



Strengthening Tuberculosis Control in Kano and Jigawa

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Laboratory Services, Jigawa

Strengthening Tuberculosis Control in Kano and Jigawa

Summary

Tuberculosis is a leading cause of morbidity and mortality in Nigeria, which has the highest estimated number of TB cases in Africa, and the fourth highest in the world. The National TB programme (NTP) was launched in 1991, and the Directly Observed Treatment Shortcourse (DOTS) strategy was initiated in October 2001.

PATHS initially provided support to the Jigawa state TB programme by assisting them with the design of a communications strategy. The communications strategy was based on the results of interviews with key groups. This included the development of materials for use in a Directly Observed Therapy – Short Course (DOTS) communication campaign. Support was also provided to strengthen laboratory services with an initial focus on TB and malaria.

In Kano, activities focused on strategic planning. A five-year plan was developed with emphasis on expanding and decentralising TB services. Following this, assistance was provided to strengthen management and laboratory services

As a result of this support, there has been a significant expansion in TB DOTS and laboratory services in both states.

Results from Kano show an increase in case detection. This was less marked in Jigawa. Cure rate had remained stable in Kano and had increased in Jigawa.

Both rates were below international norms but the gap had narrowed.

Models and tools were developed in a number of areas and can be used by other states in Nigeria. Interesting examples included the laboratory External Quality Assurance (EQA) model and the DOTS decentralisation strategy based on the Kano Strategic Plan.

Introduction

This Technical Brief describes PATHS support to the TB programme in Kano and Jigawa states. It also includes some reference to interventions in other PATHS-supported states where PATHS support was not as extensive due to the presence of other donors.

Tuberculosis is a leading cause of morbidity and mortality in Nigeria, which has the highest estimated number of TB cases in Africa, and the fourth highest in the world. The National TB programme (NTP) was launched in 1991, and the Directly Observed Treatment Shortcourse (DOTS) strategy was initiated in October 2001, following the Abuja Stop TB declaration. The NTP operates at the federal, state and Local Government Area (LGA) levels. The federal-level Central Unit is headed by a National Coordinator. State programmes are run by State TBL Control Officers (STBLCOs) with DOTS providers being supervised by TB and Leprosy supervisors at the LGA level.

In 2003, an expansion of DOTS commenced so that at least one LGA¹ in each of the country's 36 States, and the Federal Capital Territory of Abuja, was implementing DOTS. The Federal Ministry of Health receives substantial support in its efforts to combat TB from the Damien Foundation; German Leprosy Relief Agency; Netherlands Leprosy Relief; World Health Organisation; Canadian International Development Agency; USAID; International Union Against TB and Lung Disease; UK Department for International Development; Global Fund to fight AIDS, TB and Malaria (GFATM) and other voluntary organisations under the NTP.



Key components of DOTS

- Government commitment to sustained TB control activities
- Case detection by sputum smear microscopy among symptomatic patients self-reporting to health services
- Standardised treatment regimen of six to eight months for at least all sputum smear-positive cases, with directly observed therapy for at least the initial two months
- A regular, uninterrupted supply of all essential anti-TB drugs
- A standardised recording and reporting system that allows assessment of treatment results for each patient and of the TB control programme performance overall

In 2006 the NTP launched its 5 year strategic plan for tuberculosis control. Its goal is “to reduce significantly the burden, socio-economic impact, and transmission of TB in Nigeria”. To attain this goal the following objectives were set:

- To strengthen the technical and managerial capacity of the National TB and Leprosy Control Programme at all tiers to ensure achievement of at least 80 percent implementation rate of programme activities by 2010.
- To promote behaviour change in the community about TB such that 70 percent of the adult population know about TB and TB services, its prevention and free treatment; and at risk groups are motivated to seek prompt care by 2010;

¹ Nigeria has 774 LGAs.

