

Stop TB Partnership

From DOTS to the Stop TB Strategy

*...Building on Achievements
for Future Planning...*



France, 30-31 October 2006

**Meeting of 22 High Burden Countries
and Core Groups of the
Stop TB Partnership**

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SUMMARY OF 2-DAY MEETING

Meeting Theme:

“From DOTS to the Stop TB Strategy; building on achievements for future planning”

Date: 30-31 October 2006

Venue: La Maison des Polytechniciens, Paris, France

DAY 1

Major Highlights

■ The meeting addressed the major challenges to scaling up TB in 22 HBCs in accordance with the new Stop TB Strategy and Global Plan to Stop TB 2006-2015 and presented some solutions to the challenges.

■ Recommendations were made on how the Working Groups on implementation could work together at the country level.

DAY 2

Major Highlights

■ Stop TB symposium in connection with the 37th World Lung Conference of the International Union Against Tuberculosis and Lung Disease (The Union).

■ The TB community was updated on the progress made in HBCs and by the core Working Groups of the Stop TB Partnership

Perspectives from high TB burden countries on the new Stop TB Strategy

Achievements

A cornerstone of the Stop TB Strategy is pursuit of high-quality DOTS expansion and enhancement, which continued over the past year as evidenced by increased DOTS coverage and strengthening of DOTS infrastructure.

Examples of bolstering the DOTS infrastructure include initiation of laboratory strengthening activities such as the introduction or expansion of external quality assurance systems, the implementation of monitoring and evaluation activities and the sharing of best practices. Countries have developed their own national strategic plans, which will be executed between 2006 and 2010.

Policies for collaborative TB/HIV activities including monitoring and evaluation, have been developed, with implementation currently under way in several contexts.

Resource mobilization and political commitment at the national level is improving in response to MDR-TB, and increased funding for second-line anti-TB drugs has been secured from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).

Anti-MDR-TB treatment is being scaled up in many countries, with training programmes under way to develop human resources equipped to manage the disease.



Opening of Meeting

By October 2006, the Green Light Committee (GLC) had approved treatment for more than 23, 000 patients with MDR-TB.

National TB control programme (NTP) managers reported a significant contribution to health systems strengthening in several areas, including laboratory strengthening, training and management, capacity for drug storage and distribution, and innovations in service delivery such as public-private mix (PPM). Guidelines have been developed for PPM, and the scale-up of successful pilot projects has directly contributed to increased case detection.

Cured patients, affected communities and civil society are now involved in TB control and the media is being used to increase awareness of TB through radio messages and TV spots. In the areas of community empowerment, Global Fund grants now have ACSM components to operationalize social mobilization.

DOTS Expansion and Enhancement continued in many countries over the past year

Challenges

Formidable gains have been made over the past year in DOTS implementation, often in the face of competing priorities and resource constraints; nevertheless, significant challenges have yet to be overcome, and emerging obstacles such as XDR-TB need to be dealt with proactively and efficiently.

Key overarching challenges identified by HBC representatives include alignment of national plans with the Global Plan. Sustainability – of government and donor commitment and financial support – was a central theme that cut across all components of the Stop TB Strategy.

A major challenge will be to raise and maintain political commitment in large federal systems. Political and financial commitment are critical to sustain all of the components that have led to the successful implementation of the DOTS strategy.

The introduction and scale-up of TB/HIV and MDR-TB activities continue to pose highly complex challenges, as does expanded outreach to special populations such as miners and prisoners. Collaboration between TB and HIV control programmes and co-location of services for co-infected individuals remain suboptimal in most places. Non-decentralized HIV/AIDS services pose difficulties for TB/HIV collaboration at the district level.

Laboratory strengthening and human resource development are critical components to overcoming these challenges, but present their own set of difficulties.

Staffing continues to be a major concern. In many sub-Saharan African countries for example, the HIV situation has led to human resource attrition; thus, rehiring and retraining staff to provide services and laboratory support are critical issues to overcome.

