

Report of the Regional Workshop on TB control planning, implementation and monitoring

Jakarta, Indonesia, 29 - 31 May 2012



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Abbreviations

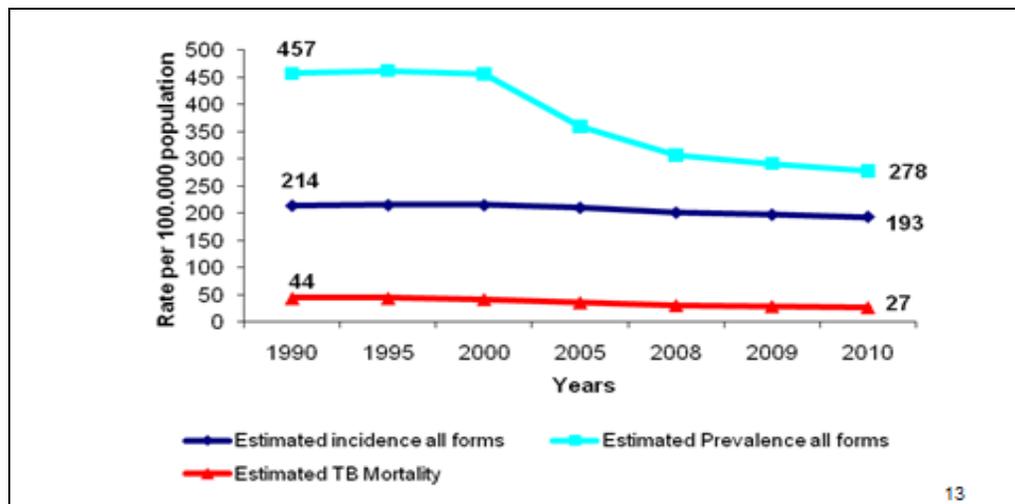
ACSM	advocacy, communication and social mobilization
AIDS	Acquired Immune Deficiency Syndrome
CDC	Centers for Disease Control, Atlanta, USA
DST	drug susceptibility testing
FLD	first-line (anti-TB) drugs
GDF	Global TB drug facility
GF	Global Fund (to fight HIV/AIDS, TB and malaria)
GOI	Government of India
HIV	human immune deficiency Virus
IC	infection control
ICN	International Council of Nurses
LED	light emitting diode
LFA	local funding agency
MDC	Millennium Development Goal
MDR-TB	multi-drug resistant tuberculosis
M&E	monitoring and evaluation
NTP	national tuberculosis programme
PMDT	programmatic management of drug-resistant tuberculosis
PPM	public-private mix
PR	principal recipient
SEAR	WHO South-East Asia Region
SEARO	WHO Regional Office for South-East Asia
SLD	second-line (anti-TB) drugs
TA	technical assistance
TB	tuberculosis
TBTEAM	TB technical assistance mechanism
USAID	United States Agency for International Development
USG	United States Government
WHA	World Health Assembly
WHO	World Health Organization

1. Introduction

The South-East Asia Region of the World Health Organization is home to about 40% of the world's total number of TB cases. Much progress has been made in the SEA Region since WHO declared TB to be a global emergency in 1993 and the estimated TB prevalence, incidence and mortality has been declining since 1990 (Figure 1).

However, too many people still have undetected TB for too long; late detection of TB increases their risk of transmitting the disease to others, having poor health outcomes, or that they and their family will suffer distress and economic hardship. TB remains a major cause of morbidity and mortality in many countries in the Region and a significant public health problem worldwide despite the availability of highly efficacious treatment for decades.

