



**A SITUATION ANALYSIS REPORT ON THE
EXISTING ACCESS BARRIERS TO QUALITY
TB SERVICES FOR KEY AFFECTED
POPULATIONS (KAP)**

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Association

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Abbreviations:

ACSM	Advocacy, Communications, and Social Mobilization
AFB	Acid-Fast
BCC	Behavior Change Communications
CCM	Country Coordinating Mechanism
CME	Continuing Medical Education
CPD	Continuous Professional Development
DOTS	Directly Observed Treatment Short-course Strategy
DR TB	Drug Resistant Tuberculosis
FM	Family Medicine
FP	Family Physicians
GFATM	Global Fund to Fight AIDS, TB, and Malaria
GFMA	Georgia Family Medicine Association
GF	Global Fund
GHRN	Georgian Harm Reduction Network
GPN	General Practice Nurse
GLC	Green Light Committee
GOG	Government of Georgia
HIV	Human immunodeficiency virus
HR	Human Resources
IC	Infection Control
IDU	Injection Drug User
WHO	World Health Organization



1 Background

Tuberculosis and especially drug resistant TB are critical public health threats in Georgia. TB incidence and prevalence in Georgia have shown a decline in recent years but remain high. According to WHO, the latest estimated TB incidence was 106 per 100,000 population (for 2014), which is the fourth highest level among 53 countries of the WHO European Region. The estimated 2014 mortality rate was 6.6 per 100,000 population (excluding TB/HIV cases).¹

In 2014, 39.2% of previously treated culture positive TB patients and 11.6% of new culture positive patients were estimated to have multidrug resistant TB, which is higher than in 2013. The increasingly high rate of MDR-TB identified in new TB patients is a warning sign that MDR-TB is intensively spreading in the community. Georgia must have a substantial “reservoir” of MDR-TB patients serving as sources of infection for these patients who were never treated for TB in the past, indicating that specific interventions are needed to identify and cure the MDR-TB patients in this reservoir, and stop the spread of MDR-TB to others.

While the treatment success rate for new bacteriologically confirmed DS pulmonary TB cases has reached 80% (2013 cohort), the MDR TB treatment success rate gradually decreased as the numbers of patients lost-to-follow up has grown. In 2009, the treatment success rate was 55%, in 2011 - 50% and for 2012 cohort decreased to 46% while rates of lost-to-follow up increased from 27% (2009) to 34% in 2013 with slight reduction to 32% in 2014.

2 Common barriers to access TB care

Access to health services highly determines the overall performance of health systems and the clinical outcomes. “Access” is a multidimensional concept. It is influenced by many systemic and patients related factors, which determine if a patient in need can seek and obtain medical care timely and easily. In general, “the access is viewed as the possibility to identify healthcare needs, to seek healthcare services, to reach the healthcare resources, to obtain or use health care services, and to actually be offered services appropriate to the needs for care and to actually have a need for services fulfilled.”^{2,3}

Common barriers to health services identified by various authors include the following³:

- Waiting time and direct payment for services
- Unwelcoming staff attitude or poor interpersonal skills as well as complex billing systems at hospitals
- Lack of assertiveness and low self-esteem by users from among the poor, which increases the difficulty of accessing services
- Restrictions on the tasks that can be performed by various health staff, such as policies



that favour the use of urban-based services E.g. failure to delegate certain tasks to nurses or having centralized clinical decision-making capacity and system

- The late referral or non-referral to more specialist care of patients who may report with a condition at lower-level health facilities
- Stigma associated with a disease or condition, such as tuberculosis
- Failure to deliver integrated health services together with complementary programs provided to a target group
- The effect of non-financial barriers, such as lack of health awareness, apparent unmet need or lack of opportunity (defined as exclusion from social and health providers)
- Other non-financial barriers, such as means of transport, private–public dual practice through which patients are siphoned off from public health facilities to health workers’ private practices, where they may be subjected to more expensive, often irrational, treatments. This is evident for example in the implementation of health equity funds in Cambodia (third-party-payer mechanisms that reimburse public health providers for health services provided to eligible poor)
- Staff absenteeism, limited opening hours that do not allow for dealing with emergencies or working times are not convenient for patients, especially working people.

For purposes of this analysis, access to TB services in Georgia is assessed against the five dimensions such as (1) **Geographical accessibility:** This is about physical existence of TB clinics in right locations to be easily reached by both urban and rural dwellers and also ability of Georgian citizens to reach out those services when in need.

(2) **Availability:** This dimension describes if all services that comprise quality TB care are in place including medical, psychological and social support.

(3) **Equality in access to quality services:** This focuses on effectiveness in TB care and examines systems, tools and mechanisms in place for delivering TB care according to the evidence-based guidelines for achieving the best possible clinical outcomes.

(4) **Affordability** describes the extent to which TB services are subsidized by the Government and what’s ability of a TB patient to pay for services which remain out of coverage by state.

(5) **Acceptability** is about sensitivity of the health system towards the needs of those with presumptive and diagnosed TB. Acceptability includes factors such as culture, beliefs, religion, gender, ensuring patients' privacy and the confidentiality of their medical information, treating everyone fairly and equally.⁴ It also looks at community resources which are made available beyond the formal health care system for providing social support and facilitating patients’ journey through the health system.

