Understanding the management of TB-like illness in the private sector

Jeremiah Chikovore

Human Sciences Research Council, South Africa

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Background

TB is a leading cause of death in South African (SA)

TB control requires identifying early and treating effectively infected individuals

Antibiotic use can cause diagnostic delay, risk of death, transmission and drug-resistance

29% of people with TB-related symptoms first present to private general practitioners (GPs) (Chin & Hanson, *JID*, 2017)

Little is known about TB management in the private sector

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Objectives and Approach

To describe the quality of TB and HIV care among GPs, using the Standardised Patient method

Standardized patient:
An "actor" trained to systematically present a complaint or set of symptoms in real clinical settings

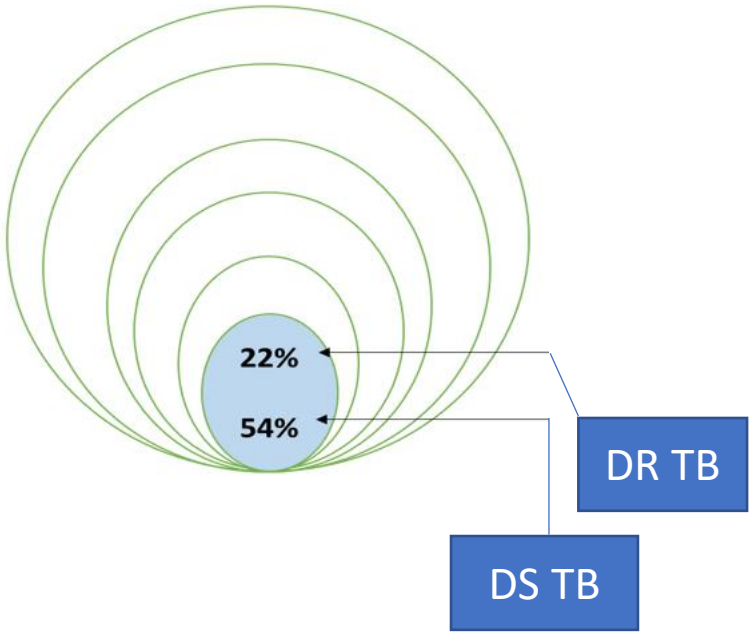
Objectives

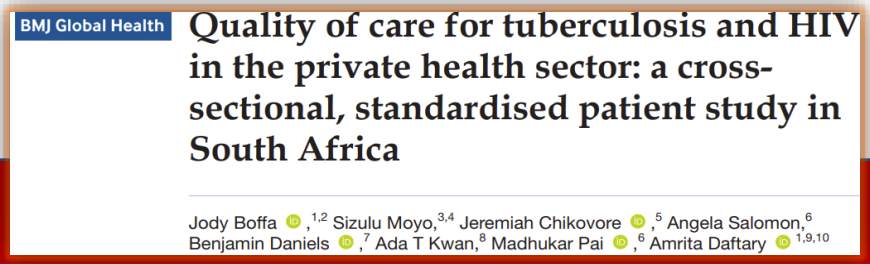
To qualitatively assess the social and behavioral factors associated with quality of care

In-depth interviews
30 GPs in 2 cities,
Purposively chosen to vary by age, sex, ethnicity, and location

Age → How well managed TB & HIV → Gender → Practice setting

Treated / cured outcomes of the TB cascade in SA




BMJ Global Health

Quality of care for tuberculosis and HIV in the private health sector: a cross-sectional, standardised patient study in South Africa

Jody Boffa ,[1,2] Sizulu Moyo,[3,4] Jeremiah Chikovore ,[5] Angela Salomon,[6] Benjamin Daniels ,[7] Ada T Kwan,[8] Madhukar Pai ,[6] Amrita Daftary [1,9,10]


BMJ Global Health

Prescribing practices for presumptive TB among private general practitioners in South Africa: a cross-sectional, standardised patient study

Angela Salomon ,[1,2] Jody Boffa,[3,4] Sizulu Moyo,[5,6] Jeremiah Chikovore ,[5] Giorgia Sulis ,[2,7] Benjamin Daniels ,[8] Ada Kwan,[9] Tsatsawani Mkhombo,[10] Sarah Wu,[11] Madhukar Pai ,[2,7] Amrita Daftary [12,13]

Ethical issues and analysis

Ethics

Approval from HSRC Research Ethics Committee and McGill University Ethics Board

Informed consent sought from GPs; Anonymity and confidentiality were maintained

Analysis

Was both iterative and deductive;