Figure 1: Estimated TB prevalence, incidence and mortality: SEA Region, 1990-2010



Source: National TB Control Programme Managers and Partners; Report of the Meeting, Bangkok, Thailand, 6-9 December 2011, WHO SEARO, New Delhi 2012

Actions need to be taken, not only by the TB control programmes and the health sector to achieve TB control goals and objectives, but also beyond, by other programmes and sectors. Where general health services are inadequate or absent, it is not possible to scale up even basic DOTS; TB programmes will not be able to scale up MDR-TB treatment without adequately equipped laboratories and a competent and motivated health workforce and without abolishing the financial barriers patients encounter in seeking health care services. If anti-TB drugs continue to be available over the counter and used irrationally by private providers, the efforts of TB programmes to provide care based on international standards will have limited impact. Similarly; if TB is not mandatorily notifiable and vital registration systems remain weak, it will continue to hamper national and global TB surveillance. It is often beyond the capacity of TB programmes alone to address these and other systemic issues.

To ensure active involvement of all stakeholders as well as other sectors beyond the TB control programmes, strategic planning, implementation, monitoring and evaluation becomes increasingly important. Countries in the Region are already well advanced in the development and implementation of national strategic plans. However, with the increased complexity of many stakeholders as well as to ensure universal access to quality TB prevention, care and control, additional efforts are needed.

This report summarizes the work during a regional workshop to strengthen national strategic planning and the coordination of technical assistance for tuberculosis control.

2. Opening session

Dr Khanchit Limpakarnjanarat, WHO Representative to Indonesia welcomed participants and subsequently delivered the welcome address on behalf of Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia. Full text of address is in Annex 1.

The workshop was opened by Professor Tjandra Yoga Aditama, Director-General for Disease Control and Environmental Health, Ministry of Health, Republic of Indonesia. Professor Tjandra pointed out that TB was serious problem in the SEA Region, despite the good results obtained by

national TB control programmes. There are several TB high-burden countries (HBC) in the Region, highlighting the challenges for TB control in the Region. Collaboration will play an important role in this Region and it is important for countries to exchange experiences and views and for NTP managers to communicate more frequently. Migration of patients is also an important challenge pointing to the need for the implementation of the International Health Regulations.

The objectives of the workshop were presented by Dr Md Khurshid Alam Hyder, Regional Adviser-TB, WHO-SEARO. The general objective was to strengthen country capacity to plan, implement and monitor technical assistance needs. The specific objectives were:

- To update participants on latest developments in the Stop TB strategy and link to technical assistance;
- To provide an overview of TBTEAM, and technical assistance planning, implementation and monitoring at country and regional level;
- To review existing country and regional TBTEAM plans for technical assistance and develop/update country-specific and regional TBTEAM technical assistance.

Dr Malgosia Grzemska, Coordinator of the Technical Support Coordination (TSC) unit of the Stop TB Department, WHO-HQ, briefly described the work on the development of the new Stop TB strategy for the “post-2015” period as discussed in the Sixty-fifth World Health Assembly and how countries will be involved in this process.

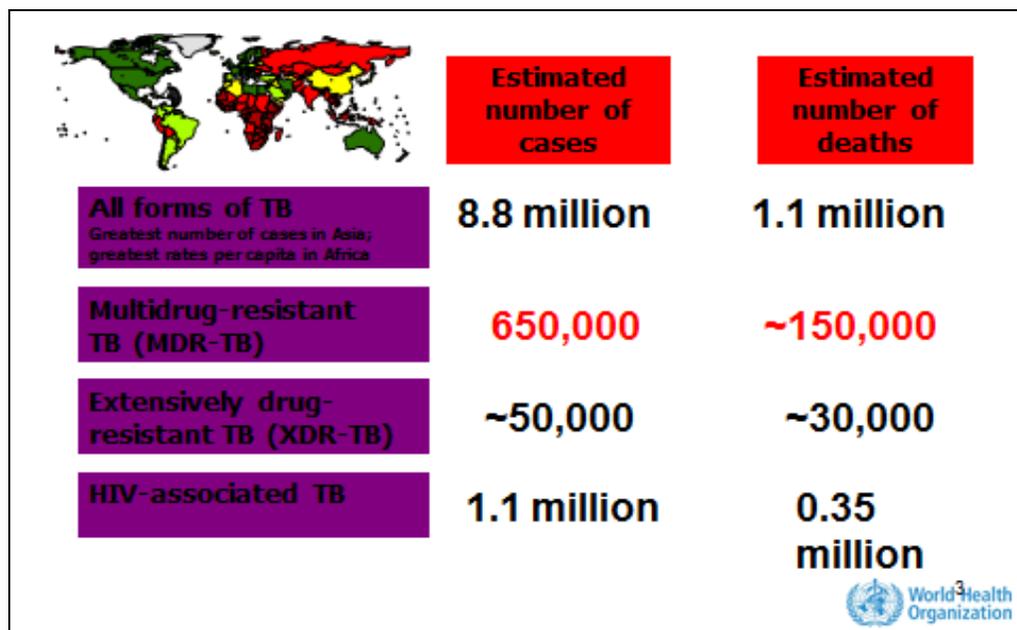
The agenda of the workshop is in Annex 2. For the list of participants please see Annex 3.

