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TB Control in the South-East Asia Region

*Report of the First Meeting of the
Technical Working Group (TWG)
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1. BACKGROUND

Tuberculosis (TB) is the leading killer amongst single infectious agents. It is estimated to kill more women than all causes of maternal mortality combined. Two billion people, constituting one-third of the world's population, are infected with TB. About 2 million deaths from TB globally constitute 26 per cent of avoidable deaths. Every day over 23 000 people develop active tuberculosis and nearly 5 000 succumb to it. If current control efforts are not expanded massively, it is estimated that 70 million people may die of TB within the next two decades. Since two out of every three people affected with TB are young adults, the greatest burden of morbidity and mortality on account of TB is borne by those in the most productive age group of 15-60 years. Over 90% of TB cases and deaths occur in low and lower-middle-income countries with an estimated economic cost to poor households of more than US\$ 12 billion per year. TB often kills the main wage earner in a household, pushing the entire family into long-term debt and destitution. Those TB patients who survive, lose on an average, 20-30% of their annual income due to lost productivity, resulting in a vicious cycle of poverty and TB. TB, therefore, apart from a health issue, is an important economic and social issue. With this background, WHO declared TB a global emergency in 1993.

Of the 8.5 million new cases estimated to occur every year globally, 95 per cent occur in developing countries. Rapid population growth, large-scale migrations and poor socio-economic conditions pose major challenges favouring the spread of the disease. India, China, Indonesia and Nigeria account for nearly half of the world's TB cases. The SEA Region with nearly 25 per cent of the world's population carries 40 per cent of the global TB load which is disproportionately high. Five out of 22 high burden countries are from this Region, where, every year, 3 million new cases and 750 000 deaths occur. Of these, 250 000 are women. Every day more than 1 500 people die of TB – 3 persons every 2 minutes. The economic loss sustained in the Region is estimated at US\$ 4 billion. All these factors make TB a major health emergency in the Region.

2. EMERGENCY ISSUES

2.1 TB/HIV: The deadly duo

It is estimated that, till the end of 2001, of the 40 million people living with HIV worldwide, about 23 million were in Sub-Saharan Africa. Because of an increase in new infections, the epidemic is now spreading rapidly in Asia. Till March 2002, more than six million people were infected with HIV in the South-East Asia Region and 216 443 AIDS cases have been reported; 90% of these cases from India, Myanmar and Thailand.

TB is known to be the most common life-threatening opportunistic infection associated with HIV infection. This assumes alarming significance in the Region where 40 per cent of the population is infected with *Mycobacterium Tuberculosis*. The rate of progression to clinical TB jumps from 10 per cent in a lifetime in a TB-infected, HIV-negative individual to 10 per cent every year in a TB-infected HIV-positive individual resulting in a parallel epidemic of TB following the AIDS pandemic. Nearly 2 million people in the Region are co-infected with HIV-TB. A rapid increase in TB incidence, attributable primarily to HIV, after being observed in USA, Tanzania, Zambia, Malawi and Burundi started emerging in a northern province of Thailand where the reported TB cases increased by 9% between 1989 and 1994. TB prevalence in the North of Thailand in Chiang Rai increased over three-fold from 40/100 000 in 1990 to 140/100 000 in 2002. In India, Myanmar, Nepal and Thailand, between 56% and 82% of AIDS cases are also suffering from TB. Tuberculosis accounts for at least one-third of AIDS deaths world-wide and 40 per cent of AIDS deaths in Asia.

In addition to the triple problem of a huge TB-infected population, increasing incidence of HIV and HIV-accelerated TB the diagnosis of TB in HIV-positive individuals, particularly in the late stages of HIV, poses considerable challenges primarily because of infiltrative lesions which, in turn, result in missing sputum positive cases. Although DOTS is equally effective in the treatment of TB in HIV-positive individuals but HIV-positives are more susceptible to MDR and have a low cure rate on account of the high death rate and high relapse rate.