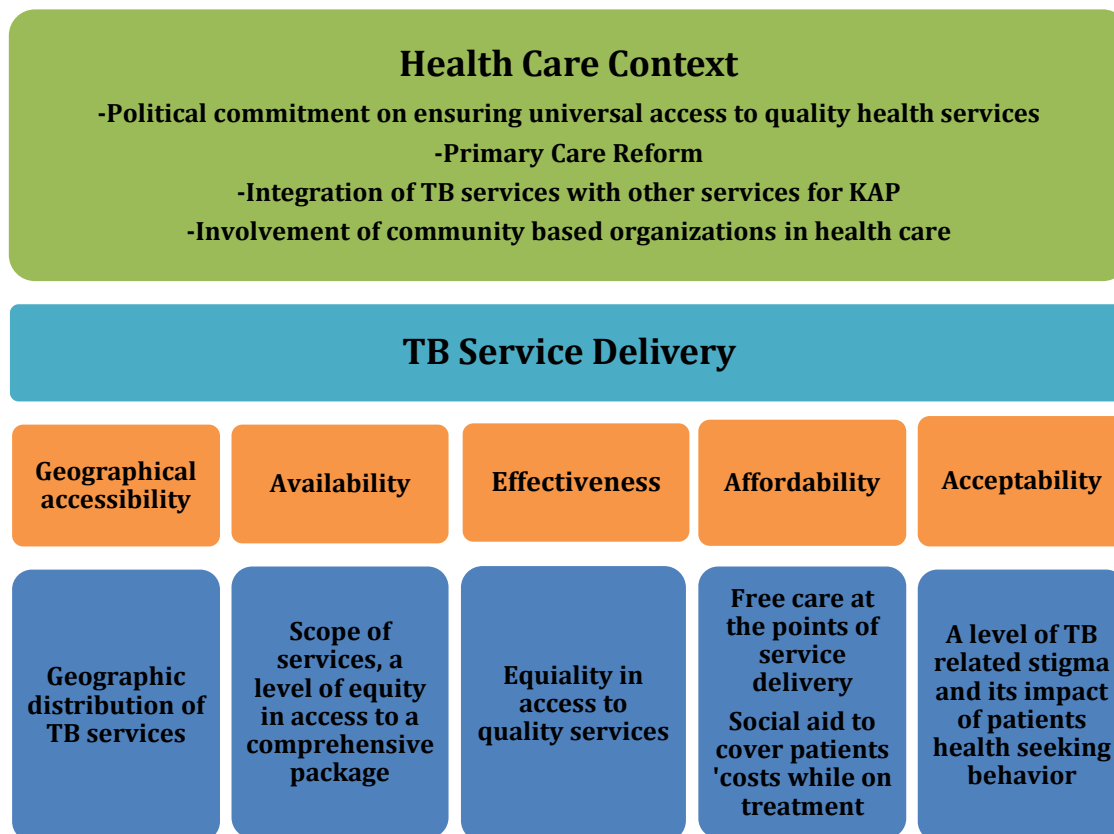
TB service delivery is heavily influenced by the overall health care context (access to general health services, performance of primary care providers, referral linkages and the degree of integration of a vertical TB program with general health services). Therefore, this analysis presents systemic features of the Georgian health system, which play a substantial role in how TB services are organized, delivered and taken up.

See figure 1 for a framework for this situation analysis aimed at identifying and summarizing barriers to access to TB services for key affected populations (KAP) in Georgia. Findings are derived from recent TB national program assessment reports produced by international and national partners. All consulted documents are referenced. The analysis and a set of



recommendations on strategic and programmatic changes needed for strengthening outpatient TB care model were discussed and finalized during the national consultative meeting in May 2016.

Figure 1. A framework for analyzing access barriers to TB services for KAPS in Georgia



3 Health Care Context

3.1 Political commitment

The Governmental policy on health is aimed at full elimination of financial access barriers to high-quality health services for the entire country population. The Government of Georgia launched the Universal Health Care Program (UHCP) early 2014. This significantly improved access to health services for Georgian citizens. Compared to the year 2010, in 2014 the share of the population covered by UHCP has increased from 30% to almost 100%.

With the introduction of UHCP the government health expenditures increased from GEL 426.4 million (about USD 258.2 million) in 2012 to GEL 720.8 million (about USD 408.2 million) in 2014¹ (69% increase in absolute national currency terms), with further projected increase to GEL 804.7 million in 2015 and GEL 904.9 million in 2018. In 2014, the Government expenditures on

1. Average annual exchange rate, GEL for USD 1: 2012 – 1.651, 2013 – 1.663, 2014 – 1.766 (Source: National Bank of Georgia, www.nbg.gov.ge)

health already constituted a 10.0% share of the total Governmental spending and were at the level of about USD 110 per capita.⁵ **Despite this positive development Georgia still fails to meet the World Health Organization (WHO) benchmarks on good access to health services measured by under-five mortality (13 (range: 11-16) per 1000 live births)², and an out-of-pocket payment level that was as high as 66% (2013).**~~Error! Bookmark not defined.~~

In December 2014, the Government of Georgia adopted the Georgia Health Care Concept for 2014-2020 “Universal Health Care and Quality Assurance for protecting patients’ rights” which stipulates national health priorities for 2014-2020. The concept identified TB and M/XDR TB as major public health challenges and set the following actions for adequate TB control:

- Strengthening leadership and governance for a well-coordinated multi-sectoral response to TB, HIV and hepatitis C.
- Introducing electronic health management information systems in various areas including the TB program.
- Achieving sustainable financing of priority health interventions, and from 2016, starting a gradual transition from international funding (Global Fund, GAVI, USAID) to state funding of priority programs (immunization, HIV/AIDS, TB).
- Improving prevention and management of priority infectious diseases - In order to reduce the burden of HIV/TB co-infection, HIV testing in TB patients and routine detection and treatment of latent TB among HIV infected will continue.
- Supporting intensified efforts aimed at early identification of presumptive TB cases. This will be achieved through the integration of TB services in general hospitals, strengthening of NCDCPH epidemiological services and screening and DOT programs in the penitentiary system.
- Introducing new diagnostic technologies for quick and accurate TB diagnosis
- Strengthening quality assurance and control mechanisms in TB laboratory networks.