3. Update on latest developments in the Stop TB strategy

3.1 Overview of global and regional TB situation

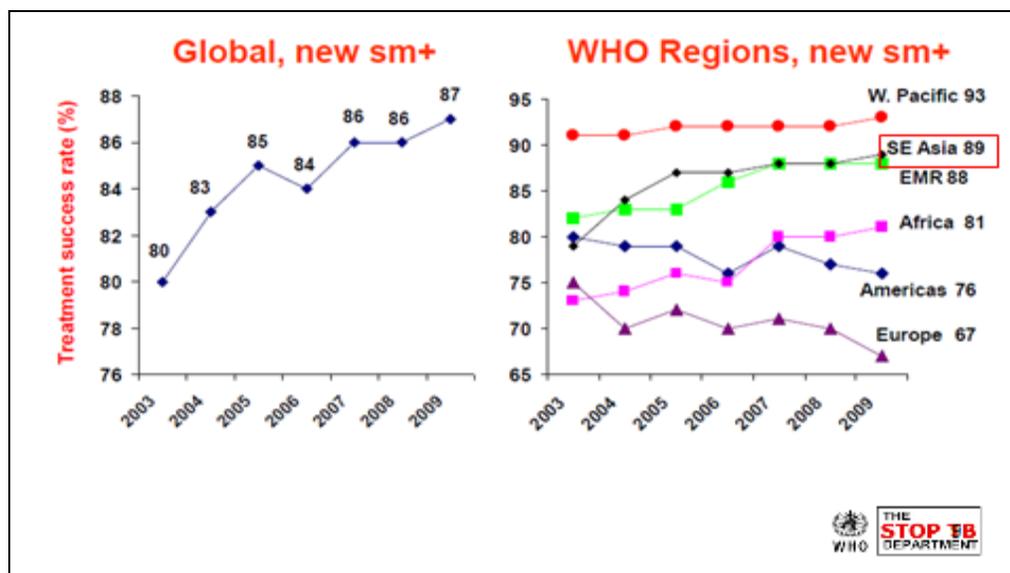
The overview of TB and TB control highlighted progress and challenges from a global and regional perspective. The situation is summarized in Figures 1, 2 and 3.

Figure 2: Latest global estimates



Source : Global Tuberculosis Control: WHO Report 2011, WHO, Geneva 2011

Figure 3: Global TB treatment success rate



Source : Global Tuberculosis Control: WHO Report 2011, WHO, Geneva 2011

There is an urgent need to develop and pursue within national TB control plans the means to ensure:

- (1) Adequate, trained and motivated staff;
- (2) Laboratory capacity for diagnosis of MDR-TB and use of new, rapid diagnostics;
- (3) Quality drugs meeting international prequalification or national regulatory standards;
- (4) Wider and effective involvement of hospitals, health centres, prisons, other care providers and the community;
- (5) Capacity building and accreditation of all providers;
- (6) Attention to needs of special populations such as persons with HIV; and
- (7) Implementation of infection control measures.

