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Advocating for a Socially Accountable Package of Care for Adults Hospitalized with Tuberculosis in the Western Cape, South Africa: A Policy Brief

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Abstract

South Africa is consistently listed among the 30 high TB-burden countries, with a national incidence estimated at about 615 per 100,000 population, and a provincial variation ranging between 427 and 835 per 100,000 in 2019. Adults hospitalized with TB often face complex biopsychosocial challenges, including poverty, substance use, HIV co-infection, and housing instability, that are inadequately addressed by the current biomedical model of care. This policy brief advocates for the provincial adoption of a socially accountable, interprofessional model of care tailored to the needs of hospitalized TB patients.
Despite progressive national and provincial policy frameworks, implementation at the hospital level remains fragmented, with limited integration of clinical and psychosocial services. The proposed policy framework promotes person-centred, multidisciplinary care through ward-based teams, structured discharge planning, and community-linked follow-up. Grounded in Human-Centred Design (HCD) and the Partnership Pentagram Plus (PPP), it emphasizes co-design with patients, frontline workers, and civil society.

Key implementation steps for the proposed policy include stakeholder engagement, Theory of Change development, patient journey mapping, and pilot testing in provincial TB hospitals. The model aims to improve treatment adherence, reduce hospital stays, and enhance patient dignity while remaining operationally feasible through strategic task-sharing and resource realignment.

This policy brief calls for formal adoption and scale-up of a new standard of care that embeds equity, collaboration, and accountability into routine practice. By closing the implementation gap, we can advance ethical, effective, and socially responsive care for one of South Africa's most underserved patient populations.

Problem Statement

Tuberculosis (TB) and the Challenge of Holistic Care in Hospital Settings

Tuberculosis (TB) remains a major public health challenge in South Africa, which is ranked among the 30 high TB-burden countries globally, with a national incidence estimated at about 615 per 100,000 population and provincial incidence rates in 2019 ranging from 427 to 835 per 100,000 (Department of Health 2021). The burden of TB is closely linked to structural drivers

such as poverty and inequality, which exacerbate vulnerability and limit access to care. Economic impacts are profound; pre-treatment unemployment rates of 48 percent can rise to 80 percent during treatment, reflecting the catastrophic costs borne by patients and their households (Wang et al. 2025).

Policy responses have increasingly emphasised person- and family-centred care. The National TB Strategy (Department of Health 2024) and the Policy Framework on Decentralised and Deinstitutionalised Management of MDR-TB (Department of Health 2019) advocate for decentralised models, including ambulatory care, satellite sites, and community-based services, which have improved access and reduced treatment delays. However, these approaches acknowledge that hospitalisation remains necessary for patients who are severely ill, have complex comorbidities, or face infection control challenges at home.

Within hospital settings, TB patients often present with multiple clinical and social vulnerabilities, including HIV co-infection, non-communicable diseases, poverty, food insecurity, substance use, and unstable housing. Despite this, the dominant biomedical model in TB hospitals remains poorly equipped to address psychosocial and structural determinants of health. Studies highlight limited coordination between clinical teams, allied health professionals, and social services, with discharge frequently occurring without adequate psychosocial preparation or linkage to community-based follow-up (Firfirey 2020; Marais et al. 2021; Mitrani et al. 2022). This lack of integration contributes to poor continuity of care, high readmission rates, and ongoing transmission.

International and local literature consistently underscores the value of integrated, interprofessional practice (IPP) models, particularly when they embed principles of social accountability, in managing complex conditions such as TB. The Lancet Commission on the Future of TB Care calls for people-centred, intersectoral approaches to address both medical and social needs (Reid et al. 2023). In South Africa, research has demonstrated that integrated discharge planning and stronger hospital–community linkages improve adherence, reduce treatment default, and lower readmission rates (Firfirey 2020; Marais et al. 2021; Mitrani et al. 2022).

Marginalised populations, such as residents of informal settlements, migrants, and people with substance use disorders, remain disproportionately affected by TB and face persistent barriers to sustained care (Department of Health 2019). Comparative evidence from India suggests that TB vulnerability is shaped by historical and structural inequalities, including caste, poverty, malnutrition, and stigma, and that pro-poor, socially accountable care models must integrate medical treatment with nutritional, psychosocial, and economic support (Bhargava et al. 2012).