To avoid the increasing numbers of HIV-TB co-infected persons in the Region additionally overstressing the already overburdened health infrastructure, there is an urgent need for multipronged action to ensure universal accessibility to quality DOTS in the entire Region.

2.2 Multi-drug Resistant Tuberculosis (MDR-TB): An Emerging Challenge

Although reliable data on MDR-TB is not available in the Region, it is estimated that the incidence of primary MDR-TB is around three per cent. At this stage it is therefore not a public health problem. It is well known that MDR-TB reflects poor implementation of TB control. Treatment failures are primarily on account of non-completion of the full course of drugs rather than failure of the drugs to cure most of the patients. A poorly functioning control programme will generate more MDR-TB cases than those who can be treated even with unlimited resources. The only effective way to tackle the problem of MDR is to stop MDR which, inter-alia, means universal implementation of quality DOTS.

The rising incidence of HIV and MDR-TB together can potentially create a public health emergency by accelerating the spread of MDR particularly in crowded settings. It would be tragic if TB, particularly MDR-TB, were allowed to spin out of control when proven strategies and inexpensive and effective drugs to contain the TB epidemic are easily available. The emergence of MDR-TB as a public health problem is an obstacle in the effective control of TB. Effective implementation of DOTS not only prevents, but has been shown to successfully reverse MDR trends.

3. TB CONTROL IN THE REGION

3.1 Status of DOTS Implementation

Although 90% of the world's population lives in countries where DOTS has been adopted, less than one out of every three new smear positive cases have received DOTS. In order to rectify the situation, WHO has been supporting Member Countries in the Region to rapidly expand DOTS. By December 2002, DOTS was made available to more than 64 per cent of the population

in the Region, with more than 2.5 million patients being treated. While the overall treatment success rate amongst new smear positives has been high at overall 84%, the case detection rate of under 40 per cent is far below the set target of 70 per cent.

3.2 Challenges

The magnitude of the problem of TB and HIV, the disastrous consequences of a possible explosion of HIV-TB as well as the rising trends in MDR-TB are the major challenges facing the Region. While detailed steps for controlling HIV are discussed separately, the areas that need focused attention for TB control are:

- Rapidly expanding the coverage, accessibility, acceptability and utilization of DOTS. Case detection needs to be increased in order that greater numbers of those affected are successfully treated and cured, particularly those with infectious sputum smear positive TB.
- Establishing national coordination mechanisms and partnerships to ensure effective collaboration between the private and corporate sectors, self-help groups, communities, NGOs, donor agencies and other stakeholders in effective implementation, monitoring, evaluation and optimal support for TB control through DOTS.
- Building good technical managerial capacity.
- Intensifying monitoring and evaluation of the programme.
- Developing a mechanism for sharing resources, best practices and tools within countries and across borders.
- Promoting advocacy on improving urban TB control programmes.

4. REGIONAL TECHNICAL WORKING GROUP ON TB: GENESIS

The Stop TB Initiative launched in 1998 focused on providing an impetus to global TB control especially in the 22 high-burden countries five of which are in this Region. Under this initiative, Member Countries are being assisted to:

- Enhance regional collaboration and form partnerships with donors including NGOs and others
- Undertake a systematic analysis of country-specific constraints and identify effective solutions
- Build sustainable resources to strengthen all technical components
- Make high quality DOTS services universally available, accessible and acceptable
- Ensure universal access to high quality anti-TB drugs
- Build capacity for undertaking need-based operational research; effective programme implementation including its monitoring and evaluation

To meet the challenges faced by the Region and to ensure steady improvement in the quality of support being provided to Member Countries and effectively carry out the agenda of the Stop TB Initiative, a Technical Working Group (TWG), comprising experts including NGOs of international repute as well as programme managers from high-burden countries was constituted.

