

## Assessing the impact of a district multisectoral accountability framework for tuberculosis control in Pakistan



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### Abstract

This is an opinion paper on the process leading to the initiation of a model multisectoral accountability framework (MAF) project in the coastal district of Sindh. Dopasi Foundation in collaboration with Stop TB Partnership Pakistan conducted several meetings with senior policymakers of Sindh province drawing their attention towards the international commitment for establishing a Multisectoral Accountability Framework (MAF) to control TB. Thereafter, operational meetings were held with key government functionaries and district Badin. Subsequently the first sensitization meeting of stakeholders comprising of the district MAF team was convened and a problem analysis encompassing the current case notification, intersectoral challenges were drawn from the discussion these includes; likely benefits, zakat provision, mapping of community services, augmenting the role of drug inspectors, sputum transport and various dimensions related to the control and elimination of TB was conducted. This problem analysis, MAF implemented in the district and found effective in case detection likewise; during 2020, 2,519 TB cases were notified as compared to 2,464 in 2019, depicting a nominal increase, despite an overall decline of 17% in TB notifications owing to COVID-19 nationwide, while promoting self-reliance, pooling of resources and comparative advantages of each partner. This extremely cost-effective exercise based on WHO principles showed promising results, although the COVID-19 related disruption rendered a proper program evaluation impracticable. It is recommended that the government leaders need to work effectively with ministerial officials, civil society and affected communities, parliamentarians, private sector and academia, involved in diverse sectors including health and social protection, justice, labor, among others through this effective MAF.

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### Introduction

The imperative of adopting a bio-social model for Tuberculosis (TB) control, to address the social determinants of health through a multi-sectoral approach and increased financing of TB care services, has been repeatedly advocated since a long time (1-6). That approach enabled most of Europe to do away with the disease even before the advent of TB drugs during the 1940s (7). As the global elimination of Tuberculosis comes within sight, the clamor for a multi-sectoral accountability framework has rapidly gathered momentum. The WHO Model for Multi-Sectoral Accountability Framework for target-setting, delineating actions and reviewing progress on approved actions with stringent monitoring and reporting is placed at figure 1.

What is clearly warranted is a system-wide approach for TB control enabling health structures to liaise with other social sectors and safety nets and forging a holistic approach for elimination of the disease with an overall improvement in the quality of life and general health services. These considerations have positively influenced the evolution of TB control policies (8) that now call for adopting a people centered approach with attention paid to human rights and gender issues (9).

The establishment of a multisectoral accountability framework (MAF) is now absolutely

incumbent upon high burden TB countries like Pakistan following the 'Moscow Declaration to End-TB' endorsed by ministers in November 2017 (10). The Moscow Declaration was followed by a World Health Assembly resolution in May 2018 that called for the "development of the framework, as well as its adaptation and use at country level" (11). Subsequently the first UN General Assembly High-Level Meeting on TB held in September 2018 attended by several heads of state and government, senior ministers and over 1,000 participants, adopted a 'Political Declaration on Tuberculosis', which inter-alia requested the Director General of the World Health Organization to "develop the multisectoral accountability framework and ensure its timely implementation no later than 2019" (12) in an epoch-making event that made TB formally enter the international agenda for health at long last (13).

The matter is all the more relevant for Pakistan which together with India, China, Indonesia, Philippines, Nigeria, Bangladesh, and South Africa accounts for two-thirds of the new TB cases appearing globally every year (14). Keeping in view the urgency of the matter, the Dopasi Foundation and Stop TB Pakistan carried out advocacy with provincial government and legislators in Pakistan's Southern province of Sindh.



Figure 1: WHO Framework for Multisectoral Accountability

## Background

Dopasi Foundation and Stop TB Pakistan carried out a series of meetings with the Sindh Minister for Health and the Speaker Provincial Assembly of Sindh. Subsequently the provincial Health Minister presided over two meetings with all stakeholders including technical and donor partners, academicians, provincial directorate of TB control and other senior officers of the finance, planning and development, social welfare, women’s development, population planning and health departments. The Health Minister nominated Badin as a model district for the purpose thereafter, a meeting was held with the representatives of the Chief Secretary, Commissioner Hyderabad division that includes Badin district, Deputy Commissioner Badin, development partners and other senior officers of the provincial government. This was followed by the first meeting of the multi-sectoral accountability framework in Badin itself.

## Recommendations

At the estimated incidence of 263/100,000, the number of annual incident cases should be 4,858, while only 49% of these (2,383) were detected in 2018, indicating that more than half the cases are being missed. An additional 259 relapse and retreatment (R&R) cases were also notified. Most cases were reported from Civil Hospital Badin. About 30% of the cases are detected through public-private mix (PPM) activities, which entail liaison with some private practitioners and private laboratories. During 2020, 2,519 TB cases were notified as compared to 2,464 in 2019, which although appears to be quite nominal needs to be viewed in the context of the advent of COVID-19 in February-March 2020 which initially disrupted the routine health activities and brought about a significant overall countrywide decline of 17% in TB case notifications. The reasons for the low yield are, a) patients cannot access TB care facilities, b) patients reach the health facilities but are not diagnosed, and c) patients are diagnosed with TB but are not put on treatment. Some of the treated cases are not cured and the treatment success rate has lowered to 90% in the district, which needs to be properly analyzed.