Finally, the literature indicates that hospitalisation without addressing underlying social needs is both costly and ineffective. High hospital costs, prolonged stays, and poor outcomes can be mitigated through integrated, patient-centred, interprofessional care models that include adherence enablers such as transport support and home visits, which have been shown to reduce costs and improve treatment completion (Janson et al. 2012). These findings highlight a

persistent gap: while policy frameworks endorse person-centred principles, hospital-based TB care in South Africa still lacks systematic, integrated approaches that address both clinical and psychosocial needs.

Current Policy

Current tuberculosis (TB) policies in South Africa are largely centred on clinical guidelines and biomedical protocols, with a strong focus on diagnosis, drug regimens, and infection control (see Table 1). While these clinical frameworks are essential for standardising care, they often overlook the broader social and systemic dimensions of health service delivery. There is a notable absence of policy frameworks that explicitly promote social accountability, which would require health services to be responsive to the lived realities, rights, and needs of patients and communities. Similarly, interprofessional practice, which is critical for delivering holistic, patient-centred care, remains underemphasized in policy despite its proven benefits in managing complex conditions like MDR-TB. There are no binding provincial or national standards mandating interprofessional care teams or social accountability frameworks in TB hospitals. Budgeting and human resources policies are rigid, making it difficult to allocate funding for social workers, allied health professionals, peer supporters, or community health worker integration within hospital care pathways.

Table 1: List of TB-related Policies in South Africa

Date / circular number	NDOH guideline / circular	Purpose of the Guideline	Western Cape provincial circular
2014		Strategic Plan	• Healthcare 2030
2018 2019 2019	• Interim guidelines on injectable free regimen for RR TB • Management of RR TB • Policy on decentralized management of DR TB	Clinical guideline	• WC Management of DR TB
2021	• TB Urine Lam guidelines	Clinical guideline	• H191/2021 Implementation of NDOH U-LAM guidelines
2021		Strategic plan	• 2021 Premiers' provincial emergency response plan for TB (unsigned)
2022	• TB recovery plan 1.0	Strategic plan	
2023	• Updated RR TB clinical Guidelines	Clinical guideline	• H157/2023 Clinical management of DR TB- updated clinical reference
2023	• TB testing and screening SOP	Clinical guideline	• H84/2023 Systematic screening using TUTT • H85/2023SOP for community TB testing, screening and sputum collection
2023	• Management of Latent TB infection	Clinical guideline	• H008/2024 Updated NDOH guidelines on TPT • H31/2025 Updated guidelines on TPT in pregnant women
2023	• National Strategic Plan for HIV, STIs and TB	Strategic plan	• Provincial Implementation plan for the NSP 2023-2028
2024	• Guideline on management of TB for children	Clinical guideline	• Circular H69/2025 Management of DS TB in children and adolescents
2024	• TB strategic plan 2023-2028 • TB recovery plan 4.0 (after versions 1-3)	Strategic plan	• H005/2025 Provincial TB recovery plan (the provincial plan has incorporated a more holistic approach)

2024	• Package of care for adults with HIV hospitalized with possible TB	Clinical guideline	• Holistic TB hospital package of care (In development):
2025	• END TB campaign • Close the Gap campaign (not signed by NDOH)	Strategic plan	• Integrated Close the Gap and END TB provincial campaign plan