Terms of Reference (ToR) of TWG

- To regularly review the progress (and constraints faced) with particular reference to achieving global targets and deliberating on strategies and interventions for the "way forward" in TB control in the SEA Region specifically in the five high burden countries;
- To advise WHO and all Member Countries in the Region on emerging issues in TB Control, including research priorities;
- To enable members to articulate and share experiences at various international fora regarding the regional initiatives, the research requirements and gaps; advocate at global, regional and national levels for increased commitment and resources and to assist Member Countries in resource mobilization, and
- To advise on intersectoral, interagency and intercountry coordination mechanisms including cross-border collaboration to sustain, expand and increase accessibility of DOTS in the Region.

The TWG would advise the Region on the various activities proposed to be undertaken by WHO and Member Countries to facilitate the achievement of global targets. The Group would serve as a "think tank" for TB control in the Region, communicate regularly through e-mail (besides meeting annually), and report its recommendations to the Regional Partners' Forum which is likely to meet formally in 2003. The TWG will ensure that the excellent work being done by Member Countries is further improved.

5. FIRST MEETING OF TWG

The first meeting of the Technical Working Group (TWG) was held at Bangkok from 10 to 12 December 2002. The list of participants is as shown in Annexure I and the Programme of the meeting in Annexure II. The meeting provided an opportunity for full participation by every participant. A 'CD-ROM' which included presentations on all the topics was given to participants. A subject-wise gist of the discussions is given below:

5.1 DOTS in the Workplace

Extending DOTS coverage in the workplace, both in the public as well as private sectors assumes considerable epidemiological importance in view of the fact that an estimated 2.5 billion people are employed and that one infectious person can infect over 15 other persons in the overcrowded / poor ventilated closed environments commonly associated with workplaces. The social and economic fall-out of the spread of TB in the workplace is high since the majorities are adults in their most productive age group. An untreated / improperly treated worker will resort to long absences from work; several such will result in significant economic losses due to several man-hours lost from work and a resultant loss of productivity. These high socio-economic costs extend beyond the employees and their families.

Most employers provide health care to their employees. Implementation of the DOTS strategy would enhance production by reducing absenteeism. In order to protect themselves from getting TB; and to stop the spread of TB at the workplace as well as amongst the families of workers all employers must ensure availability of DOTS at the workplace. This would result in long-term economic gains and overall growth and development of the workplace. DOTS is the most effective low cost intervention for cure of TB. A study in Indonesia

showed a “return” of US\$ 55 to the community over a period of 20 years for every dollar invested in TB control.

Some successful examples of DOTS at the workplace like the Jalpaiguri Tea Gardens in West Bengal, India, and the Young One Shoe factory at Chittagong, Bangladesh should be documented and widely disseminated. Initiatives taken at the World Economic Forum (WEF) held in New Delhi in December 2002, should be extended and pilot projects for involvement of the corporate sector encouraged. Umbrella business organizations should play an advocacy and coordinating role in propagating the adoption of DOTS at the workplace.

5.2 TB/HIV: A Regional Strategy

The global framework for control of TB/HIV addresses the problem in high HIV prevalence settings such as Africa. However, given the specific situation in countries of the SEA Region which account for a high burden of TB (40% of global burden), and a proportionately low burden of HIV (18% of global burden), there is a need for a Regional Strategy for implementing TB/HIV activities based on the experiences in some countries of the Region, particularly Thailand and Myanmar.

The guiding principles for developing the TB/HIV strategy include functional collaboration (and not programme integration) between strengthened TB and HIV/AIDS programmes, and creating partnerships with clearly defined roles and responsibilities. Countries with low HIV prevalence should concentrate on universal access to quality DOTS services, HIV prevention and TB-HIV surveillance. Indonesia and Nepal which have low HIV prevalence but with concentrated epidemics, should in addition to the above interventions, prepare for intensified TB case-finding, effective referral and the institution of isoniazid preventive therapy (IPT) as well as antiretroviral therapy (ART) for HIV positives. India, Myanmar and Thailand should ensure universal access to quality DOTS, TB/HIV surveillance, HIV prevention, intensified TB case finding, cross referral, IPT&ART.