Human resource issues to contend with in most HBCs include management, planning, quantity, quality, distribution, recruitment and retention. In addition, the need to provide and promote biosafety and infection control among health care workers was highlighted.

Reiterated cross-cutting themes included better coordination among the multiple partners for TB control, data management and measurement, balancing competing priorities, and maintaining or promoting high quality in all areas of TB control activities.

The Future (Way Forward)

Countries discussed how the working groups and partners could ensure adequate and coordinated responses. Securing basic DOTS quality in settings where health systems are weak and where TB/HIV and MDR-TB problems are the most severe remains the highest priority. Governments with the least capacity need the most help.

Participants were called upon to collaborate, share and document results. Finally, it is necessary to support the translation of guidelines and operational research into programmatic activities in all components of the Stop TB Strategy.

ACHIEVEMENTS (Summary)

- Strengthening of DOTS infrastructure and coverage
- Development of country strategic plans 2006-2010
- Collaborative TB/HIV policies developed
- Enhanced Political commitment and resource mobilization for MDR-TB
- Increased funding for second-line drugs secured through GFATM
- By Oct 2006, GLC had approved treatment for over 23,000 patients with MDR-TB
- Health System strengthening
- PPM guidelines developed
- Advances in ACSM
- Cured patients, affected communities and civil society now involved in TB control programmes

CHALLENGES (Summary)

- Alignment of National plans to the Global plan
- Sustaining Political commitment
- Sustaining donor and governmental financial support and commitment
- Raising and maintaining political commitment in large federal systems
- Introduction and scale-up of TB/HIV and MDR-TB activities
- Human resource and staffing issues
- Better coordination among multiple partners
- Emergence of extensive drug resistance TB (XDR-TB)

The Stop TB Strategy: Experiences from selected countries

1. PERU:

'Sustaining DOTS and moving forward with the Stop TB Strategy'



The incidence of TB in Peru has decreased steadily since the mid-1990s. New paradigms in control efforts have been included in the country's strategic plan for TB control, 2004–2010, which focuses on community involvement and participation as essential components of successful control efforts.

The aim of the plan is to ensure early detection and diagnosis and provide timely, supervised treatment for all people with TB,

MDR-TB or TB/HIV co-infection in all health care services in Peru, utilizing multidisciplinary teams of health care workers, civil society, and representatives and associations of people living with TB.

These efforts will reduce TB morbidity, mortality and social and economic implications, and ensure the progressive and sustained decrease of TB incidence in the country.

Strategic multidisciplinary partnerships must be devised to monitor the impact of TB control, not just on disease indicators but on poverty and social exclusion.

The programme must promote human dignity and human rights at all levels of programme management as a means of eliminating stigma and discrimination of people living with TB.

The need for new indicators to gauge social participation and the socioeconomic impact of TB control was called for.

2. MYANMAR:

'Planning in line with the Stop TB Strategy and Global Plan'



Myanmar is moving towards the global TB control targets despite limited resources. As of 2005, case detection was at 95% and treatment success had risen to 84%, while total DOTS coverage was achieved in 2003.

The three-disease-fund was set up with the donation from six governments and organizations (the European Commission, United Kingdom, Australia, Sweden, the Netherlands and Norway) and will support the Myanmar TB, AIDS and Malaria programmes with US\$ 100 million during the next five years.

The country has a new five-year strategic plan for TB control. The development of the strategic plan was facilitated by the new WHO tool designed to help countries with planning and budgeting in line with the Stop TB Strategy and the Global Plan.

The Myanmar NTP found the tool be easy to use as it provides a ready-made framework for planning and budgeting for all components of TB control.

Summary tables and figures are automatically generated and can be used as the basis for resource mobilization and for reporting of financial data. In addition, plans and budgets for TB control are set out comprehensively in one place and include work by the NTP and all partners.