- To increase TB case detection rate from 26 percent to 70 percent by 2010;
- To treat at least 85 percent of all TB cases detected successfully by 2010;
- To reduce by at least 25 percent the incidence of TB among people living with HIV/AIDS by 2010

Activities to attain these objectives include enhancing the technical and managerial capacity of the NTP and other implementing partners; strengthening the existing services; and establishing new peripheral DOTS centres in areas not presently covered. Regular supplies of drugs and laboratory supplies will be ensured and training, supervision and evaluation activities will be strengthened.

PATHS has provided considerable support to TB control activities in Jigawa and Kano in line with the NTP objectives. Support has been more modest in Enugu, Ekiti and Kaduna with some Behavioural Change and Communication activities being undertaken, largely because of the presence of other development partners. Thus, in Kaduna TB DOTS posters for symptoms and treatment in both Hausa and English were updated. In Benue and Ekiti, clinical protocols were introduced for an integrated approach towards HIV/AIDS, Sexually Transmitted Illness and Tuberculosis (HAST) services delivery. This involved the production of a HAST training manual and training of health providers. In Ekiti, this followed a GLRA review in 2003 where PATHS covered gaps that were identified



KEY FACTS

Nigeria TB Data (2005 estimates)¹

Incidence (all cases/100,000 population/year)
283

Trend in incidence rate (%/year 2004-2005) -0.1

Incidence (new smear positive/100,000
population/year) 123

Prevalence (all cases/100,000 population) 536

TB mortality (all cases/100,000 population/
year) 76

TB cases HIV+ (adults aged 15-49, %) 19

New cases multi-drug resistant TB (%) 1.7

¹ Source: WHO report 2007, Global Tuberculosis Control, Surveillance, Planning and Financing.

CASE STUDY:

Jigawa situational analysis pre-PATHS support

In Jigawa, support from PATHS to improve the quality of laboratory diagnosis of malaria started in August 2004. Through a combination of workshops, site visits and e-mail support, the technical and supervisory skills of local laboratory staff were strengthened. With time they were able to establish high quality malaria microscopy services and quality improvement cycles in peripheral laboratories. The programme in Jigawa included limited refurbishment of laboratories, provision of essential equipment and reagents, development of tools to measure and analyse changes in quality performance indicators, and feedback to participating laboratories and other stakeholders. Once the feasibility and usefulness of the systems for improving malaria microscopy had been established, the programme was extended to incorporate microscopy for tuberculosis. Lessons learnt from the Jigawa laboratory programme were presented at national meetings and were incorporated into the Community Diagnostics Programme, in which laboratory activities in all PATHS states were harmonised within a common framework.

CASE STUDY:

Kano situational analysis pre-PATHS support

In Kano the TB programme was initially implemented in five LGAs in 2003, and was extended in 2004 to an additional three, covering eight out of the 44 LGAs, and 20 percent of the population. The programme operated through eight designated microscopic centres, and 12 DOTS treatment centres with an additional five LGAs prepared to start DOTS during 2005. A TB drug supply system was in place and high quality TB drugs were available. Although drug storage and supply at the State level was adequate, stock management at various levels needed improvement. The case finding rate of 10 percent in 2005 was well below the international target of 70 percent.

Community Diagnostic Programme

The Community Diagnostic Programme is a cross state initiative focused on providing simple, quality assured laboratory tests for anaemia, malaria and tuberculosis for communities where there are no laboratories. Test providers in PHC facilities are supervised by laboratory supervisors/trainers from within the states.

For more details see the PATHS Technical Brief on Strengthening Laboratory Services for Communities: The Community Diagnostics Programme (CPD), 2006-2008

The Response

In Jigawa a five year proposal and one year plan of action on **DOTS implementation** and expansion in the State was developed and submitted to PATHS by the State Primary Health Care Development Agency for consideration and support as a 'quick win' project in 2002. This plan was reviewed with PATHS and areas for PATHS support agreed with the state. This provided the focus for most of PATHS interventions. Later, PATHS also supported a review mission of TB services which recommended improving **DOTS microscopy, TB awareness, treatment supervision, drug management, Ministry of Health (MoH) communication and integration with other services.**

In Jigawa, PATHS assisted with the development of a **TB communication strategy and materials** which supported the state DOTS expansion strategy. The State Health Communication Group managed this aspect.

