Available online at www.sciencedirect.com

ScienceDirect

journal homepage: http://www.journals.elsevier.com/indian-journal-of-tuberculosis/

Short Communication

Social inclusion: An effort to end loss-to-treatment follow-up in tuberculosis

S. Balakrishnan [a,*], J. Manikantan [b], A. Sreenivas [c], S. Jayasankar [d], M. Sunilkumar [e], P.S. Rakesh [f], D.S.A. Karthickeyan [a], C.R. Mohandas [a]

[a] Medical Consultant, WHO Country Office for India, New Delhi, India
[b] District TB Officer, Pathanamthitta, Kerala, India
[c] National Professional Officer, WHO Country Office for India, New Delhi, India
[d] Director of Health Services, Thiruvananthapuram, Kerala, India
[e] Director, State TB Training and Demonstration Centre, Thiruvananthapuram, Kerala, India
[f] Department of Community Medicine, Travencore Medical College, Kollam, Kerala, India

ARTICLE INFO

Article history:
Received 23 November 2015
Accepted 23 November 2015
Available online 23 January 2016

Keywords:
Treatment support group
Social inclusion
Lost to follow-up
Initial default

ABSTRACT

Situation analysis: Pathanamthitta district is implementing Revised National Tuberculosis Control Program as a pilot district since 1993. The district programme was reporting approximately 5% of their diagnosed smear positive patients as never put on treatment (Initial lost to follow up – ILFU) and 5% of the new smear positive [NSP] Pulmonary TB patients as lost to follow up [LFU] during treatment. Attempts based on reengineering of DOTS were not largely successful in bringing down these proportions.

Intervention: A treatment support group [TSG] is a non-statutory body of socially responsible citizens and volunteers to provide social support to each needy TB patient safeguarding his dignity and confidentiality by ensuring access to information, free and quality services and social welfare programs, empowering the patient for making decision to complete treatment successfully. It is a complete fulfilment of social inclusion standards enumerated by Standards for TB Care in India. Pathanamthitta district started implementing this strategy since 2013.

Outcomes: After intervention, proportion of LFU among NSPTB cases dropped markedly and no LFU were reported among the latest treatment cohorts. Proportion of ILFU keeps similar trend and none were reported among the latest diagnostic cohorts.

Lessons: Social support for TB care is feasible under routine program conditions. Addition of standards for social inclusion in STCI is meaningful. Its meaning is translated well by a society empowered with literacy and political sense.

* *Corresponding author at*: World Health Organization – RNTCP Technical Assistance Project, State TB Cell, Red Cross Road, Thiruvananthapuram, Kerala 682391, India. Tel.: +91 93881 58442.
E-mail address: balakrishnans@rntcp.org (S. Balakrishnan).

http://dx.doi.org/10.1016/j.ijtb.2015.11.007

1. Introduction

TB care is complex. Morbidity, catastrophic expenditures, difficult access, social stigma, confidentiality issues and adverse reactions to drugs often weave a tricky web around the sick patient. Quite often these rank high among the determinants of patient's adherence to TB treatment. Supervised treatment by a health worker has proven to be effective in experimental models and under program conditions in significantly improving adherence to treatment and outcomes of treatment.[1] However, Direct Observation of Treatment (DOT) alone has not resulted in 100% adherence to treatment and a significant proportion of patients are lost to follow up [LFU] even in settings, where DOT is practiced well. Adherence to TB treatment is important in preventing relapse and emergence of resistance. There may be effective interventions beyond DOT to promote adherence to treatment.