A step-by-step approach for implementing the TB/HIV strategy commencing with a situational analysis, establishing stake holder coordination, preparing objectives and plans of action, mobilizing resources,

and then implementing planned activities, followed by monitoring and evaluation needs to be undertaken. The district being the operational unit should be the focus of implementation and providing an interface between health services and community at district level can be considered as an ideal choice for piloting TB/HIV activities. The successful interventions can then be expanded and scaled up to other areas.

5.3 DOTS in the context of Health Sector Reforms

The international scenario, the political scenario and the scenario of the pattern of disease burden have all become very dynamic. The projected disease burden measured in DALYS would give a ranking of 10 to HIV in 2020 as compared to 28 in 1990. TB is the only disease whose projected ranking in three decades is likely to remain unchanged. Although 60% of the world's population lives in areas where the DOTS strategy has been adopted, only about 30% of the estimated number of new smear positive cases (who are highly infectious) are being detected under DOTS. The poor, who need health services more, have less access to appropriate interventions. Those not getting DOTS apparently are at a higher risk of dying which, by itself, is social inequity. There is also a need for promoting ownership of health care activities by the community and increasing their efficiency and effectiveness. These multiple issues are further compounded by limited human and financial resources, lack of responsiveness and other operational constraints. The challenge for Health Sector Reforms (HSR) is to effectively respond to all such issues.

To maintain the strategic position of TB control in the context of changing health systems, giving priority to TB control should be balanced with the need to simultaneously address other health and development concerns. The possible consequences of HSR on DOTS programmes should be analysed and interventions made with specific inputs for countering the potential negative effects of reforms. To ensure adequate financing for DOTS, information on deaths averted and infections prevented, quantified in terms of economic gains, showing TB control as a poverty alleviation strategy and projecting DOTS as a most cost effective intervention should be widely disseminated.

To ensure maintenance of technically sound implementation and to compensate for reduction in vertical function, core normative functions should be monitored at central level. A focal point should be appointed at every level and technical monitoring at all levels through standardized reporting formats should be considered. To avoid duplication and to ensure comprehensive supervision, specific activities requiring supervision should be specified and the expertise of the supervisor ensured.

The important interventions for prioritizing DOTS in the context of Health Sector Reforms are summarized below:

- Advocacy with health planners/resource allocators should be focused on DOTS as a “cost effective poverty alleviation intervention” and on WHO’s policy of “free treatment for TB”
- TB experts should adopt health sector reforms ensuring that key elements of DOTS are retained
- There should be ownership of TB control at all levels
- Effective interaction between the National Tuberculosis Programme, health sector system planners and decision-makers should be promoted

5.4 Human Resource Development: The Indonesian Experience

Indonesia has a population of 213 million spread over an archipelago the size of Europe, with 7 200 health centres and 1 100 hospitals located in 30 provinces and 357 districts. An external review mission in 2000 identified the low level of knowledge and skills of staff at all levels as a major constraint in the programme.

- To focus on capacity building and human resource development, a proposal at a cost of US\$ 5 million for a period of three years (2000-2002) was developed for funding by the Dutch Government.
- During the preparatory phase of the project, all available training materials were reviewed; national guidelines on TB were revised and, in the wake of decentralization, roles and responsibilities of various functionaries reviewed. Thereafter, a training curriculum on updated job descriptions with the emphasis on practical issues was

developed. The training was based on active as well as problem-based learning. The duration of training varied from two months for Master Trainers' (MT) to seven days for Health Centre (HC) staff.