In Kano, the state TB programme's **planning capacity** was strengthened. This led to the production of a five year strategic plan. The programme management was then supported for the first year of implementation.

In both states, improvements in the **quality of laboratory services** were supported. The community laboratory diagnosis program (with a focus on rapid malaria diagnosis, Haemoglobin estimation, and quality improvement) contributed in improving the quality of laboratory services.

Communications strategy and Materials Design

To develop the Jigawa TB communications strategy, the State Health Communication Group² was assisted to design research studies into TB, were trained to use research instruments and assisted in the analysis and synthesis of research results. On completion

2 Members were from the Jigawa State Peoples' Congress, National Association of Women Union Journalists and the Primary Health Care Agency.

The Grand Khadi Speaking at the TB/DOTS Launch, Jigawa



of the research a workshop on communications was held with stakeholders and implementers to formulate the communications strategy.

The objective of the research was to gauge community and client knowledge, attitudes, perceptions, myths and practices (traditional and modern), around TB, how they respond to treatment, and issues related to access to and affordability of services. Gender information related to accessibility of services and responses to TB prevention and treatment were assessed. The information obtained was used as a basis for the communication strategy development.

Key Findings

Rural		
Issue	Men	Women
symptoms	knew the main symptoms of TB	did not know the symptoms of TB and confused it with whooping cough women are secluded at home and much less likely to have come into contact with information
cause	did not know cause, mentioned physical reasons, none of which are correct	TB caused by supernatural forces
Advice that could be offered	confused about whether hospital has a cure avoid public places know about immunisation for children	visit traditional healer and make sacrifice of animal or bird
cure	TB can be cured by both traditional and modern medicine	no cure for TB
know anyone with TB	all dead no, stigma	no, stigma
effects	stigma daily life interrupted loss of income high cost of drugs/not available	stigma men divorce wives who become humiliated
gender issues	women look after husbands who are sick women keep secrets men go to hospitals men believe women fear harassment at hospital	visit traditional healers not allowed out to go to the hospital husbands unwilling to spend money on drugs mis-use of religion to keep women at home no health care/distance to hospital

Key Findings (continued)

Urban		
Issue	Men	Women
symptoms	knew common symptoms	knew common symptoms
cause	did not know cause, mentioned physical causes	did not know cause, mentioned physical causes
Advice that could be offered	go to hospital/test/ accept treatment stop smoking avoid public places	go to traditional healer go to hospital for medicine
cure	very difficult but possible drugs only in hospital	no cure
know anyone with TB	some die some cured	some die some cured
effects	stigma isolation loss of income	can't afford drugs stigma
gender issues	men go to hospital more than women men take their drugs women get more attention in hospital	men go to hospital earlier than women women are not free to come and go without permission women are compliant in taking traditional medicines (herbs) more stigma attached to women with TB

The following recommendations arose from the research:

- **information materials** were needed,
- **communication training** was required for health workers and CBOs,
- **teaching aids** were required for schools, information materials were needed for religious leaders and for the Traditional Herbalist Association
- an **advocacy kit** was required to reach community and political leaders.

Generally there was a need to address women and men separately; all materials must be in local languages and materials needed to be as visual as possible (pictures not words).

A list of target groups was produced and methods on how best to reach them and core themes and messages were decided on. A draft communications strategy and work plan was produced. Based on the communication strategy, further activities included:

- Interpersonal communication and counselling (IPCC) training for TB service providers
- Radio jingles and discussion programmes
- Advocacy visits to opinion leaders
- Signposts identifying DOTS centres
- Production and use of posters in facilities and communities
- NGOs informing communities about TB
- Community outreach around the TB centres
- Provider's badges.

The messages and materials were straightforward and quick to produce, needed to have high impact and be a replicable model for similar workshops in other states and for other health communication campaigns.

Strategic planning for TB control in Kano state

The need for a five-year strategic plan for TB control in Kano state was highlighted by an audit of the TB programme undertaken in June 2005.

