EXPERIENCES FROM THE FIELD

PRIMARY HEALTH CARE ON THE GROUND

In the Karamoja region, one of Uganda's poorest, tuberculosis is tackled thanks not only to dedicated anti-TB interventions, but also to primary health care programs. Launched by Doctors with Africa CUAMM in partnership with local authorities, this care model includes medical intervention, health worker training and awareness-raising initiatives, and continues to prove effective.

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In both high- and low-resource countries, health care models based on primary health care (PHC) principles continue to be fundamental in ensuring equity of access to health care, service quality and improved health outcomes.

This is also the case when it comes to tuberculosis (TB) in the Karamoja region, one of Uganda's poorest, where a fragile and under-resourced health care system means continued high morbidity and mortality from the disease[1]. Poverty, catastrophic expenditures, and excessive distances from diagnostic and treatment centers are the factors most closely associated with the region's low TB treatment success rate, which, at around 48% of notified cases, is Uganda's lowest, and high dropout rate (nearly 45%)[2].
In 2018, in partnership with district health authorities, Doctors with Africa CUAMM launched an innovative program to tackle TB in five districts in southern Karamoja. Inspired by key PHC principles – patient-centeredness, a focus on communities, and leverage of the peripheral health network to improve continuity of care – the program continues to be implemented today and is based primarily on medical care intervention, but also incorporates some health personnel training and mentorship and community awareness-raising activities.

The key pillars of the PHC approach include, first and foremost, strengthening community TB diagnosis and treatment services through intensified case-finding; reducing the number of cases lost to follow-up through the direct and systematic involvement of health center and community workers (village health teams) in the active surveillance of cases by way of scheduled appointments, phone calls and home visits (the bring-back-to-care strategy); launching a "TB day" at health centers with improvement of the quality of laboratory and clinical diagnoses (TB clinic day strategy), and creating a "one-stop shop" to offer integrated services for TB and HIV, COVID-19, malnutrition and diabetes.
In addition, in an effort to ensure local services, we piloted a successful "decentralized" outpatient care model for patients with stable, uncomplicated forms of treatment-resistant TB (MDR-

FIGURE 1 / TREATMENT SUCCESS RATE (PERCENTAGE OF ALL NOTIFIED CASES)