Multiple analysts for confirmatory views

Identified emerging concepts, merged them using constant comparison into themes

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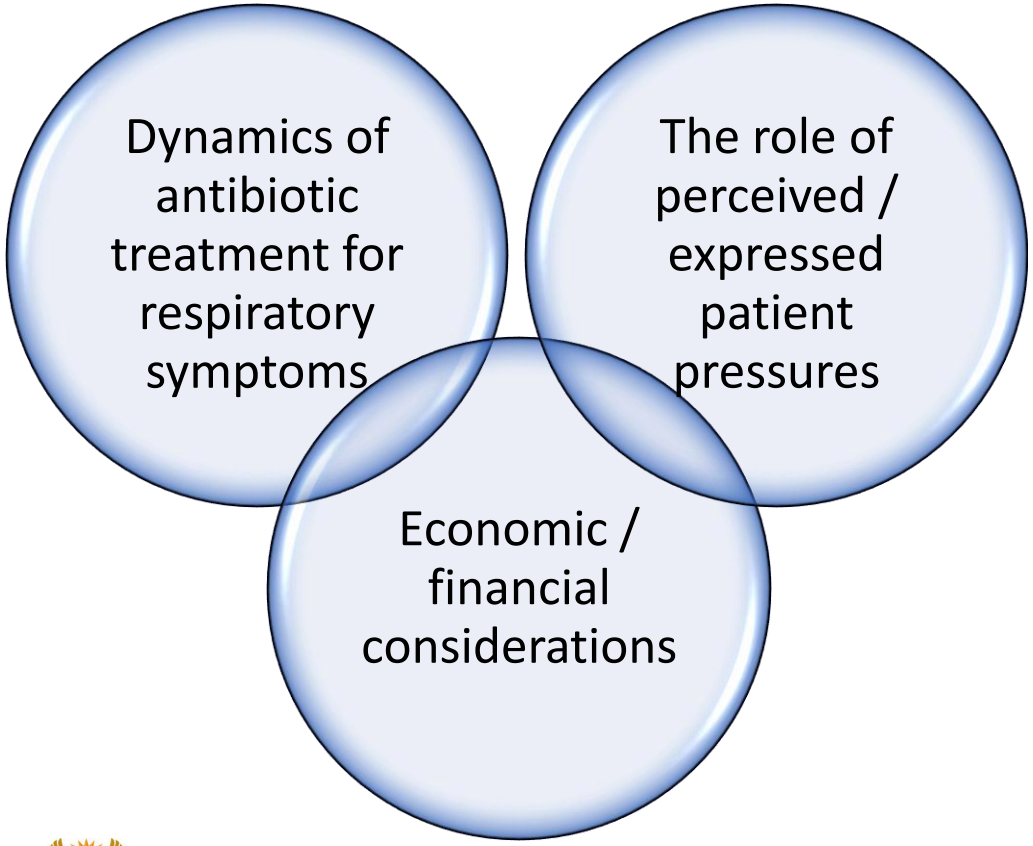
Emerging themes regarding dynamics of management decisions for TB-like illness



Antibiotic treatment for respiratory symptoms is common

1

Treating with antibiotics & observing was deemed a best practice

- Mitigated care seeking costs
- Reduced inconvenience
- Mitigated illness anxiety

2

Antibiotics are held to stop transmission of alternate diagnoses without routine microbiological testing

3

Antibiotics are seemingly held as a part of the patient management algorithm

Antibiotics used to pre-empt community spread of ‘unidentified infection

“Again it’s… we don’t have the resources to test for infection … but I bet you this patient is gonna go home … 15 people in one house… chances of contact with the bacteria are very high… and you gonna say, ‘Let me take your sputum now to test… and you’ll return (for results)’?... Its not gonna work.”

Male, mid 50s

Antibiotics perceived as a central part of the diagnostic algorithm

"best … is to treat the basic things ... cover broadly … use an antibiotic injection and give some oral antibiotic… So, say I was treating for bronchitis; if you're not improving after 5 days -- I've given you a strong antibiotic, … an injection -- the next thing let's do a sputum, let's do an X-ray... always the basic things then advance or refer after".

Female, late 30s

"(If) their mark is suggesting bacterial. ... obviously they need an antibiotic, so we give them… usually something penicillin-based …and obviously if it's not improving -- you know, once we hit the two-week sort of barrier -- then you worry about TB"

Female, mid 30s

A complex emerging picture of management approaches and antibiotic dispensing

From 1 participant

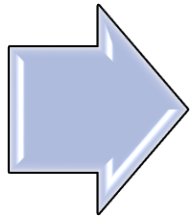
A wide interpretation of guidelines, at times, even when TB is suspected

With TB you'll suspect from the outset. One comes in saying, "I've used everything… it's 3 weeks now … month maybe. … I'm losing weight, … appetite ... feeling weak. Now I'm starting to cough blood, I'm having night sweats," And you're thinking, **Okay, I should continue (with TB)** … But the protocol is at least I should give antibiotics for a week, simple infections like pneumonia, bronchitis etc. should clear on good antibiotics. We then assess again.' (if) still unwell, I then write a (referral) letter."

Male, mid 30s

Patient pressure for antibiotics: Some GPs accede but generally they resist

"sometimes they would ask … and we should be able to provide them with that ... They don't (necessarily) demand anything, but I think they expect certain medicines … instead of giving them a script, go to a pharmacy … most of the cash people wouldn't be happy about it … I mean the sooner you think about the GP practices: you cannot confirm with each patient exactly what sort of bacteria… we don't do microbiology … you can't do sputum and swabs on everyone, you sort of use your discretion … and cover in broad (terms) what you (think you) can." Male, 50s



"…speak to them strongly that we don't want to cause resistance because that's a big thing in our country…. They may not like it, but you must be firm … 'next time you're sick the injection won't work if you take it for every flu and small thing.' " Female, late 30s.

Enhancing patient care and inconvenience

"In general, we try to give our patients the facility of getting everything here and save them the trouble of getting medicines from the chemist… there are some who do not always have transport … we tend to be compassionate towards the patient." Male, 60s

Conclusions and implications

Empirical antibiotic use is widespread and driven by complex intersecting factors

It leads to delayed diagnosis, elevated patient costs and inconvenience, and potential for drug resistance

Consider strategies to elevate salience of TB to GPs during consultations

Consider availing microbiological testing within reach of GPs

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