The framework for a five year strategic plan was discussed with key stakeholders within the state and nationally. Workgroups were formed based on the key areas of DOTS, with the addition of an Advocacy, Communication and Social Mobilisation workgroup.

Cross cutting issues identified during the workshops included: Organisational Structures, Governance and Institutional Strengthening; Human Resources; Finance, Procurement and Maintenance; HIV/TB; and co-ordination with other health services. Later, two extra working groups (Co-ordination with other Health Services and TB/HIV) were added on the basis of the plenary discussions.

The scoping mission and the workgroup reports formed the basis of the discussions and meetings that led to the adoption of the five-year strategic plan.

One of the major strategies in the five-year plan was the *decentralisation of DOTS services from hospitals to LGAs*. The aim was that at least one health centre in each political ward would function as a DOTS treatment centre, with sputum smear diagnosis being performed at the nearest functional hospital laboratory. Decentralisation was intended to reduce the distances rural patients had to travel to receive treatment and also a stronger relationship between the DOTS provider and patient could develop. The DOTS provider in each DOTS centre would be supervised by the LGA TB and leprosy supervisor.

Six LGAs were chosen initially and the six TB and leprosy (TBL) supervisors were trained in the development of LGA level micro-plans needed for implementation of decentralised DOTS.

Decentralised DOTS Activities for LGA TBL Supervisor

- Managing and co-ordinating NTP activities
- Assisting the STBLCO in planning training programmes for health care workers and village level volunteers
- Ensuring regular sputum collection from the designated sputum collection centre and transportation to the laboratory
- Assisting health care workers in categorisation of sputum positive patients and initiating treatment within a week of diagnosis
- Ensuring health care workers treat patients as per the national guidelines
- Maintaining proper record keeping of all NTP programme activities and ensuring timely compilation and submission of monthly/quarterly reports to the STBLCO
- Ordering supplies of drugs, laboratory reagents and consumables, registers and forms from STBLCO and maintaining an adequate stock and supplies in each health unit
- Liaising with the LGA PHC co-ordinator and health educator to organise health education activities

These micro-plans were reviewed and implementation was piloted in two LGAs (Gwardzo and Wudil). Performance indicators were also identified to allow monitoring of the decentralised DOTS intervention in the state.

State TB Programme Performance Indicators

- Total TB cases detected annually
- New smear-positive cases detected annually
- New smear-positive case detection, cure and success rates
- Treatment outcome of new smear-positive cases
- Total TB case detection and cure rate by LGA

Programme monitoring indicators used by TB and Leprosy Supervisors

- Expected number of smear-positive cases per quarter
- Expected number of non-smear positive cases per quarter
- Expected number of TB suspects in the community per quarter

Another major strategy in the five-year plan was the *expansion of DOTS services to LGAs not presently covered*. Tools were developed to assist the state TB control programme in auditing the LGAs not providing DOTS to allow a more evidence-based planning approach to expansion.

To *improve the data handling and usage* in the programme both at the state and LGA level, LGA TB and leprosy supervisors and the state programme team were supported in developing and setting targets for TB case finding. In order to use the data more effectively, the quarterly programme meetings changed from recording data to using data for managing the programme. Simple tools for tracking performance were also developed.

To *strengthen managerial capacity* the STBLCO attended a course on 'Management of Managers for TB Control Programmes' in the Philippines and went on a study tour of TB programmes in India. To share progress made in Kano to a wider international audience the state team were guided through the process of writing an abstract detailing the planning for decentralised DOTS in Kano for the International Union Against Tuberculosis and Lung Disease which the deputy STBLCO attended.

Refurbished State TB Office



Laboratory Strengthening

Laboratory strengthening activities concentrated on improving the quality of smear microscopy results in district microscopy centers (DMCs). Two different approaches were developed according to the systems already operating at the state and LGA level.