There is also a need to take advantage of opportunities provided by the Global Fund, national and international funding agencies, and expanded national investments in health systems to improve logistics/supply management systems, public and private laboratory services and to

strengthen surveillance mechanisms and routine notification systems. It is also essential to ensure sufficient funding as well as medium-and long-term technical assistance.

New challenges, policies and interventions include universal coverage; revitalization of primary health care; introduction of newer and rapid diagnostics; TB control beyond the health sector; scaling-up of TB care and civil society involvement; and operational research on new anti-TB medicines.

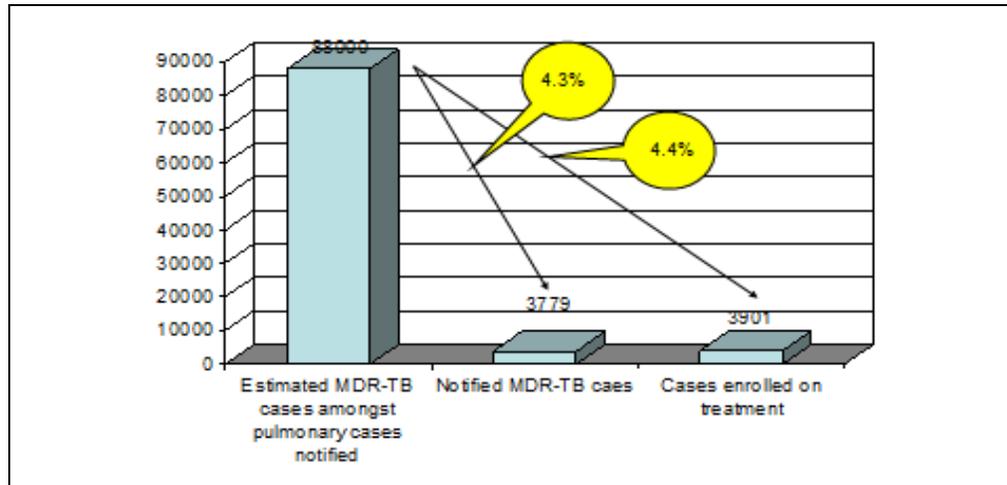
3.2 Overview of MDR-TB situation in the SEA Region

The Global Plan to Stop TB 2011-2015 calls for a renewed focus to strengthen the fight against M/XDR TB. In the SEA Region relatively low levels of multidrug-resistance (2.1%) are reported among newly detected cases but higher rates (18%) among previously treated cases. However, this translates into around a fourth or nearly 105 000 of the world's MDR-TB estimated to occur annually in the Region. Extensively drug resistant TB (XDR-TB) has also been reported from five countries in the Region, making the situation alarming.

Several challenges are faced in the Region with regard to addressing the DR-TB problem:

- more than 1/3 of estimated cases are not registered by NTPs;
- poor access for several pockets of populations; the private sector being the first contact for a majority of TB patients;
- less than 5% of the estimated MDR-TB cases being registered for treatment by NTPs; poor drug regulation of anti-TB medicines (both 1st and 2nd line);
- overburdened health infrastructure with no infection control policy;
- several countries in the Region have poor housing conditions and specifically overcrowding in urban areas that facilitate spread of infections.

Figure 4: Estimates v/s notifications



A response plan to address the MDR-TB challenges has been developed by the Region. The plan provides an overview of planned regional response to M/XDR TB and draws a roadmap for regional contribution to achievement of global targets set forth for M/XDR TB in the Global Plan, 2011-2015.