2. Situation analysis

India is implementing Revised National Tuberculosis Control Program (RNTCP) since 1997. The erstwhile National TB Control Program (NTP) was accused of detecting only 30% of the estimated TB cases and successfully treating only 30% of the notified TB cases. RNTCP based on DOTS strategy has dramatically improved the situation by enhancing case detection to 70% and favourable treatment outcomes to 85%, among the newly smear positive pulmonary TB patients. However, 5% or more of such patients were being LFU during treatment at country level.[2] Studies have described social stigma, access issues, alcohol addiction, adverse reactions to drugs, co-morbidities, etc. as to the cause of this loss.[3] It varies from state to state. LFU during treatment was beyond the entity termed as ''initial lost to follow up'' [ILFU] which literally translates into ''diagnosed but not put on treatment'' that amounts to approximately another 5% of the cohort of diagnosed patients.

Kerala, the southernmost state of India, is implementing RNTCP since 1998. It is estimated to have a relatively low TB burden compared to other parts of the country.[4] Since then, the state was reporting approximately 5% LFU among new smear positive (NSP) cases and approximately 6% ILFU among all diagnosed smear positive cases.

Pathanamthitta district started implementing RNTCP since 1993 as a pilot district [Fig. 1]. This rural district has 1.2 million population with a density of 452/km^2, moderately hilly terrain with reasonable access to health care services including TB care. Urban segment is 11% and adult literacy rate is 97%. Being the national pilot district, RNTCP infrastructure is ideal, with adequate human resources provided by the state health services. During each quarter year, the district program approximately tests 4000 presumptive TB cases, diagnoses

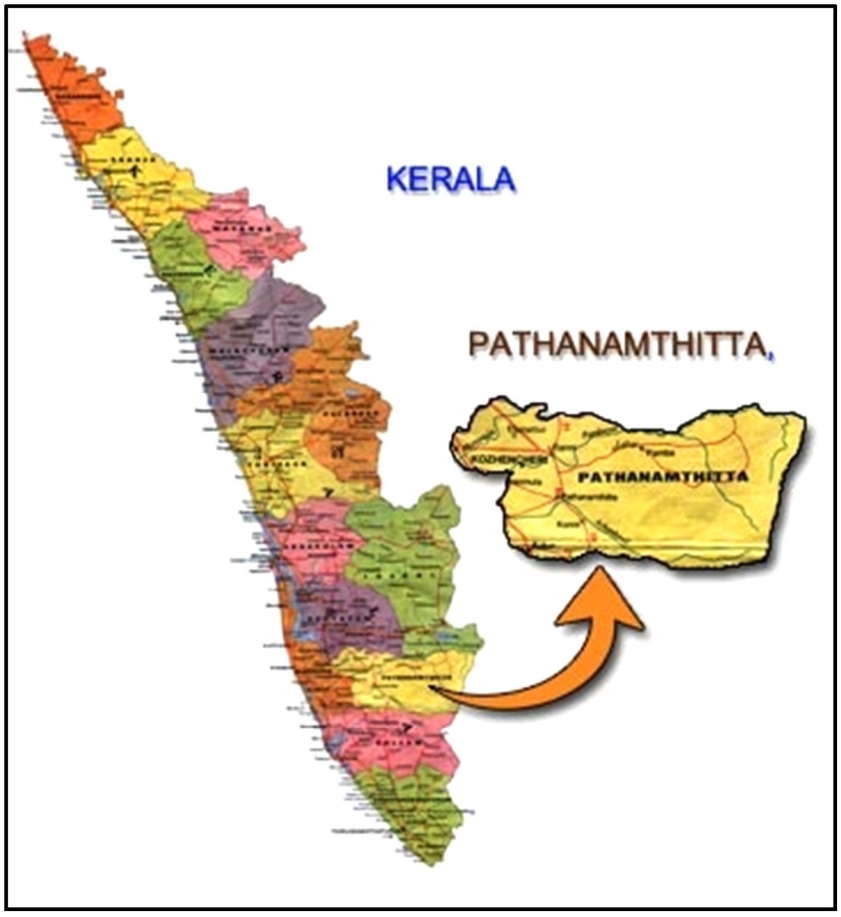

Fig. 1 – Political map of Kerala showing Pathanamthitta district.