- For establishing a cadre of MTs to conduct and supervise training, 23 MTs were recruited. Four existing Regional Training Centres were identified as TB Training Centres for the different regions. 948 supervisors at provincial and district level were trained by MTs from April 2001 to February 2002. The training of HC staff which started in March 2002 is continuing.
- An external review of the training initiative was undertaken in Nov/Dec 2001. The review found the progress to be good and the contents and methodology satisfactory. However, concerns were expressed on the delay of HC level staff training.
- The impact of this step-wise approach to capacity building resulted in the establishment of a core group of MTs who trained 950 supervisors in the provinces and districts. The facilities and infrastructure were upgraded at all the four Regional Training Centres. The scope and responsibilities of the MTs were expanded in October 2002 to cover all aspects of programme management and extended to national TB facilitators at the provincial level. Since the support for training in the Dutch project covers only 20% of HC staff, TBCTA, Canadian International Development Agency (CIDA) & Global Fund to fight AIDS, TB and Malaria (GFATM) will cover the rest.
- The important lesson learnt in implementation of the project was that the National Training Coordinator should be located in the Central TB Unit to facilitate coordination and follow-up. The major constraints resulting in slow disbursement of funds and subsequent delays in implementation were related to organizational and bureaucratic procedures.

5.5 Communication for Social Mobilization – The COMBI Approach

While there is a new case every two minutes in Bangladesh, TB takes a life every 10 minutes. Although there is 100% geographical coverage by DOTS and the treatment success rate is satisfactory at about 80%, the case detection rate among new smear positives is less than 30%. Despite many challenges,

the TB control programme in Bangladesh is set to achieve the global of 85% success rate among new sputum smear positives and 70% detection of all such cases by 2005. To achieve these targets there is a need for generating public demand for DOTS, significantly improve detection rates by increasing public and private health sector support as well as improving service quality and enhancing TB resources. Communication for social mobilization also needs to address the issues of stigma and gender access.

“Coughing, coughing, coughing Get the TB sputum Test” is the Behavioural Theme of the Communications for Behavioural Impact (COMBI) plan for TB. Beyond the traditional communication interventions, the TB COMBI workplan uses certain innovative approaches. In addition to 30 000 Community Health Workers working as TB assistants with TB badges and information sheets, 6 million school children will be taking home paper “charkis” or wheels with TB behavioural messages and information worksheets, serving as “personal sellers”. A modest incentive in the form of a small packet of a popular health drink to the first 100 symptomatics coming for sputum examination at each site and small packets as gifts to the community health workers are also a part of the proposed strategy.

To have a meaningful impact evaluation, base line data of important indicators would be collected and a mid-term evaluation for incorporating corrective actions would be undertaken to improve the final outcome of the TB COMBI workplan. To ensure focused activities, two full-time consultants will support Bangladesh’s National TB Control Programme, in implementing the TB COMBI workplan.

5.6 DOTS Expansion and HIV – Thailand

Thailand ranks 16th amongst 22 high burden countries and in the last decade the annual risk of TB infection (ARTI) has reportedly come down from 1.89% to 1.5%. The country is estimated to have 100 000 new cases / year of TB with an overall success rate of about 80%. Of a total population of 62 million, about 670 000 are PLWHA. Health sector reforms, HIV migratory populations and MDR-TB are the major challenges to effective TB control in the country.

To avoid fragmentation and interruption of the National Tuberculosis Programme network, the health system is being brought closer to the

community level and the training network is being widened to include more health care workers. Closer coordination between National Tuberculosis Programme and National AIDS Programme (NTP & NAP) and treatment of latent TB infection as part of integrated care strategies are the fresh initiatives to meet the HIV-TB challenge. Strengthening the urban TB control programme, increasing access to TB care among prison inmates and the immigrant populations, strengthening TB services along the border areas and scaling up activities with GFATM support are some of the important interventions proposed for combating the challenges being faced by the control programme.