The first approach established a robust external quality assurance (EQA) system. Initially training needs for TB microscopy were assessed and major shortcomings in the performance, interpretation and recording of sputum smear microscopy were identified. Shortcomings identified were the result of deterioration in skills and knowledge and Standard Operating Procedures that were not utilised. Thus, these procedures were reviewed and discussed with the head of the laboratory and with staff performing the test. To help staff identify causes of errors, procedures were demonstrated and randomly selected TB slides were checked.

Simple quality indicators were developed to monitor staff skills in TB diagnosis in representative DMCs. The Laboratory Quality Assurance Team was assisted to plan and facilitate quality assurance workshops for TB and malaria. This strengthened the laboratory supervisors' supervisory skills to review the quality of sputum smears for AFB, to check the accuracy of results from the participating laboratories, to identify specific problems and to recommend corrective actions.

The second approach focused on improving a TB microscopy system where an EQA system was already in place.³ Audits of laboratory services in LGAs not providing DOTS services were carried out prior to the expansion of DOTS. A site was identified for the TB reference laboratory and a list of recommended improvements produced. Two alternative stock control procedures to reduce "stock outs" of reagents were designed; the first system was designed to support a supply system with sufficient supplies to allow robust buffer stock levels at all levels and the second was designed to cope with minimal stock being received from the national level. In addition, a transport system for the use of the two programme vehicles was developed to ensure equitable usage between core programme activities (including supervision).



Examining TB slides

A review of the TB microscopy EQA results in pilot LGAs resulted in proposals for rolling out the system to more LGAs. The results showed that the slide concordance rates for these microscopy centres had reached and maintained an acceptable level of quality (>90 percent concordance). An excel workbook system was developed and trialled using real data to help the laboratory EQA officer calculate and display key laboratory quality and workload indicators. This data was reviewed in quarterly programme meetings. A system for utilising DOTS centres as sputum collection points, with the TBLS transporting sputum to the DMC, was devised. This system would reduce the distance patients had to travel to obtain a laboratory diagnosis. By early 2008, this system had not yet been implemented.

Both approaches involved the refurbishment and equipping of some district microscopy centres.

³ This EQA system had been developed by Faruk Sarkinfarda, a doctoral student.

Results

Jigawa

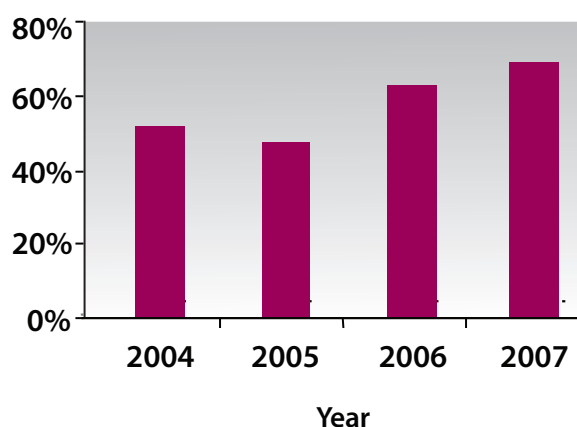
In Jigawa, 17 DMCs and 37 Treatment Centres, including two prisons, have been established in 17 LGAs since DOTS started. Despite a doubling in trained staff, Treatment Centres, Microscopy Centres and LGAs from 2004 to 2006, cases detected had only increased from 415 in 2003 to 685 in 2006 (by 65%) and had, in fact, marginally decreased from 2004 to 2006. In addition, very few of the registered patients received treatment directly observed by a health worker or community member during the initial intensive phase of treatment as demanded by the NTP guidelines. **The Jigawa TB programme treatment outcomes were improving** but still below national averages. For example, in 2004 there was a low cure rate of 48 percent compared to a 66 percent national average and a high defaulter rate of 23 percent compared to a 12 percent national average. **By 2007, the cure rate had improved to 65 percent.** Performance was affected by a continued lack of technical and managerial capacity at state programme level resulting from the change in the program leadership and other responsibilities of the new STBLCO.

