Social Inclusion a fast track for TB care in India

Preethi Selvaraj

1Final year post graduate in MD community medicine, Yenepoya Medical College, Karnataka, India.

Introduction

Tuberculosis is a disease which is atavistic. It is a Global health emergency (Zumla et al, 2016). The expanding population is making the trend of new infection to increase day by day. World Health Organization has notified chronic respiratory diseases and respiratory infection as fifth and seventh cause of death among the ten leading causes of death from the environment (WHO, 2009). The existing quality treatment for tuberculosis services which is available free of cost and is accessible at the door step of primary health care level is indeed a great achievement. The country needs an equitable, comprehensive and buoyant health system. Ten international standards of TB care were formulated and had engaged private sector for the prompt and accurate diagnosis of the disease (Hopewell et al, 2006). The detection of multidrug resistant tuberculosis and extensive drug resistant tuberculosis is another barricade in the treatment of tuberculosis (Makanjuola et al, 2014). Stigma prevailing in the society is yet another quandary to be looked in. Stigma results in delay in pursuing the treatment, poor acceptance and family members keeping confidentiality of death which all contributes to the further expansion ever rising tuberculosis disease burden. The predicament in poor adherence and loss of follow up is mainly due to the need for transportation cost, lack of knowledge, ignorance about the disease transmission, lack of social support groups, poor communication with community health care workers, the level of support available to patients from family and other networks and the stigma that emanates from these relationships become a delicate issue to deal with (Balakrishnan et al, 2015). The dearth of sensitive surveillance system, radical laboratory services allowing the rise in the undetected cases. The inclination towards the traditional healers is also a contributing factor to the ever-increasing trend of tuberculosis diseases. The joint efforts of WHO and special programme for research and training in Tropical diseases (TDR) has announced grant scheme in the research of infectious disease of poverty for the year 2016-17 (WHO, 2017). Give well published an updated review of Stop TB and concluded that "The Stop TB Partnership does not currently qualify for our highest ratings. Collectively, all partners should support communication of the new agenda, strengthening partnerships for implementation, and filling in the gaps in available data for

*Corresponding author: Preethi Selvaraj, Email: preenessy@gmail.com

Received January 14, 2017 Accepted February 9, 2017 Published March 14, 2017


Copyright: © 2017 Selvaraj. This is an open access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.
monitoring and review to fulfill the sustainable development goals.

Variations in the existing programme

Social inclusion means equitable distribution of health care services to all the genres of society. The 8 A’s and 3 C’s of primary health care is also useful in addressing the anti-tuberculosis treatment in the community. The services should be appropriate, adequate, accessible, assessable, acceptable, affordable, available, and accountable; need to comprehensive, complete and continuous. The services provided are even though of acceptable standards, there need to be a thorough surveillance and monitoring of the programme from grass root level. Need of the hour is to address the anti-tuberculosis health care services to all and especially including the disadvantaged, marginalized and backward groups of populations and all special groups like people living with HIV/AIDS, diabetes and among substance abusers. Many case studies have already proved and addressed the dearth of treatment support groups including Balakrishnan et al (2015) where they did an interventional study in Pathanamthitta district, Kerala, India involving treatment support groups 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. Even though all caste groups utilize the health care services at primary level sometimes the response and behavior of care providers is not friendly. In view of all these points there is a need to race against time to save the tuberculosis burden of disease. Even though we say our country is secular and democratic still there are differences in provision of treatment for marginalized sections of societies.

How equality can be achieved?

Equality in treatment can be brought about by three ways. One is by involving skilled voluntary health worker’s representation from all the sections of society and to involve them in provision of the treatment to their respective genres of society (Balakrishnan et al, 2015). This will be helpful in removing the social contributing factors to the disease such as poor communication with health workers and stigma. Another way is to involve the head of the family or earning member to become the DOTS (Directly observed treatment for short course) provider for a tuberculosis patient or if he himself is diseased then the next earning member or bread winner could be the DOTS provider (Dave et al, 2016). The chances of loss to follow up, poor adherence, poor communication, lack of transportation cost which can all be managed. In addition, these people need to be given performance based incentives monthly and it could be another way to tackle the social burden of disease. The third way is to involve various institutions for behavior, change and communication activities in their own locality. This could be achieved by involving the NSS students, pre-final year paramedical students, pre-final year medical students to get involved in the mass campaign to address the importance of drug adherence, resistance to anti-tuberculosis drugs and follow up (Vijayapushpam et al, 2010). Performance based incentives need to be given to those institutions. As of now there are no intervention studies involving these groups in the access to anti-tuberculosis services.

Trifling factors: sequestered predicament in Tuberculosis care

Social support for TB care is feasible under routine program conditions. Addition of standards for social inclusion in international standards of tuberculosis care is meaningful. Its meaning is translated well by a society empowered with literacy and political sense. Major concerns are alcoholics who have more tendencies to loss of follow up and poor drug adherence and it’s all due to ignorance and less knowledge about the virulence of the disease (Makanjuola et al, 2014). Nutrition requirement in tuberculosis patients are the most neglected part in the international standards of tuberculosis care (Bhargava, 2016). There should be a separate set of social groups working for the nutrition among tuberculosis patients by which tuberculosis related morbidity and mortality can be decreased. They must be trained to utilize locally available resources to enrich the nutritional component.
Conclusion

To improve the quality of care, trained skilled voluntary health workers, uninterrupted supply of drugs and nutrition are certain issues which need to be taken care of. Strict laws need to be amended against substance abuse and our country needs to ban certain products for the goodwill of people. By these small innovations in the already existing health care delivery system of tuberculosis the health services will be met in all marginalized sections of society. Lots of research is needed to adopt these methods in the routine services. Field level evaluation activities and central level evaluation activities need to be formed which, with Government of India officials from the Ministry of Health and Family Welfare (MOHFW) and to also discuss arrangements for these support groups under NRHM, TB/HIV coordination. A real-time monitoring and evaluation framework is to be formulated and a visual conceptualization of how the elements of a programmed can fit together, that is, which inputs are necessary for the program's activities, what outputs are expected from the activities, and what short and long term outcomes will ultimately result from these support groups. These creation interventions can make a great impact by reducing the disease burden. It is a very easy and feasible way to be adopted under routine programme.

Conflict of Interest: None

References


Bhargava, A. 2016. Undernutrition, nutritionally acquired immunodeficiency, and tuberculosis control.