POLITICAL COMMITMENT TO HEALTH

- Georgia launched the Universal Health Care Program in 2014 which guarantees unlimited access to basic primary care and hospital services for the entire population
- TB Control Law was adopted in 2015 to strengthen TB control framework through effective governance and sustainable funding
- Improving access to quality services was declared as the highest priority

Political commitment towards strengthening the National TB Response was translated into a new law on “Tuberculosis Control” adopted by the Government in December 2015. The law intends to protect personal and public health through efficient control of tuberculosis, to prevent the spread of tuberculosis in Georgia, to establish the legal basis for management of TB cases and ensure adequate support to TB patients. This Law defines the main legal, institutional and

2. WHO Global Health Observatory data repository

financial principles for the organization of TB control measures in Georgia, issues related to TB control and rights and obligations of patients with TB. The law is explicit about the role and responsibilities of MoLHSA, and other public health institutions in national TB response. The law describes a comprehensive framework for TB control and outlines means and measures for effective preventive, diagnostic and treatment services. The social assistance to TB patients through cash incentives is deemed as an integral component of TB case management model.

The law introduces involuntary isolation as the extreme measure to be used in exceptional cases only, after all other options for infectious patient adherence to treatment have been exhausted. The criteria and procedure for isolation are described in line with the ethical principles to ensure protection of human rights and patient dignity. Also the draft law stipulates that the TB case management should be implemented in line with best practice recommendations and international standards, which implies the continued transition to outpatient management of TB cases. Full enactment of these new legislative provisions is planned from the year 2017.

3.2 Primary Care Reform

Universal access to health services opened up new opportunities for developing an integrated model for TB service delivery. In the governmental resolution “Georgia 2020”, the GoG stressed the importance of strengthening primary care and shifting more resources towards PHC services to ensure effective primary, secondary and tertiary prevention and improve efficiency of the system.⁶

For the last two decades, Georgia has made several attempts to reform its primary care system. The PHC reform has been oriented towards introducing family medicine based primary care model instead of one based on specialized outpatient services. Supported by the World Bank and the European Commission, Ministry of Labor, Health and Social Affairs invested substantial resources in the rehabilitation of physical infrastructure and retraining of up to 2000 family physicians (FPs) and 2000 general practice nurses (GPNs). Since 2009, a vast majority of rural FPs and GPNs were dis-attached from Ambulatory-Policlinic unities at a rayon level. Legally they became independent entrepreneurs and were directly sub-contracted by the MoLHSA Social Service Agency. In 2009-2012, a focus for the health reform shifted from primary to secondary care. The government announced a wide-scale privatization of health facilities aiming to improve physical infrastructure and build a new model for public-private partnership in health care delivery. With the launch of the UHCP the need for strengthening primary care services, thus improving efficiency of the system, became more than urgent. MoLHSA is currently working on elaborating national PHC strategy, which will set a new agenda for PHC development and introduce effective tools and mechanisms to strengthen the gatekeeping capacity of primary care providers.



Severe functional deficiencies of the current PHC system have been a subject for discussion at many high-level meetings for the last couple of years. PHC challenges described in various reports include weak institutional capacity for high-quality service delivery, poor physical infrastructure, low payment and lack of incentives to promote good performance, limited gatekeeping capacity to mention a few.

It should be noted that Georgia has one of the lowest number of PHC providers relative to the population when compared to CIS and EU countries. Nevertheless, the geographical access to PHC has slightly improved according to HUES study⁷, i.e. the share of those accessing a PHC provider within 30 minutes has reached 78% in rural areas and 94% in urban locations in 2010. Despite good geographical access services are not fully utilized. Over the past decade Georgia reported one of the lowest outpatient service utilization in the European region 2.7 visits per person per annum (out of which PHC visits were less than 2). This is several times lower than that observed in CIS and EU countries.³ This data indicate that primary care in Georgia has extremely limited gatekeeping role and does not necessarily serve as the entry point into the health system.

It is no longer argued that primary health care is the backbone of an effective health-care system, and can improve health, reduce growth in costs, and lower inequality.⁸ A strong primary health care orientation is a critical condition for achieving universal health coverage targets particularly in resource-limited settings. Therefore, intensive efforts for strengthening PHC in Georgia is more than necessary for delivering high-quality services safely, effectively and efficiently.

BARRIERS TO INTEGRATING TB SERVICES INTO PRIMARY CARE SERVICE PACKAGE:

- Inadequate physical infrastructure
- Lack of transportation and communication means
- No financial motivation to stimulate the treatment completion
- Weak referral mechanisms
- Weak linkages with TB specialized services
- No cooperation model with CSOs
- Donor reliance for continuous professional development and capacity building

For the last decade, the Global Fund and USAID have made substantial investments in building capacity of primary care providers (PCP) to improve TB detection and community based follow up care. Training resulted in improving PCPs' ability for recognizing TB signs and symptoms at an early stage. The proportion of TB suspects referred by trained family physicians to TB service sites for diagnosis has increased from 2% in 2012 to 18% in 2015. PCPs became more responsive to TB patients' needs. Many of them reported adjusting time and place for providing DOT considering patients' needs and expectations. Performance appraisal conducted six months after the training revealed positive changes in providers' communication skills including TB related counseling. Moreover, it proved that interactive and solution-oriented trainings improve providers' performance in TB management by promoting positive attitudes, encouraging creative

3. <http://data.euro.who.int/hfad/>, Health For All Data Base



problem solving and building self-confidence and responsibility. Despite these changes PCPs reported that a lack of communication and transportation means, poor physical infrastructure that does not allow for adequate environmental infection control, a lack of respirators for personal protection, low salary and no motivation for achieving good clinical outcomes significantly limits their capacity to practice what they have learned and what they believe is the best practice for the care of patients with TB.

3.3 Role of civil society organizations

Involvement of civil society organizations in Georgia in the National TB Response has been very limited until very recently. In 2013 the USAID Georgia TB Prevention Project launched a small grants program to build the capacity of local CSO in TB detection, care and support. Eighteen programs were implemented by 11 CSOs for the last three years. These initiatives included ACSM activities to improve TB awareness and reduce a stigma level among KAPs and general public, active outreach of hard to reach communities e.g. nuns and monks in monasteries and nunneries, injecting drug users, prisoners and their families, and sex workers; capacity building of teachers and non-TB specialists; operational research. Seventeen CSOs united in 2015 to establish the Georgia TB Coalition as a platform for partnership and dialogue on potential solutions to challenges of the National TB Program.