Expansion of TB Services in Jigawa

Description	2003	2004	2005	2006
Number of Microscopy Centres	5	8	11	17
Number of Treatment Centres	10	16	22	37
Number of Registered Cases	415	712	738	685

Significant improvements in the TB laboratory service were achieved by upgrading infrastructure and equipment and by training and monitoring the performance of laboratory staff. Interest in the capacity building of microscopy centre laboratory staff has already been shown by the other PATHS-supported states, by Federal organisations and by

Cure Rate



national programmes. The laboratory technical assistance helped the state establish a laboratory quality assurance team. This team established agreed sets of quality indicators for TB microscopy. Standard Operating Procedures were implemented in some District Microscopy Centres and an EQA system was put in place. Workshops were run for laboratory supervisors but further support in this area is warranted as supervision is challenging in this environment.

Kano

By early 2008, Kano was the only state in Nigeria to have a five-year strategic plan and LGA micro-plans. Both these initiatives were favourably commented on during a USAID evaluation on the TB programme which said Kano was the "Place where they had seen real progress". Copies of the Kano state strategic plan and an LGA micro-plan were given to the Federal Ministry of Health. The emphasis on decentralisation of treatment centres to one centre per ward interested the NTP. This led to the production of national guidelines on a community TB programme, an area that also received substantial inputs from PATHS.

An examination of the data available for the first three months of decentralisation shows a wider geographical distribution of smear positive cases than in the first quarter of the previous year which suggests a greater outreach of DOTS services away from the wards surrounding the hospital. However it was too early in the decentralisation process to predict if this trend would continue.

Basic (hospital based) DOTS coverage had expanded to 27 of the state's 44 LGAs by June 2007 from the 8

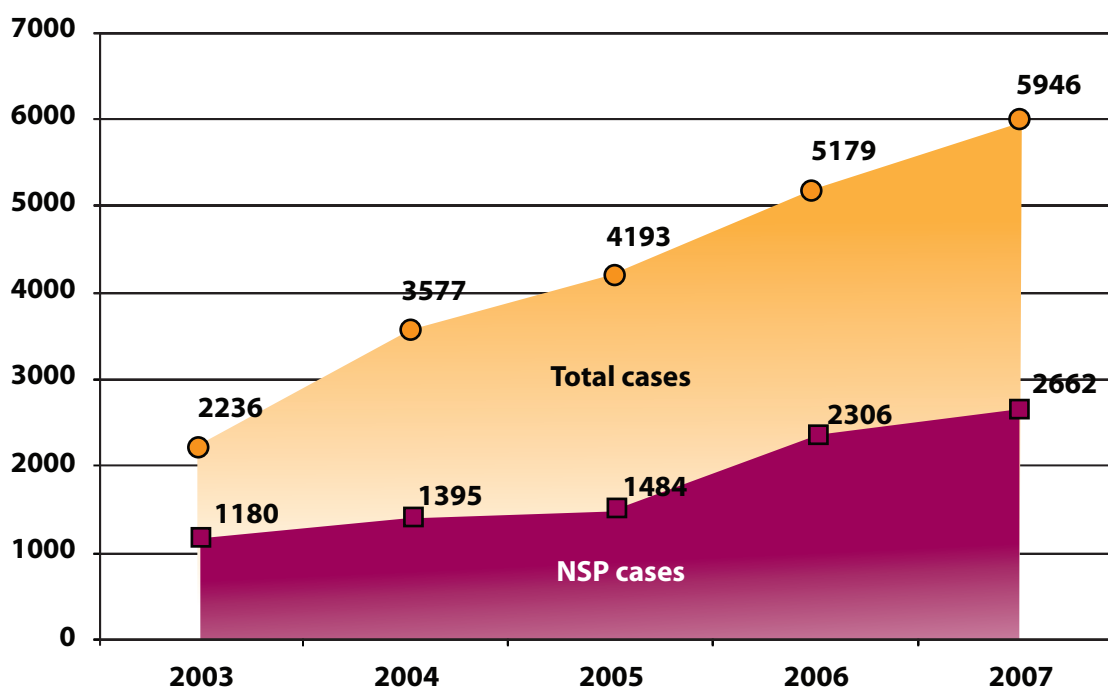
covered in 2005. Case detection had increased from 4,193 in 2005 when PATHS support started to 5,946 in 2007 a 42 percent increase which is probably due to the increase in DOTS coverage. All LGAs with District Microscopy Centres now offer DOTS services with expansion into the remaining LGAs being planned in 2008. Dependant on the individual situation in each remaining LGA, laboratory services will either be established or covered by a DMC in a neighbouring LGA.

