of indicators at community and health facilities is sub-optimal (Kenya, DRC). It emerged during the meeting that countries collect additional operational indicators. The inclusion of these and other non-core indicators was debated during the meeting. There was a call to look into possibility of adopting new indicators depending on maturity of implementation in countries.
Data collection and reporting: Recording and reporting tools and mechanisms for data collection and reporting vary. In all countries, data collection and reporting from service delivery level is largely paper based, data is physically shared with health facility and aggregated at sub-district level for reporting to the national health management information systems (HMIS). Expansion of the District Health Information System (DHIS2) is currently underway in Mozambique, Kenya, Tanzania and DRC and an indigenous electronic system in Kenya.

There was a general consensus that nationwide scale up of DHIS2/electronic data systems and electronic data collection and reporting tools is the way forward to minimize recording and reporting burden and improve quality. An innovative approach of using satellite technology to strengthen data collection and reporting for monitoring and evaluation from remotest areas in Ethiopia was shared by Next2People and YAZMI (a satellite technology firm). However, lack of adequate resources to acquire and maintain digital solutions and poor availability of electricity and internet connectivity remain major hurdles (all countries).

Coordination: The engagement between the national TB programme and community stakeholders remains limited. The coordination mechanisms vary and few countries have dedicated focal persons to coordinate. While Mozambique reported regular meetings at national, provincial and district level, Kenya and Tanzania organize quarterly reviews with implementing partners and CSOs at regional and national level. Kenya and Tanzania have representation of civil society organizations at the national coordination forum. Formal coordination mechanisms do not exist in Indonesia and DRC however fora for NGO and CBOs exist under national Stop TB partnership platforms. At least four countries (Tanzania, Kenya, DRC, Nigeria) undertook mapping of community-based providers for HIV, Malaria, Immunization and TB for optimization and strengthening of service delivery.

Integration: Overall integration of community based TB activities with other themes remains limited. National guidance on integration of community programmes does not exist in countries, although Nigeria is currently developing one and efforts at highest levels are evident in participating countries (e.g. involvement of ministry of Labour and Mining in Mozambique). Community stakeholders often focus interventions only on one disease or area and adopt vertical approaches and training strategies for CHWs (DRC, Kenya, Mozambique). The NTP Indonesia also has new opportunity of working with PKK, the largest network of community-based organizations with volunteer cadres across Indonesia, and provide integrated services.

Key Ingredients for nationwide scale up

Standardized implementation tools: There was general consensus that the ENGAGE-TB approach can guide systematic programming of community-based TB activities and should be adopted for nation-wide implementation. Successful examples that support prevention, detection, referral, treatment, social and livelihood support, advocacy and stigma reduction should be identified, replicated and scaled up nationally.

Resources and sustainability: The national strategic plan (NSP) should provide overall framework for implementation of community-based TB activities. All partners should align interventions to NSP unless other major gaps are identified. The implementation plans should also be aligned to avoid duplication. National programmes should support induction and refresher training of CHWs and CVs and recording and reporting using standard curricula and tools across partner organizations, preferably delivered in local language. Ministries of health should consider inclusion of CHWs into the public health systems as salaried employees to ensure sustainability. Funding for CHW salary or incentives, capacity-building and other support should be systematically reflected in NSP and budgets as well as provincial and district
action plans. Implementing partners and donors should review remuneration systems and consider alignment and optimization.

**Integration:** Integration of community-based TB activities with other community interventions (health or development) is one of the ways to achieve nationwide scale up. Community health programmes should cover a broad range of key health topics relevant to needs of local community. Integrated approaches avoid duplication and fragmentation of efforts. This enables provision of comprehensive care, increase efficiency and pool resources to ensure good quality services.

**Strong monitoring and evaluation:** The core WHO indicators on community engagement in TB response viz. percentage of newly notified cases coming from community referrals; and treatment success of patients who benefited from any form of community treatment support. Data for these core indicators should be systematically recorded and reported at all units across the country. National programmes should enhance investment and graduate from paper based to digital recording and reporting systems including nationwide expansion of DHIS2. Only the data necessary for day to day programme management should be routinely captured, all additional data needs should be fulfilled through periodic collection such as surveys or national reviews. It is desirable to include community data during data quality audits. NTP should provide supportive supervision for community-based TB services across all partners. Integrated performance review at facility and district level, quarterly data harmonization meetings and regular coordination meetings with all stakeholders are critical to ensure good quality data.

**Effective coordination mechanisms:** All countries should establish or strengthen coordination mechanisms between the NTP and all key community stakeholders, at all levels - national, sub-national, district and facility. These might include, but are not limited to, representatives of other relevant Ministry of Health programmes, the Global Fund PRs and SRs, community actors delivering services, nongovernmental organizations and other civil society organizations. NTPs should lead establishment of such platforms and convene quarterly meetings. These may be aligned with other coordination mechanisms or technical meetings (e.g. TB/HIV, MDR/TB technical working group) to optimize resources and staff time. Close collaboration at subnational and service delivery levels is crucial for quality services and monitoring and evaluation.

**Next steps/recommendations**

1) Participating countries to finalize the road maps developed during the meeting through in country consultations and define technical assistance needs with clear timelines, availability of funding and scope of needed support.
2) All countries should review data and indicators currently captured and reported at the community level, systematically involving community actors in the review to develop a standard set for use by all stakeholders including streamlining with DHIS2 and one national system.
3) Implementation tools should be standardized and simplified across all community stakeholders in the respective countries.
4) Participating countries to establish/strengthen coordination mechanisms between the national TB programme and key community stakeholders, at all levels, national, sub-national, district and facility/service delivery, including harmonization of resources among partners.
5) National TB programmes to actively engage with other Ministry of Health programmes, other line ministries and NGOs to promote integration of community based TB activities and seize existing opportunities.
6) WHO to update the ENGAGE-TB operational guidance for use by all stakeholders implementing or supporting integrated community-based TB activities to support nationwide scale up.
7) WHO to establish a global platform for sharing best practices, experiences and models for nationwide scale up of integrated community-based TB activities.

8) WHO, NTP and Partners to define the approach and next steps for finding missing persons with TB through community-based activities in Pakistan as a priority country outside of the participants at the workshop.