## Initiation Of A Multi-Sectoral Accountability Framework:

Intra-sectoral and Inter-sectoral collaboration was initiated in the district through an extension of the Adelaide Declaration of the Health in All Policies (HiAP) approach based on the values and principles for building healthy public policies through cross-sectoral efforts and regards Health as a human right, while promoting health equity and calls for a new social contract between all sectors to advance human development and equity to improve health outcomes. After a series of consultations at provincial level, an initial 2-day meeting materialized in Badin on September 30 – October 1, 2019.

The provision of TB care services is not mainstreamed with the main hospital and are located around 4 kms away in a different setup, resulting in a high proportion of lost to follow up patients. It is advisable to relocate TB services in the main campus for better coordination with the Pediatrics department for enhancing linkages with Childhood TB cases.

**Zakat provision:** The system of Zakat disbursement is quite well organized down to the union council (UC) level with established committees. A concrete plan needs to be developed encompassing improved access of the patients to this vital support including rehabilitation support, and appears to be quite doable. The eligibility criteria of identified TB cases will be ascertained from the village zakat committee, coordinated through the local BHU, to link deserving patients to the admissible subsistence allowance on a monthly basis. Based on the eligibility criteria, a voucher scheme can also be employed.

**Education:** A huge untapped potential exists in the shape of over 3,000 primary level and 1,200 secondary level teachers who can act as TB activists in schools, raise awareness and help in identifying presumptive TB cases while ensuring that they urgently reach the appropriate facilities.

**PPHI:** The government has outsourced several first level care facilities to the Peoples’ Primary Healthcare Initiative (PPHI) for optimizing their efficiency. With over 100 referral facilities and 4 TBMUs under their supervision in Badin, the PPHI can offer a lot of support in terms of TB care that is currently not being utilized. The current quarterly reporting of around 22-30 cases can easily be accelerated manifold through better referral linkages and an effective sputum transportation mechanism. PPHI will be encouraged to establish TBMUs in all BHUs of the district by equipping them with microscopy services. Pending that, the BHUs will be involved in identification of presumptive cases, sputum collection of presumptive cases, transportation of sputum to the Xpert site using the newly established mechanism, ensuring early feedback.

**M&E Framework:** Technical Assistance was sought to finalize the M&E framework while allocating output indicators to each stakeholder. The same will then be used by the Deputy Commissioner and District Health Office for effective monitoring. Resource mobilization needs to be carried out to ensure proper monitoring and evaluation of the Badin project.

**Mapping Community Services:** The district authorities will ensure a mapping and clustering of lady health supervisors and workers and ensure their proper refresher training for TB control. Through their routine household visits, LHWs will inquire about the TB symptoms and identify presumptive cases. LHWs will then collect sputum samples of the identified presumptive cases and facilitate sputum transportation. They will also carry out contact screening of new identified cases and those already registered in their catchment areas. The positive reports from the GeneXpert site will be communicated urgently to the LHW as well as to the TBMU/BHU concerned. LHWs and CBOs will also serve as treatment supporters and impart community awareness related to treatment adherence. EPI vaccinators, SRSO and other NGOs/CBOs in areas not covered by LHWs will perform the same functions in areas covered by them.

As part of its efforts geared toward the attainment of Universal Health Coverage, the province of Sindh has done away with disease-specific programs in order to integrate disease control efforts and enable focus without duplication and wastage of human and financial resources at the district level, which is the hub of all health implementation (11-15). Badin was one of the few districts in the country that remained unaffected and even enhanced case notification under the shadow of the COVID-19 pandemic ostensibly owing to the institution of a Multisectoral Accountability Framework there. The framework aims to support governments and other stakeholders at all levels for accelerating the progress for culmination of the TB epidemic in line with the End TB Strategy and 2030 agenda for Sustainable Development. Towards this end, a healthy political choice will be employed with efficient use of resources, addressing the social determinants and risk factors, strengthening of health system for achieving universal health coverage, scaling up research and ensuring access to all facilities (5).

Challenges include limited financial support in terms of embarking on new interventions or innovative methods that go beyond the current structures. The limited (52%) coverage of lady health workers is also a major concern requiring the use of other community-based organizations (7-9). Frequent administrative changes might also pose a challenge to the smooth implementation of the project warranting fresh sensitization to the new incumbents in the civil administration and health leadership of the district, which at present are adequately motivated and aware of the technical project modalities. The issue of the Civil Hospital Badin's premises and having a TB care facility at a different location, was partly addressed to avoid the high loss to follow up. The way forward emerging from the experience sharing helped in designing innovative interventions that could be undertaken immediately (10). It is also a very cost-effective exercise that will lend considerable support to End-TB efforts, based on the WHO model and principles. It is unfortunate, however, that the COVID-19 pandemic rendered a proper review of the health gains made in Badin impossible, particularly concerning TB control. Hopefully the losses vis-à-vis TB care caused due to the pandemic can be offset in the coming years through additional efforts. Mobilization of adequate funds for TB

control should constitute an utmost priority for policymakers at all levels. The past experience in developing countries indicates that international commitments may not necessarily be translated into increased allocations, (11) and constant reiteration of the issue may be in order particularly at provincial and federal levels, in view of the overall lack of fiscal space for health, education and other social sectors.

## Conclusion

The establishment of a multisectoral accountability framework at district level, for the first time anywhere in the history of Pakistan has been a highly rewarding experience. The foregoing makes it apparent how interaction among several diverse groups of players can unfold lines of collaboration to the mutual benefit of all the stakeholders.

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