Thanks to a high level of political commitment, dedicated staff, strong support from communities, excellent coordination with partners and continuous WHO technical assistance, the Stop TB Partnership in Myanmar is moving towards the global targets for TB control.



3. PHILIPPINES: 'Expansion of MDR-TB Control'

The Philippines is scaling-up the programmatic management of MDR-TB according to WHO guidelines. The starting point for MDR-TB control was a PPM project in Makati Medical Centre, Manila, where 75% of referrals were from private practitioners.

In the mainstreaming stage, MDR-TB control was integrated into public DOTS through a stepwise implementation.

A community-based component was an integral part of the mainstreaming stage, and sought to decentralize to public health centers, with participation from community volunteers.

In the scale-up stage, the programme was expanded geographically and engaged additional community-based facilities including public- and private-initiated units, district hospitals and other public health centers.

MDR-TB control utilizes an overarching DOTS framework, but coordinates activities at facilities including treatment centers and sites, culture centers and laboratories conducting drug susceptibility testing.

Requirements for the scale-up include:

- Mapping of existing resources and capacities and strategic selection of expansion sites
- Advocacy to ensure political commitment
- Creation of essential organizational structures and policies
- Human resource development and standardization of training materials
- A network of laboratory services
- Management of first and second-line anti-TB drugs and drugs for adverse reactions
- Community involvement
- Public-private mix
- Standardized information and data capture systems
- Monitoring, supervision and evaluation

The NTP is engaging potential agencies in the government, nongovernmental and private sector arenas to provide both technical and financial support for scale-up activities.

4. KENYA: 'Scaling up collaborative TB/HIV activities'

Kenya, with a population of just over 33 million people, reported 108 401 new cases of TB in 2005.



The HIV prevalence was estimated at 6.7%, and approximately 57% of TB patients have been diagnosed with HIV. To date, Kenya has accomplished several milestones in collaborative TB/HIV activities.

In 2004, policy on HIV testing in clinical settings was released, and the national TB/HIV steering committee was put in place. In the first six months of 2005, TB data tools were revised, printed and disseminated.

A TB/HIV curriculum was developed, health care workers were trained and guidelines were adopted locally. At the same time, provincial and district TB/HIV steering committees were set up. Targets have been set that aim for:

- HIV testing in 80% of TB patients;
- 80% of HIV-positive TB patients on co-trimoxazole preventive therapy (CPT);
- 80% of HIV-positive TB patients on antiretroviral therapy (ART);
- At least 20% of people living with HIV/AIDS screened for TB.

As of the second quarter of 2006, 60% of TB patients had been tested for HIV, & more than 80% of HIV-positive TB patients were receiving CPT; approximately 25% of HIV-positive TB patients are taking ART.

Update from the Stop TB Partnership Working Groups on implementation

DOTS Expansion Working Group

(a) ISTC

The document *International Standards for Tuberculosis Care* (ISTC), aimed primarily at engaging private health care providers in TB control, was simultaneously launched in several countries. A total of 10 HBCs have developed plans to use ISTC as an advocacy and training tool for PPM.

(b) TA for the development of strategic plans

The components of the Stop TB Strategy have been gradually implemented in countries. Technical assistance was provided through the DEWG network of partners (TBTEAM), with particular support provided to the development of country strategic plans to ensure their compatibility with the Global Plan.

All WHO regions have initiated (and three of them have finalized) the development of

regional medium-term plans in line with the Stop TB Strategy. These plans include inputs of all DEWG partners; implementation is being monitored on an ongoing basis through in-country reviews and monitoring missions.

(c) TB Proposal Preparation Workshop

WHO and Stop TB partners in coordination with the Global Fund Secretariat held a TB proposal preparation workshop in Geneva in May 2006 for round 6 of the Global Fund proposals using the Stop TB Strategy planning frameworks.

In addition, TB experts were mobilized to support countries in proposal preparation through the coordination of TBTEAM (TB Technical Assistance Mechanism).