TB Surveillance Data showed a general increase in case detection since the first quarter of 2006. There was also an increase in case detection among smear positive patients.

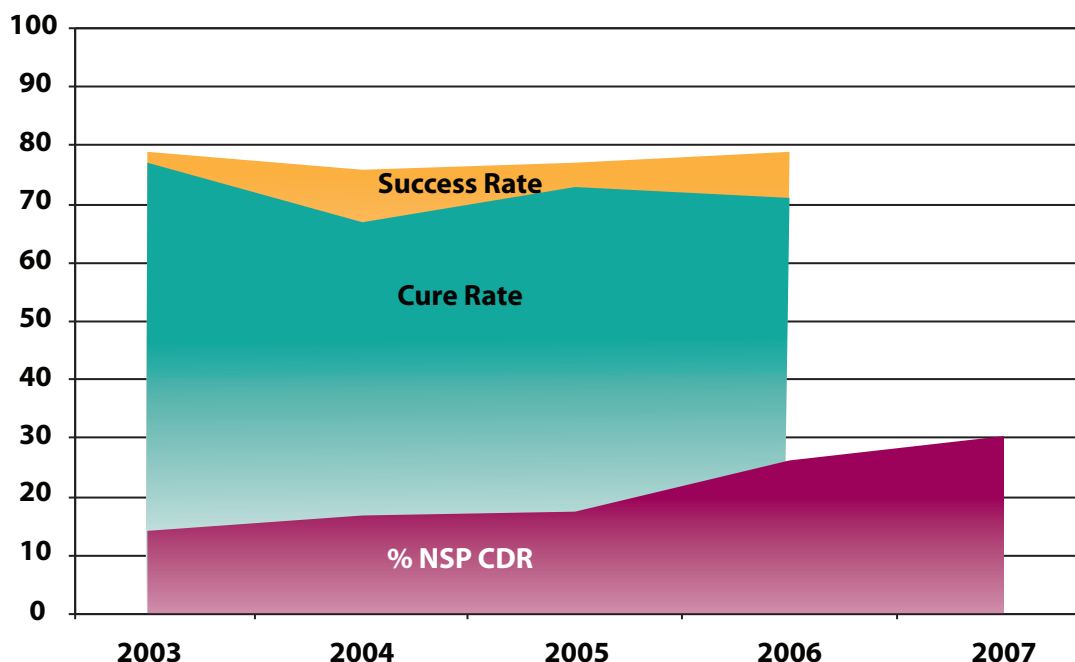
Expansion of TB services in Kano

Activity	2005	2007
Number of Microscopy Centres	8	32
Number of PHC facilities with DOTS Treatment Centres	0	63
Number of hospitals with DOTS Treatment Centres	8	22
Number of LGAs with DOTS at a least one Treatment Centre	8	27
Number of Registered Cases	4,193	5,946

Kano State: Total TB cases and New Smear positive (NSP) cases detected Anually (2003 - 2007)



Kano State: NSP Case detection (CDR), Cure and Success Rate (2003 - 2007)



The chart shows that case detection rate among new smear positive patients has increased from 18 percent to 30 percent from 2005 to 2007; whereas, the cure rate remained steady at between 67 and 73 percent. Thus, it has not reached the desired level of 85 percent.

The computerisation of laboratory Quality Assurance recording and reporting, based on a quality assurance system has improved the quality of data presented at management level. This has allowed the programme team to target their limited resources to laboratories in need of improvement. Support and familiarisation with operational planning has also helped programme staff. The appointment of a Medical Officer as a deputy STBLCPO has been noted as being a model for other state programmes. Case detection targets have been set for each TB and leprosy supervisor based on the population of each LGA.