5.7 Increasing Case Detection through Partnerships – Nepal

Nepal is the largest country in the SEA Region which has achieved global targets for case detection and treatment success. This achievement is largely due to effective partnerships with communities, private/corporate sectors, donors/NGOs/INGOs, intellectuals/media and others. Municipal clinics/governmental hospitals including police, army and prison hospitals/mission hospitals, all medical colleges, nursing homes and polyclinics have been involved in service delivery. Support from traditional healers and school children has been valuable. Village & district DOTS committees include motivated people belonging to all walks of life ranging from TB patients to political leaders are responsible for increasing awareness of TB and facilitating TB services in the community. The urban TB Control Programme in Kathmandu which is run by a Coalition Against Tuberculosis (CAT) involves INGO's/NGO's beyond municipality clinics and private teaching hospitals. Awards have been established to recognize outstanding contributions in TB control.

The Public-Private Mix project has consistently shown over 90% treatment success rates. Case notification has increased from 75/100 000 to 120/100 000 in one year. The sale of TB drugs in the private sector decreased by 60% in three years. To sustain improvements in programme implementation, an annual meeting is held with medical colleges. Through effective involvement of all players, the TB Control Network (TBCN) in Nepal has been brought under the umbrella of the National TB Control Programme.

5.8 Engaging the Private Sector in DOTS Implementation

The South-East Asia Region has the highest burden of TB and the largest private health sector. By and large, private health care providers -- individuals and institutions -- have not been involved in DOTS implementation in countries of the Region. The need to involve the private sector is being increasingly felt to help improve case detection and achieve the global targets by 2005.

Though precise figures on the extent of TB diagnosis and treatment in the private sector are not available, estimates based on the sale of anti-TB drugs in 2000 indicate that in India, Indonesia and Bangladesh alone, about a million TB cases might have taken partial or complete TB treatment during the year. With the aim of eventually developing guidelines for NTPs, WHO Headquarters Geneva undertook a global assessment to study the involvement of the private sector in TB control and assisted in setting up and documenting "learning projects" at some sites in Asia and Africa. The assessment carried out during 1999-2000 highlighted the wide variation in the role of the private sector in TB control among and within countries. Many initiatives in various countries however offered enough information to develop a generic framework for Public-Private Mix for DOTS (PPM DOTS). The assessment report emphasises the need to develop regional, national and local strategies and plans for PPM DOTS.

The learning projects on PPM DOTS implemented in Hyderabad, Delhi, Pune, Nairobi and Ho Chi Minh City demonstrated that collaboration with the private sector is indeed possible and helps in improving case detection. In the first project year, the case detection rate in Ho Chi Minh City increased by 18% while that in Delhi rose by 36% when compared with the preceding years and with control areas. Desirable treatment success rates were also achieved in all sites except Ho Chi Minh City. The project in Hyderabad is maintaining target case detection and treatment success rates and has now been integrated into the Revised National TB Control Programme of India. Based on the experiences in diverse sites, some simple practical tools to help implement PPM DOTS have emerged. A document on the subject is being prepared and will soon be published.

The presentation highlighted the need to undertake programme-based, problem solving operational research on various unaddressed issues including

developing sustainable PPM DOTS models, studying their cost-effectiveness and determining their epidemiological impact.

The global DOTS Expansion Working Group of the Stop TB Partnership recently established a subgroup on Public-Private Mix for DOTS Expansion. The first meeting of the group was held in November 2002. The group strongly recommended that National TB Programmes appoint focal points at the central level to develop a national PPM DOTS strategy, identify and pilot most suitable PPM DOTS model(s) for countries and scale-up the successful PPM-DOTS models in phase-wise manner.

6. CONCLUSIONS AND RECOMMENDATIONS

The TWG recognized the impressive and rapid gains made by Member Countries of the Region in TB control over the last few years, and the achievement of 60% DOTS coverage in the region. In spite of the rapid expansion of DOTS in the Region, overall treatment success has been maintained at over 80%. The creation of the Global Fund against AIDS, TB and Malaria, had provided an additional opportunity to contribute in a major way to poverty alleviation on a global scale. Amongst the three diseases, TB control through DOTS is a most cost-effective intervention and a tool to achieve the Millennium Development Goals.

