Why TB is not a key agenda for implementers: what is missing?

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Objectives

• Brief description of IMA World Health

• IMA and FBO Network’s involvement in TB mitigation

• Challenges and barriers to greater engagement in TB Mitigation
History of IMA

1960 - Established by 12 US Protestant relief & development agencies (*Procurement of essential medicines & supplies for mission hospitals, facilities, volunteer teams, etc.*)

1994 - added implementation of NTD projects

2000 - Integrated health project (SANRU) in DR Congo

2010 - Celebrating 50th anniversary, Implementing public health programs and building capacity of faith-based partners
Current Focus Areas

• Strengthening Health Systems

• Targeted Disease Control (Neglected Tropical Diseases, Malaria, HIV/AIDS, Childhood Cancer)

• Capacity building

• Procurement, Shipping and Distribution

• GIS Mapping and HMIS, M&E
IMA works with faith-based health networks which provide 30-70% of health care in their countries.
IMA’s Involvement in TB Work

• DR Congo – Axxes project
  - Partnership with the national program but have usurped many of their functions as their capacity or funding has diminished
  - Work in parallel with private donors such as global Fund but there is little cross over in our 57 target zones.

• Tanzania - HIV/AIDS & TB
  Ensuring that Care and Treatment clinics monitor HIV+ patients for TB and refer them for treatment if needed
Tuberculosis is a resurgent and growing epidemic in parts of DRC. Last year an alarming number of cases were detected in a cluster of AXxes-assisted health zones in remote central Katanga province (see map). With support provided by Project AXxes several thousand were screened and over 1500 were found to be positive for TB. Unfortunately none had access to treatment. ...
What do we do? In a nutshell we

1. Monitor and report on TB prevalence in our 57 health zones representing a population of ~ 8M persons

2. Oversee and facilitate:
   - diagnosis (over 10,000 cases in our zones per year) and
   - treatment (we will surpass 10,000 patients treated this year providing services to both those on the waiting list and new cases)
What do we do?  

3. Specific roles

• Training: we have provided training to doctors, nurses, and community mobilizers on TB screening, diagnosis, and treatment using and supporting MOH personnel in that training.

• Lab support: Provision of microscopes to national TB screening centers in four provinces (CDT)

• Treatment: Reception of medicine from the government, transport to regional capitals and then health zone based treatment centers (CDT)s

• Follow-up and Supervision: providing transport and support to both health zones, district, and provincial health authorities

• Data Collection and Reporting: within our integrated reporting system (below)
Why TB is not in the forefront for Civil Society Organizations

- TB Programs in general are vertical
- Decentralization attempts not well supported
- WHO connects primarily with the Governments whose TB programs are not well supported
- Grassroots workers are busy with more heavily funded programs such as HIV/AIDS, Malaria and now MCH
- Faith-based networks are not true partners of govts.
- TB generally is an add-on program for civil society
Expectations

• TB is given more visibility as a public health threat
• Greater involvement of faith-based organizations in TB diagnosis and treatment true partnership with governments., donors, WHO, etc.
• Stronger partnerships between Govt., WHO and civil society
• TB diagnosis and treatment as a stronger intervention in integrated health projects
Expectation (Contd.)

- Increased awareness, training and support of grassroots workers
- Greater involvement communities through awareness, education and communication
- Community mobilization through religious leaders.
Engaging Religious leaders

Resources for Religious Leaders
• Maternal & Child Health Sermon Guides (English, French Kinyarwanda, Swahili)
• Malaria Sermon Guides (English)
• Is developing Sermon guides on TB an option?
Thank You