This program has proved that civil society organizations (CSOs) have strong motivations to serve their communities, especially vulnerable populations. In order to ensure sustainability of CSOs implemented initiatives, currently MoLHSA with the Global Fund support is working on elaborating effective cooperation models between CSOs and formal health services. These models will aim at intensifying ACSM efforts and providing adequate support throughout the treatment course for better adherence. Involvement of former TB patients as peer educators will be given priority.

For the past year, CSOs representation has significantly strengthened at the Country Coordinating Mechanism for TB, HIV and Malaria, giving them an opportunity for a greater involvement in long-term planning and resource allocation decision making.

4 Access to TB Services

4.1 TB Service delivery model

National TB Program in Georgia is implemented by multiple partners including the Ministry of Labor, Health and Social Affairs (MOLHSA), the National Centre for Disease Control and Public Health (NCDCPH), the National Centre for Tuberculosis and Lung Diseases (NCTBLD), and the Ministry of Corrections and Legal Advice (MCLA).

TB services are delivered by specialized outpatient and in-patient clinics. There are 69 TB service points staffed by a TB specialist and a nurse in each district of Georgia. In Tbilisi, outpatient TB care is still being provided by a network of TB dispensaries and a number of DOT



spots at primary care facilities. In 2015 standalone TB dispensaries were merged with the National Center for Tuberculosis and Lung Diseases and currently they operate under one management umbrella. TB service points can offer a full range of diagnostic services to confirm the diagnosis and provide care follow-up and clinical monitoring. TB specific diagnostic tests are conducted at NCDCPH public health laboratories and the National Reference Laboratory in Tbilisi. A well functional sputum transportation system via Georgian Post allows for timely transfer of the sputum samples from district level facilities to labs.

Primary care providers (PCPs) are responsible for early recognition and timely referral of TB suspects to specialized services. If TB is confirmed, then primary care physicians and nurses with support and supervision of the rayon TB teams are expected to provide DOT in the community. Despite the availability of a wide network of PCPs across the country, patients often bypass primary care services and go directly to hospitals. Furthermore, PCPs consider TB service delivery beyond their competencies and are often reluctant to actively collaborate with NTP staff.

In addition to outpatient TB service points which are part of district level general hospitals (private and public), there are six specialized TB hospitals in Tbilisi, Batumi, Zugdidi, Abastumani and Poti. The total bed capacity amounts to 466 beds (out of which 170 beds are for M/XDR TB cases). A vast majority (70%) of new smear-positive TB cases and

almost all (90%) of MDR TB care are still hospitalized. Average length of stay is 25 for regular and 60 days for MDR TB cases. The average length of stay is lower as compared to many other countries in the region. However, out of government expenditures on TB control, the highest share (63.1% in 2014) is spent on inpatient curative care compared with outpatient care.

District level public health centers have been increasingly involved in contact tracing since late 2012. TB specialists are obliged to report the confirmed TB case to the public health service within 24 hours. Then public health personnel are responsible for visiting patients' households and referring eligible contacts to TB services for a diagnostic workup.

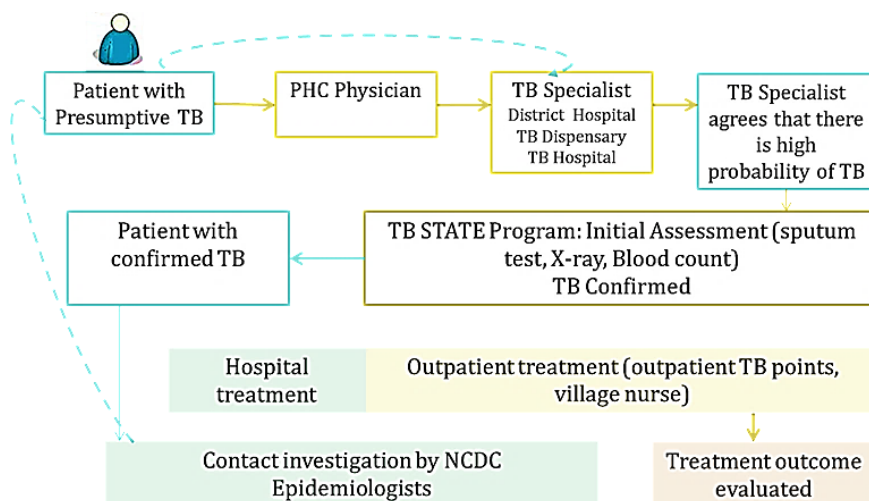
Figure 2 describes a patient pathway within the Georgian health care system from a first contact with organized health services to achieving final treatment outcome. Theoretically barriers to access can emerge at any step of the pathway. The next chapters describe major challenges to access to TB services across the pathway and offers possible solutions for consideration by MoLHSA, health care providers, professional bodies, CSOs and TB patients.

KEY FEATURES OF TB SERVICE DELIVERY MODEL IN GEORGIA

- TB care is TB specialists driven
- A vast majority of patients start TB treatment at a hospital
- PHC providers are involved in TB detection, organizing referral and providing DOT at a village level
- DOT is facility based-NTP provides no resources to encourage active outreach and home-based follow up care when applicable



Figure 2. Patient pathway when TB is presumptive or confirmed



4.2 Geographical accessibility

All recent expert missions conducted in Georgia in 2014-2015⁹ strongly emphasize the need for improving geographic access to TB services as a key requirement for ensuring good treatment adherence, improving treatment outcomes and preventing the further spread and amplification of drug resistance in the community. Despite the existence of TB service points at each district geographic access to TB services particularly for facility based DOT (that is a common practice in Georgia) is suboptimal. TB related knowledge, attitude and practices survey conducted in 2012¹⁰ showed that most of the respondents in the cohort of current or former TB patients (68.0%) need 30 minutes or less to get to the nearest health care facility. 48.9% need half an hour or less and 44% 1-3 hours to visit the facility which provides TB services. 76.7% of rural dwellers need 1-3 hours or more to get to TB specific facility compared to 46.0% who are from urban areas. These findings indicate how difficult it would be for a patient to cover 1 to 3 hours distance on a daily basis for DOT sessions. The risk of treatment loss to follow-up increases dramatically in such circumstances. In the same survey more than a half of TB patients reported that geographical accessibility was the main reason them to contact a primary care clinic or a district hospital.