Recently developed policies in the Western Cape focus on transversal health. Integrating the Western Cape Department of Health and Wellness' Make Every Contact Count (MECC) strategy, the Psychosocial Rehabilitation (PSR) policy framework, Community-Oriented Primary Care (COPC), and Differentiated Models of Care (DMoC) with existing biomedical and clinical TB guidelines offers a pathway to more holistic and patient-centred care (Western Cape Department of Health and Wellness 2025). The MECC strategy promotes the use of every healthcare interaction to address not just clinical concerns but also the broader social and behavioural factors affecting health. When aligned with TB clinical protocols, MECC ensures that each patient contact becomes an opportunity for health education, psychosocial screening, and early intervention, especially valuable in the care of MDR-TB patients with complex needs. The PSR framework reinforces this by emphasising emotional, social, and functional recovery. When integrated into TB services, it supports patients in rebuilding daily routines, managing stigma, and reintegrating into family and community life, critical components often neglected in purely biomedical models. COPC adds a community-facing dimension, helping health teams respond to the social determinants of TB by linking facility-based care with community-level support systems, including home visits and local resource mapping. Meanwhile, DMoC ensures care is tailored to individual needs, allowing for flexible service delivery based on clinical stability, adherence challenges, or socio-economic vulnerability. Together, these frameworks can transform TB care from a narrow focus on disease management to a more person-centred, recovery-oriented model that addresses both medical and psychosocial dimensions of healing. Integrating MECC, PSR, COPC, and DMoC into TB services reflects the principles of social accountability by aligning health system actions with the priority needs and realities of the communities they serve. These approaches move beyond treating TB as solely a biomedical issue, ensuring that care addresses social determinants, supports recovery and reintegration, and adapts to individual and community contexts. In doing so, they foster a more equitable, responsive, and trust-building health system, one that is accountable not just for clinical outcomes, but for improving the overall well-being and agency of people affected by TB.

Policy Solution

This policy proposes a provincially standardised, socially accountable, interprofessional model of care for TB hospitals. Key components include multidisciplinary ward teams—such as social workers, occupational therapists, psychologists, and peer navigators—conducting biopsychosocial case reviews, implementing socially informed discharge planning to support effective reintegration into communities, and providing staff training in equity-oriented, collaborative practice.

Improving TB treatment outcomes requires a shift from fragmented biomedical approaches toward integrated, patient-centred models that address both clinical and social determinants of health. Although such approaches may initially appear resource-intensive, strategic task-sharing and optimal use of existing staff can offset costs. Evidence from South Africa demonstrates that fragmented care undermines adherence and continuity, whereas holistic, interprofessional models improve patient engagement and treatment success (Firfirey 2020; Marais, Kallon, and Dudley

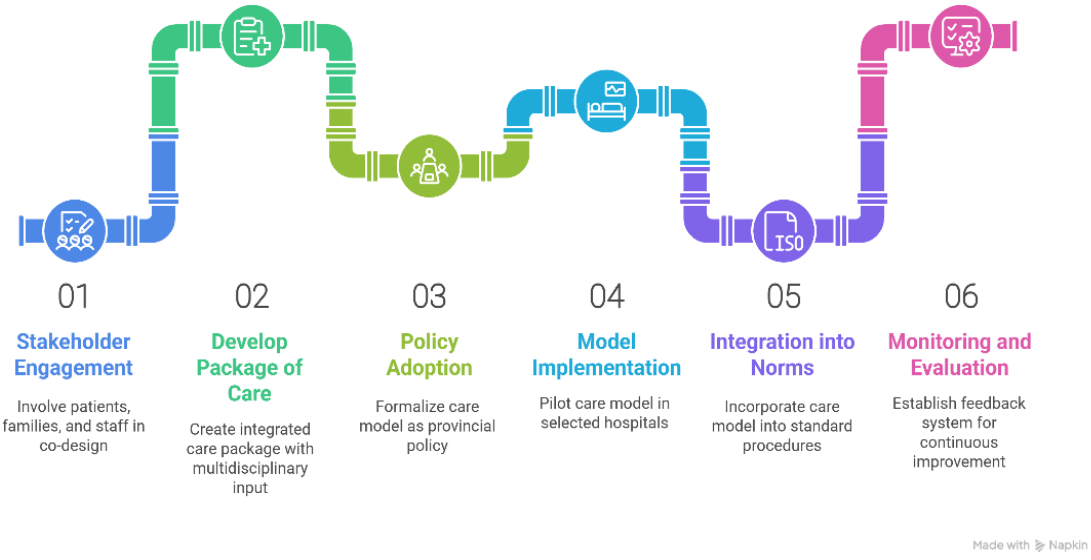
2019; Mitrani et al. 2021). Broader literature reinforces these findings: Furin et al. (2020) highlight how patients with rifampicin-resistant TB in South Africa continue to experience significant psychosocial and economic burdens with minimal support, while Miller et al. (2020) show that rigid protocols and poor coordination hinder TB care in remote Indigenous communities. Belrhiti et al. (2021) further illustrate how medical dominance and weak interprofessional collaboration fragment hospital-based care.