The strategies enlisted in the plan include:

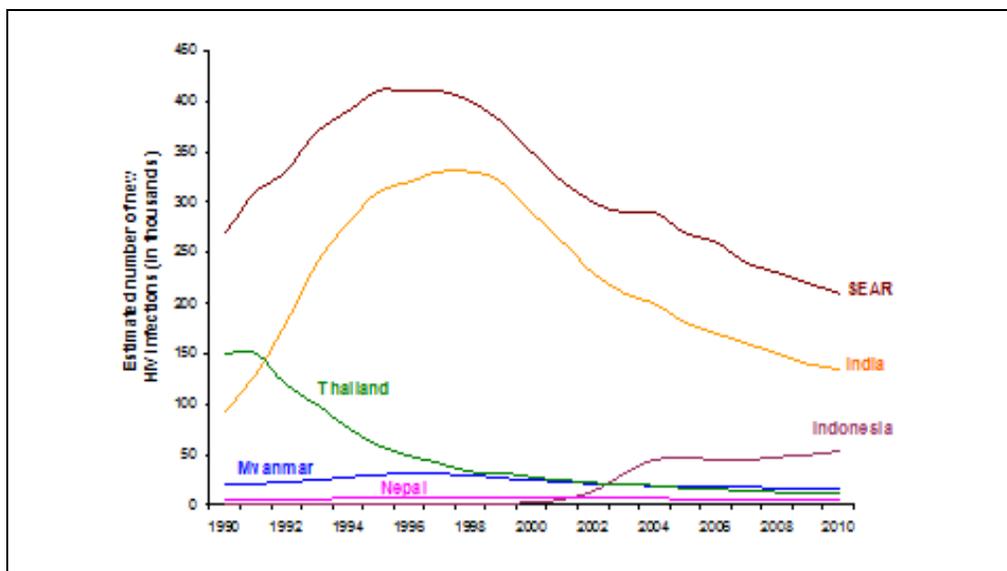
- Preventing the emergence of resistance through sustained and enhanced efforts to reach all TB patients with quality care.
- Scaling-up PMDT.
- Implementing TB-IC in health-care facilities and congregate settings.
- Strengthening surveillance, including recording and reporting of drug-resistant TB.
- Strengthening health systems to ensure capacity for PMDT integrated with primary health care.
- Forging partnerships and ensuring coordination with stakeholders to mobilize the requisite resources.
- Supporting PMDT through ACSM.
- Undertaking research.

A new global framework to support PMDT scale-up has been developed. The goal of the framework is universal access to DR-TB management by 2015. According to the new framework, a Green Light Committee (GLC) approval will no longer be required and there shall be open access to quality-assured, second-line anti-TB medicines. The procurement of drugs will be undertaken by GDF on condition of annual monitoring coordination of TA aimed at nationwide MDR-TB services and expanded monitoring and evaluation of country performance annually will be strengthened. There will also be increased advocacy through coordination with Stop TB Partnership.

3.3 Overview of TB/HIV in the SEA Region

The SEA Region has the second highest burden of the HIV epidemic after Sub-Saharan Africa, with an estimated 3.5 million people living with HIV/AIDS in 2010. The Region accounts for nearly 15% of the global burden of new HIV-positive TB cases, with the majority of cases found in four countries (India, Indonesia, Myanmar and Thailand).

Figure 5: Estimated number of new HIV infections in South-East Asia Region, 1990-2010



Source : Tuberculosis control in the South East Asia Region 2012 , WHO SEARO, New Delhi 2012

Progress has been made in addressing TB/HIV with national governments in the Region acknowledging the importance of addressing the growing TB/HIV problem. This includes making a comprehensive package of TB/HIV interventions available to around one billion population of the Region; increasing the efforts for intensified TB case finding; inclusion of infection control measures in national plans; and wider availability of integrated management of both TB and HIV infected persons. However, it was noted that IPT implementation is slow in most countries due to a variety of reasons.