Primary care providers, which function at a village level, can successfully assume the role for DOT delivery. Recently implemented capacity building efforts (that were not complemented by performance related incentives or targeted payments for TB services delivery) resulted in increased participation of primary care providers in DOT provision. Overall share of TB patients who receive DOT at PHC level has been steadily increasing from 13% in 2012 to 20% in 2015.¹¹

Clinical outcomes of DOT given by a PHC provider as compared to DOT by TB specialized services has yet to be evaluated.

4.3 Availability

As mentioned earlier outpatient TB services are located at each district for optional coverage. National Center for Tuberculosis and Lung Diseases (NCTBLD) is a place where most of TB patients start treatment in Georgia. NCTBLD offers a broader range of services as compared to other TB clinics. The availability of various specialists and psychological support services is higher at a central level while at a district level TB service points patients may experience difficulties in obtaining consultation of mental health specialist, psychosocial counselor etc. A survey on risks to MDR TB treatment loss to follow up conducted in 2013 showed that all components of a comprehensive TB care package are not equally available to all patients enrolled in the program. Forty five percent (74 individuals) of respondents reported the absence of services provided by psychologists, social workers or the services provided by the educator for compliance with treatment at nearest TB clinic. Availability of drugs for side effects management also varies across health facilities. Patients report the need to buy the side effect management drugs if not available for free within the program.⁴

AVAILABILITY OF TB SERVICES IN GEORGIA

- A full range of TB services is available in the civilian and penitentiary health facilities
- Psychological counselling, peer support, specialists' consultation and drugs for side effects management are not equally available to all TB patients

In order to improve TB detection and make the diagnostic process faster, the MoLHSA/NTP in Georgia has supported several innovative approaches. NCDCPH with USAID TB Project support has introduced The FAST (find actively-separate-treat) strategy¹² at two private general hospitals in Tbilisi and Rustavi. All patients admitted to selected hospitals having cough were screened for TB with GeneXpert test. The six-months data showed that out of 413 individuals tested 59 (14%) were confirmed with TB, out of which 11 (19% of confirmed cases) were with MDR TB. This short implementation experience shows that availability of TB diagnostic services beyond the National TB Program can significantly contribute towards finding new TB cases which otherwise would long remain unnoticed.

Integration of TB services into the harm reduction programs, thus making it easily available to injecting drug users, is becoming increasingly important in Georgia. The Georgia Harm Reduction Network staff is equipped with knowledge and skills to recognize patients with presumptive TB and organize timely referral. GHRN staff screened all beneficiaries (13943 individuals) on TB symptoms in 2014 and 2015. They found 814 (6%) PWIDs with TB presumptive symptoms and referred them to TB clinics. Eight percent of those referred were diagnosed with active TB disease.

4. Unpublished data collected by the Georgia Patients' Union, 2016



4.4 Equality in access to quality services

The National TB Program in Georgia follows the latest international recommendations and best practices in TB prevention, diagnosis and control. Identical quality standards are applied in civilian and penitentiary health facilities. A comprehensive package of TB services is available for prison inmates.

TB service delivery is guided by the TB management guidelines and protocols which are regularly updated and endorsed by the MoLHSA. The guideline implementation in both civilian and penitentiary sectors has been supported by the Global Fund and USAID through capacity building, on-site supervision and mentoring. National Center for Tuberculosis and Lung Diseases serves as a center for clinical excellence by setting and promoting best practice standards and providing guidance in clinical decision making through the medical committee. The latter is composed of experienced TB specialists who help physicians at peripheral clinics to evaluate a patient's needs and design the most appropriate treatment regimen. On the one hand such centralized clinical decision making allows for standardizing TB care across the country, on the other hand, it limits an individual practitioner's ability to quickly assess and respond to changing clinical needs on a daily basis.

Health facilities in Georgia lack internal quality improvement systems in general and specifically for TB. In 2012, the USAID TB Prevention project team has collected data from 30 TB service points on TB care process related indicators to establish the baseline and track progress over time. This assessment did not find major discrepancies and gaps in quality. In general compliance with quality standards (e.g. TB diagnostic tests, compliance with treatment standards, DOT provision etc.) varied from 80% to 90% in most of the facilities.¹³

4.5 Affordability

Georgia has universal access to TB services and drugs through state and Global Fund supported programs. The total budget for TB services in 2015 was at a level of 17 USD million of which 33% was funded domestically. The average expenditure per notified TB patient in 2014 was estimated at a level of US\$ 2.000, - which is moderate, compared to other countries in the region. The expenditure per treated MDR-TB patient comes to roughly US\$ 15.000, -. The WHO Tuberculosis financial profile calculates a financial gap of USD11 million, which would correspond with roughly 25% of total TB expenditure. The expenditure on inpatient care is almost double compared to the outpatient care (2014). External funding support to TB has been substantial and contributed to strengthening the TB program. Main international partners include GFATM, USAID, WHO and MSF. The level of external funding in 2014 amounted to US\$ 6,1 million. Most was used for procurement of TB medicines, laboratory consumables and social support to patients.

EFFECTIVENESS IN TB SERVICE DELIVERY

-NCTBLD serves as a center for clinical excellence and along with the TB Specialists and Pulmonologists Association promotes evidence-based TB care

-Equal clinical standards are applied in civilian and penitentiary sectors

- Routine quality measurement at a facility level is not established. Therefore, it is difficult to explain unfavorable clinical outcomes.