In spite of extensive coverage, case detection continues to be below the 70% target, calling for intensification of efforts to reach this target by 2005. The meeting identified four broad priority activities to meet global targets:

- Quality implementation of DOTS in both the public and private sectors including medical colleges and hospitals;
- Expansion and increasing access to DOTS services through enhanced outreach and partnership building;
- Adopting innovative approaches to increase case detection, and
- Adopting social mobilization approaches targeting community partnerships and ownership.

It was also decided that for detailed discussions and concentrated interventions, on issues such as capacity building, health sector reforms and their possible implications for TB control; TB/HIV; public-private partnerships

between the health and business sectors, and community mobilization, specific subgroups may be constituted. These subgroups could also co-opt experts in the designated areas and make specific recommendations to the TWG for a final decision.

The following recommendations were made:

Member Countries

- (1) The major constraints in DOTS expansion and in improving the quality of DOTS services are lack of staff, skills and motivation at all levels. There is a need for additional staff to extend the delivery of services to the unreached areas and to establish new diagnostic and treatment centres. Member Countries should undertake human resources and capacity assessment. Based on the assessed needs, individual countries should prepare a workplan and budget for human resource development to meet the needs of the existing services, and for proposed improvements and further expansion of services and mobilize resources accordingly.
- (2) Keeping in view the major challenges posed by health sector reform, TB control should retain its priority status. To ensure quality implementation, the core functions including drug procurement, quality control and distribution, should be protected and retained at the central level. While decentralization and integration would increase the DOTS network, it also has the potential to dilute some of its functions and calls for additional training. There was need for advocacy at central, regional and provincial levels for ensuring optimal allocation of resources. Effective advocacy should include wide dissemination of quantified achievements demonstrating that DOTS is one of the most cost-effective health care interventions available and that TB control is an effective poverty alleviation strategy. In order to protect the poor, national TB programmes should advocate that Member Countries follow the WHO policy of "free treatment of TB".
- (3) TB-HIV is an emerging issue in the Region. The Member Countries should assign high priority to combating TB-HIV. For establishing joint interventions, collaboration between TB and HIV/AIDS programmes with pilot projects in selected districts, should be

encouraged. Experiences from these pilots should be used for expanding and scaling up TB-HIV programme activities in other areas.

- (4) The South-East Asia Region has the highest burden of TB and the largest private sector in the world. Many poor TB patients in the Region first visit a neighbourhood private health care provider for diagnosis and treatment. Presently, in almost all countries, private practitioners and hospitals are not widely involved in DOTS implementation. Collaboration with NGOs and the corporate health sector has also been inadequate. All these constitute important constraints to improve case detection. Member Countries should identify and appoint a focal person to help develop linkages between the NTP and the private sector/NGO/corporate sector, set up pilot projects where required and scale them up in a phased manner.
- (5) The TWG was unanimous in appreciating the difficulties associated with the smooth implementation of the DOTS strategy in urban areas. Constraints include multiplicity of health care providers and authorities, many different population groups each with special needs, inadequate primary health care infrastructure, an emphasis on curative services and a demand for sophisticated interventions. The presence of urban slums and the need to implement the DOTS strategy based on primary health care infrastructure, calls for urgent interventions to improve urban TB control programmes. To bring DOTS services under one umbrella, creation of a co-ordination mechanism is the first, essential step. This would ensure unification of authority, reduce overlap and avoid duplication of services. Job responsibilities of the existing health care staff may need to be reviewed and specific responsibilities pertaining to DOTS activities appropriately assigned. This may also require some formal/informal training. Capacity building strictly consistent with the proposed job responsibilities needs to be given high priority. Because of the unique constraints, even with reallocation of responsibilities, additional staff may need to be recruited at different levels. A nodal person at each level would need to be identified.
- (6) The TWG noted that while DOTS is being established in each country, the services are not being utilized fully by the community.