TB slide **concordance rates** (agreement between the original laboratory result and quality assurance team result) **had increased from an average of 84 percent in 2005 (based on two quarters results) to 92 percent in 2006 (based on four quarters results)**. These results were based on five District Microscopy Centres. An additional three District Microscopy Centres have also been included in the EQA system in 2007 and these centres showed lower concordance rates.

Challenges

Financial sustainability

Limited government financial contributions have resulted in considerable financial dependence on external sources which is likely to continue for some time. The GFATM funds have been utilised in Kano for advocacy, laboratory and programme meetings, supervisor allowances, contact and defaulter tracing and media communication. In Jigawa, GFATM funds have supported DOTS expansion, supportive supervision, awareness creation and staff allowances. Thus, the TB programme is at high risk with regard to financial sustainability. It is hoped that this will be addressed in 2008 since with the introduction of activity based budgets, funding from government would likely improve as both states have substantial budget provisions for TB.

Sustainability at managerial level

In Jigawa, exposure to training workshops by the World Health Organisation, Netherlands Leprosy Relief (NLR) and PATHS and guidance by PATHS has led to improved technical capacity and a good sense of ownership. But, the main challenge the STBLCP faces is the lack of drive and/or managerial capability by many staff at all programme levels to deliver quality services. Routine integrated PHC supervision is also lacking or very deficient.

In Kano, there has been substantial investment by PATHS in building the managerial capacity of the STBLCP. The appointment of an additional Medical Officer for the programme has improved the capacity of the programme. Tools have been developed to assist the STBLCP in managing data and strategic planning. The programme is still at risk from the transfer of key staff (STBLCPO, his deputy and the laboratory QA officer) in whom this investment has been made.

Lessons learnt

1. The more diverse distribution of new cases in LGAs piloting decentralisation of DOTS services indicates that this strategy may have an impact on case detection and case holding but more time is needed to assess the true impact.
2. There is considerable synergy between the support given to Jigawa and Kano as Jigawa could benefit from support for programme management and Kano could benefit from communications activities.
3. The investment in a communications strategy, the strengthening of microscopy services and the expansion of DOTS to more LGAs needs to be sustained to ensure further increases in case finding.

Recommendations

1. The investment in the development of the TB communications strategy in Jigawa would make a good model for export to other states. The materials and messages produced would be of use to TB programmes in Hausa states and could be implemented after initial testing and modification. Due to the cultural and religious differences in non-Hausa states the materials may be of more limited use but the process would still be valid. Export of the communications strategy to Kano would be particularly advisable as the states are very similar culturally, the programme management has been significantly strengthened in Kano and the programme is undergoing decentralisation and expansion.
2. The five-year strategic planning process followed by the implementation of the key strategies can be used as a model framework for other states to develop similar strategies. For example, the model of decentralisation developed could be replicated in other states, particularly ones with similar demographics. Similarly, the structure of the LGA micro-plans could easily be adapted for use in other states. The planning process would assist states in ensuring their strategies are in line with the federal five-year strategic goals.
3. The tools developed to assist the STBLCO in effectively managing the programme could also be utilised in other states with minor modification, such as the setting of targets for TB and leprosy supervisors, development of electronic worksheets for laboratory data handling and the employment of an additional Medical Officer to support the programme. The laboratory EQA system would also be transferable to other states.
4. Laboratory EQA needs to be expanded to all district microscopy centres to ensure the quality of sputum smear results across the state.

Conclusion

Although progress has been made in strengthening the TB programmes in Kano and Jigawa, ongoing support is needed to ensure that coverage continues to be broadened and that the programme becomes sustainable.

It is important to note that technical viability for TB control based on the "DOTS" strategy has been accepted at the level of federal and state government. The federal TB policy is regarded in Jigawa and Kano State as the valid policy. The DOTS strategy needs to be further decentralised and the LGAs strengthened to play a key role in implementing in the TB programme.



Partnership for Transforming Health Systems (PATHS)



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