Total expenditures on TB control is showing increase, which is mainly due to increased government TB spending. This is also manifested by gradual increase in government per capita TB spending as well as government spending per TB case. However, the share of international donor funding still remains high (40%), which is calling for improved financial sustainability planning in light of decreasing international donor funding in Georgia and globally. Based on the Global Fund allocation information for Georgia for 2014-2016 allocation period, namely the amount of additional TB funding (5,395,442 US\$), it is expected that from 2016 onward, the external donor support for TB control will be reduced approximately twice.

Cash incentives scheme is operational since 2014 that provides cash payment and transportation fee to MDR and regular TB patients which comply with the treatment regimen well.

Compared with 70% share of out-of-pocket payments from total health spending in the country, 5% share of out-of-pocket expenditures on TB prevention and care is considerably low.⁵

However, in light of the aforementioned anticipated reductions in the external donor funding, there is a risk that this share may increase. It is recommended to continue close monitoring of TB expenditures in the future so that to avoid respective increase in financial burden on TB affected individuals and households.

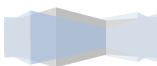
FINANCIAL ACCESS TO TB SERVICES IN GEORGIA

- Georgia provides free access to TB prevention, diagnostic and treatment services for all in need.
- Compared with 70% share of out-of-pocket payments from total health spending in the country, 5% share of out-of-pocket expenditures on TB prevention and care is considerably low.
- In the context of diminishing donor funding improving efficiency of the systems becomes even more acute.
- Shifting resources from hospital based to outpatient based care model can be a very reasonable solution to efficiency and long term financial sustainability.

4.6 Acceptability

This chapter explores barriers, which may prevent people from seeking medical care when they perceive that need medical assistance. It examines a level of TB related stigma among healthcare workers and in the community. It describes how understanding of TB related personal and public health risks and the entitlements of the National TB Program can influence one's health seeking behavior. The case scenarios included herein show how difficult it might be for KAPs with presumptive or confirmed TB to accept the diagnosis, timely seek medical care and overcome high social stigma associated with the disease.

The patient stories below are based on real cases and were collected by the Center for Reproductive Health and Counselling-“Tanadgoma” within the small grant program supported



by the USAID Georgia TB Prevention Project. Most of these stories were shared by former prisoners, injecting drug users and sex workers which face significant social and economic hardship and do not necessarily have adequate knowledge on when and how to seek medical assistance for TB. The last story by Tina reflects a health worker's experience that, despite good knowledge of TB, familiarity with the TB services and strong social support had to overcome a number of challenges while on TB treatment.

Two consecutive TB knowledge, attitude and practices survey conducted in Georgia in 2012 and 2015 showed that TB related stigma although on a decline remains high among health care workers, public and TB patients. Almost one third of TB patients report that the disease status disclosure led to a negative change in relationships with friends and community members.

A lack of knowledge about the availability of free access to TB diagnosis and treatment often prevent Georgian citizens to timely seek medical care. Health care workers beyond the national TB program mainly are not aware of what is provided free of charge to those with presumptive and confirmed TB. Therefore, they often fail to convince a patient to go to specialized TB clinics for further diagnostic investigations and treatment.

A wide scale information, education and social mobilization campaigns conducted in Georgia during the last three years with the USAID TB Prevention Project support have resulted in positive changes in health seeking behavior. The proportion of TB presumptive cases referred by PHC providers to TB specialists increased from 2% in 2012 to 18% in 2015. Number of individuals tested on TB has increased by 18% since 2012. Self-treatment rate has significantly decreased: only 6.6% of KAP study participants reported self-treatment compared to 28.3% from previous study in 2012. Disappointingly, these interventions did not improve adherence behavior which, as found by the TB defaulters survey conducted in 2013 is heavily influenced by social, economic and psychological factors.

WHAT INFLUENCES TB HEALTH SEEKING BEHAVIOR

- Knowledge of TB symptoms
- Understanding of how TB services are organized and funded
- Perception of quality of services
- Social support
- HCW Positive attitude and empathy towards TB patients
- Employment status and fear of being fired if found with confirmed TB

The survey found that a vast majority of patients loss to follow up (85%; 139) were male. More than a half (59.5%) were of working age and 64% (104) of them were unemployed. The multivariate analysis indicated that independent risk factors for default were TB drug side effects (OR 4.08, CI 1.15-14.69), depression (OR 12.00, 95% CI 2.94-69.53) and financial constraints (OR 7.94, CI 2.45-30.17). Almost one out of five patients (19%) reported self-treatment or receiving treatment from traditional healers after default. The existence of social support was found to be an important factor contributing towards positive adherence behavior. The high levels of stigma, geographic access barriers, fear of loss job, and substance abuse were also discussed but these factors were not statistically significant.¹⁴

4.6.1 Patient stories

IRMA, 41 YEARS OLD

If somebody had told me I could contract Tuberculosis, I would have laughed. We knew that people get TB if they starve, are very slim. People say so. And also you should avoid people with TB. If I had known somebody has TB, I would not have got in touch. So I was not surprised that people were avoiding me when I got sick with TB.

How did it start. . . I have been in the street for years. That's how I earn for life and send something to children in the village. I am out all days and sometimes even nights despite cold and wind. You get used to this and don't pay attention that sometimes you cough, sweat. . . I would never measure temperature. Sometimes you drink with others and forget about any complaints. Besides, I smoke and thought coughing was natural. . . I would not go to a physician myself, but NGO members came and told us about the disease and its symptoms, where to go and that it was free of charge.

I got frightened and went to see a doctor. When I found out that I needed treatment, I was almost ready to kill myself. Who wants a TB patient in the family or elsewhere, and I could infect children. They told me to calm down, explained that it is curable and everything needed would be covered by the program. They are good people, treated me normally, like others. I met other patients in hospital, more experienced. They told me what to do; that I should take pills as prescribed, tell doctor if I have complaints and do not follow own "initiatives". Everything was O.K. in hospital. I took drugs and meals offered and there were other patients, so I was relatively motivated to adhere to treatment. It became more difficult when I went home and had to continue treatment for several months. Everybody around including relatives and neighbors were giving own advices. Some said drugs were not good, others offered grandmother's prescription, etc. I had no job and lots of other problems. But when I went to a physician's consultation, they told me everything again and reiterated why the treatment was needed. . . Shortly speaking when I came for the last time to find out that I was cured, I had a feeling that I was born again. Now I know how to take care, and tell others, if it come about that. . .