(d) Private Public Mix (PPM)

During the year, significant progress was made by countries in implementing PPM for TB control, technically assisted by the PPM subgroup.

Early in the year, an important document – *Engaging all health care providers in TB control – guidance on implementing public-private mix approaches* – was published to help countries scale up PPM.

All 22 HBCs now have some PPM activity in place and 11 have started to scale up PPM. In addition, a comprehensive PPM training package has been prepared and the first PPM consultant training workshop was organized. PPM has now been integrated into the TB consultant



training courses offered in Sondalo, Italy, and by the Japan Anti-TB Association.

The fourth meeting of the PPM subgroup was held in Nairobi, Kenya, in September 2006 to highlight the relevance of PPM in engaging diverse care providers not only in TB control but also in TB/HIV collaborative activities and in MDR TB management.

A national PPM situational assessment tool developed by the subgroup secretariat was presented and endorsed for pilot testing at the meeting.

(e) Strengthening TB Laboratories

The strategy for strengthening TB laboratories launched in 2005 is being implemented in HBCs. The Subgroup of Laboratory Capacity Strengthening established its core team in order to facilitate and accelerate the decision-making process and to set the strategic directions.

A training package on smear microscopy was developed by the United States Centers for Disease Control and Prevention (CDC), WHO and other partners. Training courses for consultants and heads of supranational laboratories were organized. A survey of the laboratory situation at the global level showed the weakness of laboratory capacity in most HBCs.



National and international efforts to improve laboratory services have increased considerably. The challenges are deficiencies in infrastructure, inadequate funding, equipment and supplies and too few and untrained human resources.

(f) TB and Poverty

The Subgroup on TB and Poverty built on the high level consultation held in Italy, in December 2005 to finalize an action plan on TB and poverty, which was presented to and approved by the Stop TB Coordinating Board in Abuja, Nigeria, in March 2006. Active members of the TB and Poverty Core Team proceeded to implement some components of the action plan throughout the year.

MDR-TB Working Group

The goal for control of MDR-TB outlined in the Global Plan is to enroll 800 000 MDR-TB patients on treatment. The plan in the Stop TB Strategy is to mainstream the management of MDR-TB into basic TB control programmes to ensure access to

■ second line drug management

In order to overcome these challenges, several subgroups have been created to deal with issues around access to quality-assured second-line drugs under rational use (the GLC), resource mobilization and advocacy, research and second-line anti-TB drug management.

Major progress has been made in achieving political commitment necessary to manage MDR-TB in several HBCs. The Global Fund has approved a pilot project for 4000 MDR-TB patients in China and treatment for 7500 MDR-TB patients in the Russian Federation.

The WHO *Guidelines for the programmatic management of drug-resistant tuberculosis* have been adopted by China and India, and the Russian Federation is making progress towards building increased laboratory capacity to diagnose MDR-TB.

A total of 40 countries have GLC-approved MDR-TB programmes, which together will treat more than 23, 000 MDR-TB patients. Drug quality is being addressed by the WHO prequalification project.

A subgroup on research is developing a new prioritized research agenda on MDR-TB as its first



TB/HIV Working Group

Achievements in TB/HIV control at global level in the past year include setting policy for accelerated diagnosis of TB in HIV prevalent settings, developing training materials for TB and HIV/AIDS managers, human resource development, and devising monitoring and evaluations systems to generate trend data.

Advocacy for collaborative activities has been bolstered by a 2006 meeting of African Heads of State in Abuja, Nigeria, during which TB/HIV targets were set. In 2006, the United Nations General Assembly Special Session on HIV supported the Global Plan, and TB/HIV activities, and UNAIDS is now addressing TB through the creation of a special TB adviser.

Despite advances in control of TB/HIV, countries are moving slowly due to weak health systems and limited financial and human resources. Decentralized TB activities and more centralized HIV/AIDS programmes have impeded integration of TB and HIV services at delivery point.

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