Collectively, these studies support the adoption of culturally responsive, team-based TB care. Rather than representing an unaffordable ideal, this model constitutes a pragmatic evolution—one that realigns existing resources to deliver more effective, ethical, and sustainable TB services. While concerns about complexity and cost are legitimate, these can be addressed through phased implementation, role optimisation, and strategic task-sharing. Evidence also suggests that integrated care can reduce long-term expenditure by improving treatment outcomes and preventing avoidable readmissions (Reid et al. 2023).

Action Steps

To address the systemic gaps in care of hospitalized TB patients, we propose the following interconnected action steps (See Figure 1). These are grounded in Human-Centered Design (HCD) to ensure empathy and responsiveness; the Partnership Pentagram Plus (PPP) to promote shared leadership and accountability; and supported by tools such as the Theory of Change and Patient Journey Mapping to align activities with outcomes and centre patient experience in care redesign.

Figure 1: Action steps for developing a socially accountable service package for TB Hospitals (Image generated by Napkin AI)



1. **Stakeholder Engagement**
   The process begins by engaging patients, families, frontline staff, and civil society in co-designing the TB hospital care model. Using Human-Centred Design (HCD) and the Partnership Pentagram Plus (PPP) approach, this stage starts with empathy interviews, story-sharing, and ward observations to capture the lived experiences of those most affected. Building on these insights, structured co-design sessions are convened with all six PPP groups, creating opportunities to build trust, develop a shared vision, and co-produce a Theory of Change. Patient journey mapping is then used to pinpoint key pain points, highlight opportunities for improvement, and identify the moments of care that matter most.

2. **Developing the Package of Care**
   From this foundation, stakeholders move into co-creating an integrated, interprofessional package of care tailored for hospitalised TB patients. Drawing directly from the Theory of Change, they define the essential components such as team huddles, psychosocial screening, structured discharge planning, meaningful family involvement, and customised patient education. Ward teams and patient advisors then collaborate to prototype these tools and routines, testing them for usability, acceptability, and relevance. To ensure shared ownership, design responsibilities are distributed across PPP sectors; for example, educators may develop training materials, health professionals may pilot interventions, and researchers may assess feasibility and impact.

3. **Policy Adoption**
   Once the package of care is refined, the next step is to secure its formal adoption at the provincial level. Advocacy efforts combine compelling patient narratives with robust data to make the case for change. Proposals are translated into clear, accessible formats—such as visual briefs and one-page summaries before being presented in a multi-sectoral PPP policy dialogue. This dialogue provides the platform for broad endorsement, helping to secure commitments to scale-up, continuous learning, and adaptation over time.

4. **Model Implementation**
   With policy support in place, implementation begins in at least two TB hospitals. These pilot sites are supported with structured training, ongoing mentorship, and rapid-cycle learning using the Plan–Do–Study–Act (PDSA) method. Each hospital establishes a local learning team—comprising an operational manager, patient representative, training lead, and data champion—ensuring that adaptations are informed by both operational insight and lived experience.

5. **Integration into Provincial Norms**
   As successful practices emerge, the focus shifts to embedding them into provincial Standard Operating Procedures (SOPs) and operational frameworks. Clear, user-friendly SOPs and job aids are developed with direct input from nurses, social workers, and administrative staff to ensure practicality and relevance. In this way, a holistic approach

that integrates clinical care with psychosocial support becomes a standard feature of TB hospital practice across the province.

6. **Monitoring and Evaluation**
   To sustain improvement, a robust feedback and learning system is established. This combines quantitative indicators such as readmission rates, length of stay, and treatment completion, with qualitative feedback from patients and staff. The Theory of Change is revisited regularly, ensuring that activities remain aligned with intended outcomes and that adaptations are guided by evidence and experience.

   Ultimately, this approach seeks to enhance patient-centred TB care by embedding psychosocial interventions alongside clinical guidelines. By integrating social accountability into routine practice, it ensures that the most vulnerable patients receive care that is respectful, responsive, and effective.

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