TATO, 36 YEARS OLD

My friend died of TB. He got infected in prison and did not go to a physician after release. He was taking some herbal tea and milk serum at home, and put on the chest. He used to say that the drugs in program were poison and his family knew treatment better.. . Here if they knew. . . tortured him in vain and he died. After that I was very afraid of TB. I thought if I get it, I am dead. Then I decided to quit drugs and got enrolled in Methadone program and was screened for TB. By that time I had severe cough, lost weight, had no appetite and felt terribly. When TB was confirmed I thought to go to a village and start healthy lifestyle, eat good food, stay on fresh air, exercise, take some mixtures and thus combat the disease. I told physician about my intentions and she explained that all these were good but to be cured I needed treatment as defined by the

program. I was so scared by my friend's fate that I decided to "surrender". I spent two months in the clinic and then went home when I was not infectious any more. After that a nurse was coming to my home, giving me drugs and talking to me, asking if I had complaints and how did things went on. I had side effects and needed other therapies in parallel, but physicians agreed treatment schemes with each other.

What can I say, just thanks. They saved me. If I knew that before, I would help my friend to enroll in the program. So there should be more information available and people will not do silly things, address doctors on time and have effect.

MISHA 28 YEARS OLD

I was diagnosed with TB in prison. Before that I could not imagine I could possibly get TB. I thought only homeless and drug addicts get sick. Then I was moved to a special facility and I met other patients. Many of them were neither drug addicts, nor homeless. There we were told about this disease. I found I know nothing really. I knew Tuberculosis as people thought of it probably 2-3 centuries ago. . . I also met people who had not lung but other organ TB, such as backbone or intestine. . .

So I saw the disease completely differently. I also started reading books there, how many well-known people were ill, it was interesting. . . I had drug resistance. Some people said, it could not be cured and I got scared. The physician insisted that cure was possible but would take more time. I also met other people who were completing treatment and had good outcomes. It was difficult at the beginning, these drugs are not "sweets", some people can hardly tolerate. I also had side effects, thought would not be able to continue, but in 3 months everything was adjusted and became tolerable. If I was outside, I would probably stop treatment, but here I was with other patients, and together we managed it easier. Some of them shared own experience, others explained what happens and why. We also met physicians who told in details what to do and how to have treatment effect. Now when I am released from prison I have continued treatment at TB dispensary and will complete shortly. This far the outcome is good and the physician is also sure it will be good.

I continue to live ...

IAGO, 37 YEARS OLD

My father died of TB. Neighbors were pointing at us - here lived a patient with TB and did not let children play in our garden. For everybody it was like a plaque, like a leprosy. . . My mother was shy to go out. Why I was diagnosed with TB she got almost mad. I thought that was the end of life. People said it was hereditary. I was taken to a village clinic, had X-ray and nothing was found. I was advised to stop smoking. Then my uncle took me to a TB specialist, who told that only X-ray was not enough and sputum smear was examined. If I did not get to a TB specialist, I would probably die and this would be attributed to smoking. . . There I was told in details what

was TB, how it is transmitted and how to treat. I found out that all information we had about TB before was incorrect.

As for treatment, don't ask. . . six months. I have not heard of such before. But it was necessary. The drugs are special and you can't omit or substitute. If you don't adhere to treatment, you might end up with more complicated forms that need prolonged treatment.

I was treated first in hospital, then at home. My mother was with me all the time and I did not even think of defaulting. For her it was hope and I could not deprive her of it. The last tests showed that I was cured. I was really surprised, still could not believe that complete cure was possible. I was really happy. I just felt sorry for my father. If we knew everything maybe he could be still alive.

MERAB, 40 YEARS OLD

How did I get it? I was unemployed and my family did not want me. I used to live with several men in a dilapidated place. We did not have normal food and were drinking almost every day. You are smoking, coughing and think that this is normal. . . I had no money to consult a physician and did not think it was serious. Then one of us was diagnosed with TB and others were invited for tests as being in close contact.

I had TB and besides, I needed surgery. I was hopeless. There was one good surgeon who assured me that many people are treated, cured and continue their life. I was hospitalized, was provided with all drugs and food. I was surprised that all that was possible free of charge today. I continued treatment after hospital. They give you drugs when you don't need to be in hospital any more, but you should not drink or smoke and come for consultation from time to time.

I met one man in the hospital. He was admitted for the second time. He started treatment but then somebody told him those drugs were killing and he stopped treatment. He was advised to eat puppy meat and other foolish things. He felt well for two months but afterwards got worse and had to come to hospital again. He almost killed himself. Because of his example I complied with prescription like a small child. Now I have no problems with lungs and even got a job. Health is the most important thing in life, all the rest is linked to it. . .

TINA, 35 YEARS OLD, HEALTH CARE WORKER

I started coughing in the fall and it went on for months. I went to a family doctor, was examined and had X-ray. He found no abnormal changes and said it was possibly due to nerves. I did not like the response but what could I do, I agreed. The cough lasted and now friends advised to take some sedative. Finally, I myself believed that I was coughing because I was nervous. So I started to take a sedative tea. This went on several months.