The lack of demand for TB services is, in part, due to the lack of information within the community in general and patients in particular about existing facilities and free availability of quality services. The TWG further noted that other potential partners such as community-based organizations (CBOs) should also be mobilized in informing the population about the availability of quality TB control services. The national programmes should aim on a consumer-focused approach. This requires social mobilization and the involvement of the private/marketing sector to inform the community and thereby creating a demand for TB services. However, the cost-effectiveness of social mobilization activities should also be considered.

WHO

- (1) WHO and partners, including the task force on training (TFT), should assist Member Countries develop country workplans for human resource development, enhance management capacity through technical support and assist in DOTS implementation and evaluation.
- (2) WHO should provide advice to Member Countries on the potential consequences of HSR on DOTS strategy, remedial/alternative measures to be taken and specific NTP activities that need to be retained.
- (3) For Member Countries to gain and share experiences, WHO, in collaboration with relevant partners should urgently finalize the Regional TB/HIV Strategic Framework, provide technical and financial support in implementing the strategy in pilot districts and assist in developing national policies.
- (4) WHO and partners should advocate involvement of the private sector in TB control activities, identify focal points to assist Member Countries in proposal development, resource mobilization, project implementation and monitoring, and sharing of results with the ultimate goal of scaling up their involvement.
- (5) WHO should assist Member Countries in exploring collaboration with the corporate sector in developing "DOTS in the Workplace" policies and in implementing the programme.

- (6) WHO should promote collaborative projects for TB control in urban areas, document and widely disseminate success stories.
- (7) WHO should promote social mobilization approaches to increase the utilization of TB services by the community.

7. FUTURE ACTIONS

It was decided that the next TWG meeting be held back to back with the programme managers meeting scheduled to be held in November 2003 in Indonesia. The following was proposed as the tentative agenda:

- (1) Formulation of a strategy for disseminating the findings of Operations Research (OR) undertaken by Member Countries; prioritize the OR areas and develop generic protocols for these areas;
- (2) Discuss and formulate a policy for providing DOTS facilities to inter/intracountry migrating/floating population;
- (3) To discuss and share the experiences on the use of fixed-dose combination (FDC's);
- (4) To discuss and share the experience relating to the impact of Health Sector Reforms on the DOTS strategy;
- (5) To develop a working paper on the status of Drug Resistance Surveillance & TB/HIV in the SEA Region, and
- (6) To develop quality control networks at national and regional levels.

Annex 1

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Annex 2

PROGRAMME

Monday, 10 December 2002

- 09.00-12.30 hrs
- Welcome and introductions
 - Objectives
 - Global Overview of the TB situation and progress made – Dr Holger Sawert
 - Regional Initiatives – to Stop TB in the South–East Asia Region – D. F Wares
 - The Regional Strategy for TB–HIV and steps for implementation – Dr J P Narain
- 14.00-17.00 hrs
- Increasing case detection through partnerships – Dr Shanta Pande
 - Human Resource Development – a step – wise approach -- Dr R Day
 - DOTS in the context of health sector reform – Dr G R Khatri
 - Discussions

Tuesday, 11 December 2002

- 09.00-12.30 hrs
- PLENARY
- Communications for Social Mobilization – the COMBI approach – Dr V Begum
 - Meeting emerging challenges : HIV–TB and MDR–TB – Dr S Netnyom
 - Engaging the private sector in DOTS – Dr Mukund Uplekar

14.00-17.00 hrs GROUP WORK

- Reaching targets: Challenges, issues and possible solutions

PLENARY

- Presentations by Groups.

Wednesday, 12 December 2002

- 09.00-12.30 hrs
- Review of conclusions and drafting of recommendations
 - Proposals for agenda and dates of next meeting
 - Closing