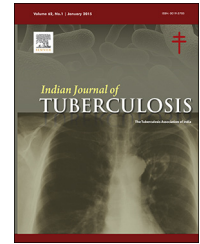


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Original Article

Meso level multi-disciplinary approach for reduction of pre-treatment loss to follow-up in Revised National Tuberculosis Control Program, Delhi, India

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ABSTRACT

Background: Universal access to tuberculosis (TB) care services emphasizes early detection and initiation of treatment for all pulmonary TB patients. Pre-treatment loss to follow-up patients needs to be actively tracked and treated to break the chain of transmission in the community.

Objectives:

- 1) To examine the various reasons for pre-treatment loss to follow-up among new sputum positive cases diagnosed under the Revised National TB Control Program in Delhi.
- 2) To propose an intervention model to reduce pre-treatment loss to follow-up based on provider's feedback and health seeking behavior of patients.

Materials and methods: A questionnaire based cross sectional study of a sample of 340 patients who were pre-treatment loss to follow-up was conducted from November 2011 to March 2012 in Delhi. Qualitative study involved focused group discussions with paramedical providers using a topic outline guide, patients were interviewed using semi-structured questionnaire and brainstorming of program managers to elicit reasons, suggestions and health seeking behavior among those who were pre-treatment loss to follow-up. **Results:** Preference for private practitioners (64.4%), lack of trust in government health system (26.7%), inconvenient time of Directly Observed Treatment (DOT) centre (18.5%) and wrong patient address (14%) were the main reasons for pre-treatment loss to follow-up. Paramedical provider's opinion elicited in focused group discussion was that there is an

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increased tendency of pre-treatment loss to follow-up in drug addicts and home-less patients. Brainstorming with program managers revealed that a lack of trust in allopathic system of medicine and human resource constraints were the leading causes of pre-treatment loss to follow-up.

A Meso level multi disciplinary model with community participation through Resident Welfare Associations (RWAs) has been designed based on the above findings. The model suggests mutual collaboration between government and non government agencies for promotion of International Standards of TB care in private clinics, de addiction services and social welfare schemes through RWAs.

Conclusion: There is a need for Advocacy Communication and Social Mobilization on a large scale. Collaboration with Resident Welfare Associations (RWAs) and with practitioners from alternate systems of medicine should be encouraged.

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1. Introduction

Sputum positive pulmonary tuberculosis (TB) patients who are diagnosed but do not initiate anti-tuberculosis treatment are termed as pre-treatment loss to follow-up.¹ Revised National TB Control Programme (RNTCP) has been implemented in the State of Delhi since 1997 and there has been a steady decline in TB burden in the community. The mortality rate for Delhi has come down considerably and presently is less than 2%.² In Delhi state, 24,665 cases were new smear positive cases out of total 55,260 cases registered in year 2015.³ Some patients do not register for treatment and are lost from the system. They may either attend the private sector for treatment or may not take treatment at all. Such cases may continue to transmit infection in the community.⁴ Pre-treatment loss to follow-up is therefore a potentially serious problem as one smear positive patient infects 10–15 persons in a year, 10% of whom develop the disease in due course.² This assumes greater importance as we face an increasing threat of multi drug resistant (MDR) and extensively drug resistant (XDR) TB.

One of the major policy decisions taken by RNTCP in the year 2010 is to change the focus of the new sputum positive case detection objective of at least 70% to the concept of universal access to good quality care for TB patients. There is now global consensus that the twin objectives of 70/85 alone is not enough to achieve adequate reduction of TB transmission and reduction in disease burden at the pace with which epidemiological impact is expected. Also, some studies suggest mortality remains higher than expected, including post TB treatment mortality. Hence it is extremely important for TB control programmes to focus on early and complete detection of all TB cases including smear positive and smear negative TB cases. This essentially means that more attention is to be paid to the processes involved in case detection and case holding and strategies to ensure that all TB patients have access to early case detection and effective treatment.⁵ Therefore, there is an urgent need to address this problem of pre-treatment loss to follow-up and create appropriate modalities for addressing it for achieving universal access to TB care. This study was done with the objective to determine

the reasons for pre-treatment loss to follow-up among new sputum positive cases diagnosed under the Revised National TB Control Program in Delhi and to devise an intervention model to reduce pre-treatment loss to follow-up based on patients' and providers' feedback and program implementation strategies.

2. Materials and methods

This was an analytical cross sectional study incorporating both quantitative and qualitative methods conducted over a period of 5 months from November 2011 to March 2012. Delhi has been divided into nine regions/zones for implementation of RNTCP. Each zone is further divided into Chest clinics for program implementation. Delhi has 24 such clinics. Each Chest Clinic is equivalent to a District TB Centre with District TB Officer as in-charge. A Chest Clinic has Designated Microscopy Centers (DMCs) and Directly Observed Treatment (DOT) centers which provide diagnostic services and intermittent DOT therapy respectively. The sample size was calculated taking into consideration the pre-treatment loss to follow-up rate of 10% among the anticipated population with 95% confidence interval and 5% absolute precision. The sample size came out to be 340 patients (with a design effect of 2). For the present study, from each zone, one district was selected by simple random sampling method to give representation to each zone. The sampling units from each selected district of nine region/zones were selected using probability proportion to size method. For qualitative study, one focus group discussion (FGD) per selected district was held. One brainstorming session was conducted with the program managers.

2.1. Study instruments

A pre-tested, semi-structured questionnaire containing items on socio-demographic data and reasons for pre-treatment loss to follow-up including treatment history, etc. was used to collect data by trained field investigators for quantitative survey. Focused Group discussions (FGDs) were conducted with providers (medical and paramedical personnel).

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