I remember that day very well - last day of summer 2014. I spent the whole day with my goddaughter - a 10 year old girl. First we went on a boat on a lake, then were at "Wendy's". In

the evening I took her home and went to meet my friend on one of the most noisy streets in the city. We had coffee and cakes in a beautiful cafe and chatted a lot. After that we decided to have a walk in the streets. I started to cough again, but this time I had a strange feeling as if something ruptured in my thorax. As usual I covered mouth with a handkerchief and was shocked - I saw a red spot on the white handkerchief. I started to cry and reiterated to my friend why blood? Why blood? My friend called an ambulance immediately. I was standing in a prestigious downtown district, coughing blood, crying and waiting for an ambulance that was not coming. After 20 minutes my friend stopped a taxi and took me to the TB hospital. The ambulance called back in 55 minutes asking where we were. By that time I was in hospital already. I am still curious how much blood I would lose, if I stood waiting to that ambulance.

I spent that night at the hospital. In the morning the TB test result was ready - positive. I was told that I had “non-infectious” lung TB. To tell the truth it was a kind of relief, I thought as non-infectious I could go home. But physicians insisted me to stay in the hospital. I refused the very idea, I was sure I could be treated at home. After a long "bargaining" they agree to send me home. When I started treatment the problems related to the disease reduced, but other problems emerged. I had to go to the center to take drugs daily. I could have taken them at home but a doctor told me that this is against the DOT rules. In two weeks I felt well enough to return to work. Besides, I was not contagious so I wanted to continue my usual life, which I had before the diagnosis. Taking several pills in the morning would make the only difference. But I worked from 9:30 a.m. to 6 p.m. What should have I say, why I was late? Not everybody in the office knew of my illness.

Eventually co-workers, friend, family and relatives helped me and I completed the treatment successfully. I realized that it is easy to combat TB, but only if everyone around - physicians, nurses, relatives and the whole society support you.



5 A set of recommendations on necessary strategic and programmatic changes to support strengthening of outpatient TB service delivery with greater involvement of primary care and community based organizations.

The Georgia National TB Strategy for 2016-2020 aims to decrease the burden of tuberculosis and its impact on the overall social and economic development in the country, by ensuring universal access to timely and quality diagnosis and treatment of all forms of TB, which will decrease illness and deaths and prevent further development of drug resistance. This overall goal should be achieved through building patient-centered systems for high-quality service delivery.

The new End TB strategy calls for paradigm shift to make health systems more responsive to TB challenges. The paradigm shift would mean changes in strategic and programmatic thinking for finding innovative solutions to traditional TB related problems at an individual and a community level. The following actions are recommended to improve access to TB services in Georgia in the context of rapidly changing health care landscape, the national movement towards universal health coverage and the intention of the National TB Program to build a patient-centered TB care model by making TB patients community a key partner in TB care and control.

RECOMMENDATIONS

TO GOVERNMENT OF GEORGIA/MINISTRY OF LABOR, HEALTH AND SOCIAL AFFAIRS

- While supporting the implementation of new TB strategy for 2016-2020, consider gradual shift of resources towards outpatient TB care delivery through primary care and specialized outpatient services
- Introduce adequate payment mechanisms to stimulate greater utilization of outpatient versus inpatient TB services
- Consider opportunities for integrating TB service delivery by primary care providers into the Universal Health Care Program
- Build and implement electronic health management information systems to facilitate data exchange between different care providers. Thus improve linkages and strengthen a referral practice
- Support continuous professional development of all human resources involved in TB care to maintain good quality standards
- Consider strengthening TB services at peripheral localities by making a full range of services equally available to all citizens in need
- Support involvement of TB patients in decision making by authorizing their presence at high level coordinating or advisory groups including but not limited to the TB strategy,

TB guideline development and transition planning groups.

TO TB SERVICE PROVIDERS

- Revise the list of available services offered by a particular facility as compared to the national standards and make necessary actions to ensure a full compliance (e.g. make psychological support and mental health specialist consultation available)
- Create adequate environment for CSOs and former TB patients to conduct peer education and counselling at health facilities
- Partner with CSOs for active community outreach of individuals who need home-based care or do not comply with DOT requirements
- Consider broadening the scope of offered services by strengthening the pulmonology profile and diversifying professional competencies of physicians and nurses currently working exclusively on TB.

TO DONOR AGENCIES

- Support implementation of innovative interventions aimed at eliminating geographic access barriers to DOT services through video technologies or outreach mobile teams
- Support pilot programs implemented by CSOs to ensure effective use of existing community resources and establish an optimal cooperation mode between CSOs and formal health services
- Support integration of TB services with other services and disease programs (e.g. HIV, Hep C) aimed at hard to reach groups
- Assist the country in transition planning to ensure long-term sustainability in access to TB prevention, diagnostic and care services

TO CIVIL SOCIETY ORGANIZATIONS

- Advocate for the “day one” outpatient treatment among health professionals, patient groups and Georgian citizens.
- Elaborate innovative patient support models to improve availability of psychological support services and achieve better compliance to TB treatment.
- Mobilize community resources for a wide scale information and communication campaigns to improve TB awareness and increase the number of individuals which will benefit from having the free access to TB diagnosis and care.
- Engage actively in disseminating positive messages about TB to reduce TB related stigma
- Establish partnerships with organized health services at primary care and at TB hospitals to ensure synergy and maximize results in TB control
- Encourage current and former TB patients to join the national movement against TB by representing TB patients’ community at the Country Coordinating Mechanism and other high level advisory groups.



TO PROFESSIONAL ASSOCIATIONS

- Georgia Family Medicine Association sees its role in redefining the scope of work and competencies of family physicians and general practice nurses for their active involvement in TB detection and long-term care
- GFMA will closely collaborate with the Georgian Association of Pulmonologists and TB Specialists in elaborating key features of the new “patient-centered TB care model”
- Professional Associations should take a lead in updating and supporting implementation of TB care guidelines and protocols in line with the updated quality standards with a strong emphasis on protecting patients’ rights and providing best possible care for optimal clinical outcomes

TO FORMER AND CURRENT TB PATIENTS

- Join the Georgia TB Coalition to make patients voices heard by the high-level decision makers
 - Build skills for sharing the information and their personal experience of fighting tuberculosis to patients newly enrolled in treatment
 - Be aware of their own rights in health system and help peers to understand entitlements of the National TB Program
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