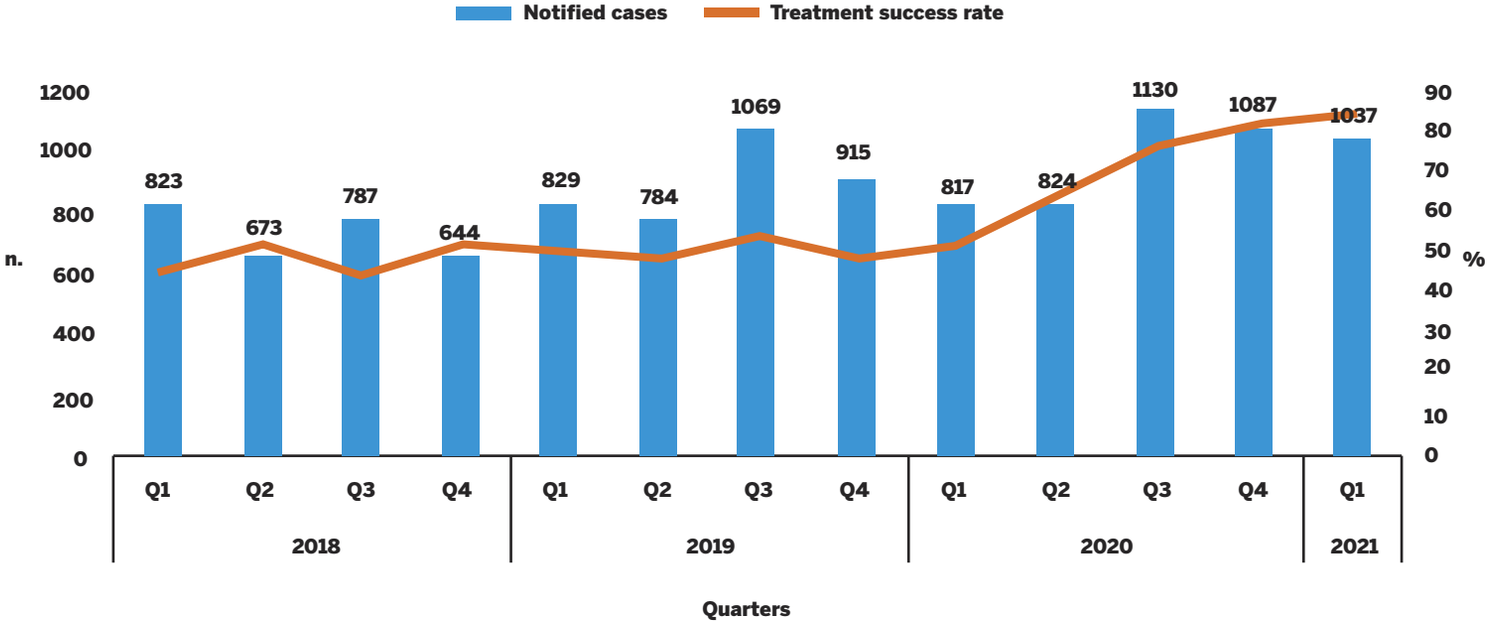
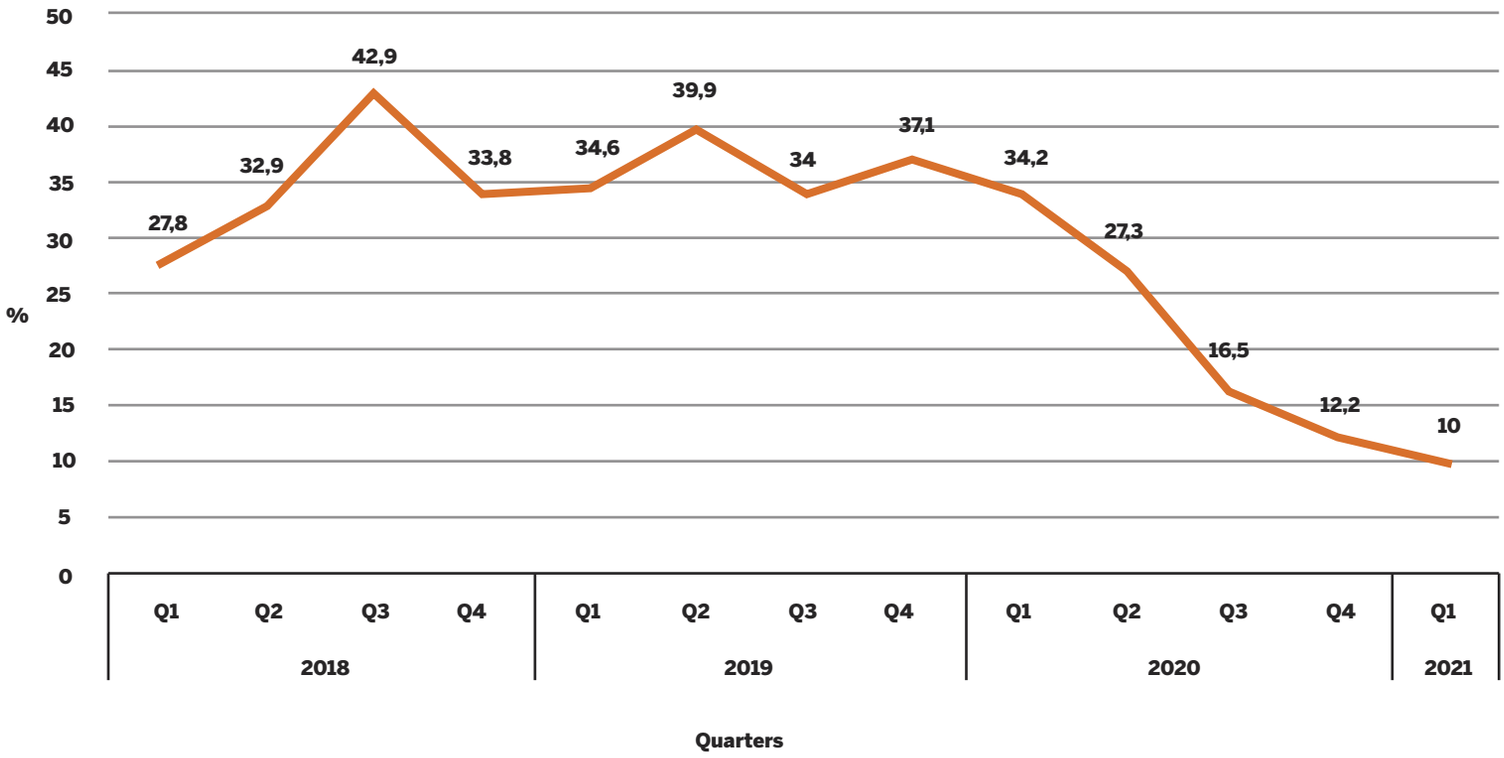


FIGURE 2 / PERCENTAGE OF CASES LOST TO FOLLOW-UP



TB) that entails training and mentorship work with the health workers who care for them, and organized mobile clinics to travel to communities in isolated areas and transport sputum samples for testing.

We also facilitated the identification and surveillance of high-risk venues and "hotspots" such as prisons and schools, and promoted community outreach activities such as door-to-door and group events, including community dialogues, dedicated days, talk show and radio ads.

In terms of the strengthening of the local health system, a significant investment was made in training, monitoring and data quality using the web-based ministerial platform (DHIS2) as well as in operational research (analysis of determinants and case-control program assessment) in support of district-level and national programming.

Even despite widespread general insecurity, the semi-nomadic nature of the population, and the disruption of services due to the Covid-19 pandemic, a trend analysis of a number of TB-related indicators in the districts where the intervention was implemented demonstrates the positive impact of this care model in a vulnerable area like Karamoja. Indeed, by early 2021 notified cases and treatment success rates had risen to 85% (see **Figure 1**), while the number of patients lost to follow-up dropped to 10% (see **Figure 2**)[3].

These figures underscore the importance of taking a PHC approach to health service provision, with community participation, service integration and equity of access becoming the foundations of healthcare that is affordable and equitable for all[4].

NOTES

1 National Tuberculosis and Leprosy Division: July 2017 – June 2018 Report. Uganda Ministry of Health 2018.

2 Nidoi J., Lochoro P. et a.l *Impact of socio-economic factors on Tuberculosis treatment outcomes in north-eastern Uganda: a mixed methods study* BMC Public Health 2021 Nov 26;21(1):2167.

3 Dr. Emina Godfrey, *Cuamm TB Project for Southern Karamoja,* presentation to MOH, 4th July 2022.

4 Theresa Ryckman et al, *Ending tuberculosis in a post-COVID-19 world: a person centred, equity-oriented approach.* Lancet Infect Dis 2022 August 10, 2022 https://doi.org/10.1016/S1473-3099(22)00500-X.