However, issues and challenges in addressing TB/HIV still remain. Programmatic challenges such as service delivery mismatch, limited availability of HIV test kits, shortage of trained and skilled personnel and limited involvement of the private sector were highlighted. There are also various challenges faced at the operational level including the lack of a sense of urgency in addressing this important public health problem. TB/HIV coordination mechanisms are in place, but the level of collaboration for planning, guidance and oversight is sub-optimal. Many common health system constraints remain unaddressed and the stigma imposed on the TB and HIV infected patients and the fear on the part of health workers are still prevalent.

The regional strategic plan for TB/HIV developed in line with WHO's global policy on TB/HIV and also in the context of the Region was presented. Key components of the strategic plan especially in ensuring joint policy and strategy development involving both programme sides, surveillance and infection control issues were highlighted. In addition to the generic components of the WHO global policy, integrated management and health system strengthening were added reflecting the regional context.

3.4 Introduction of new laboratory diagnostics especially liquid culture, line probe assays and Xpert MTB/RIF diagnostic test

The issues and challenges linked to the introduction of new laboratory diagnostics especially liquid culture, line probe assay and Xpert MTB/RIF diagnostic test in Indonesia were presented by the NTP manager, Dr Dyah Mustikawati. Earlier and higher TB case detection to reduce the diagnostic delays are global and national priorities for TB control, as well as in Indonesia. The country is facing an alarming increase in drug-resistant TB cases, despite a well-functioning national TB control programme.

Qualified TB diagnostic is one of the six pillars in the comprehensive public-private mix (INA-PPM) model toward universal access to qualified TB care in Indonesia. Major efforts have been put into the strengthening of the laboratory system in the past few years and major progress has been made (Table 1).

Table 1: Key areas of progress since 2009

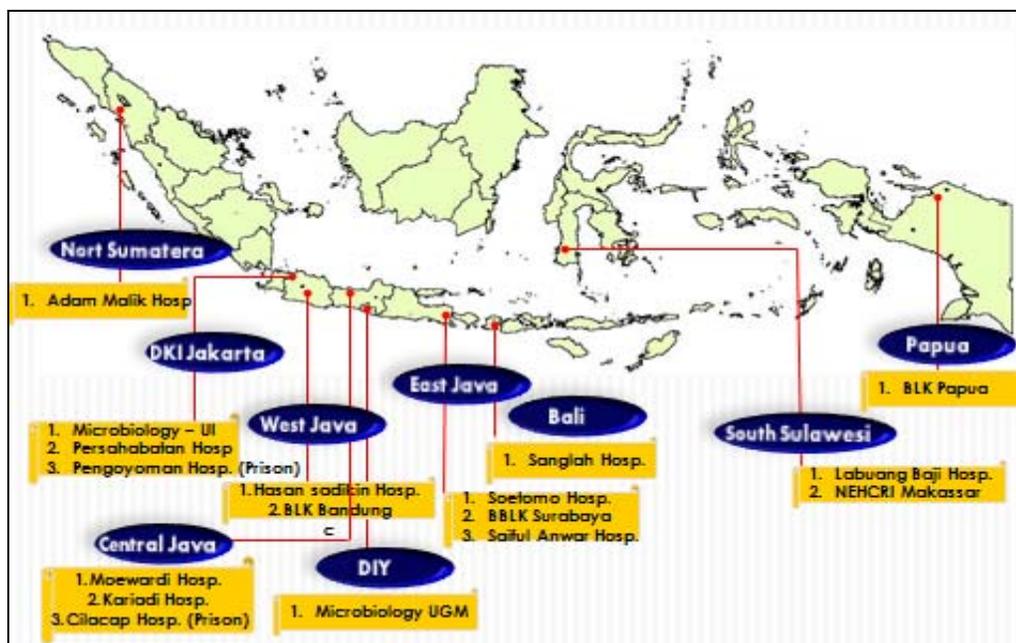
No	Key Areas	2009	2012
1	National TB Lab action plan	-	Available
2	National TB Reference Lab	-	3 labs
3	Certified FL DST Lab	3 labs	5 labs
4	Certified SL DST Lab	-	5 labs
5	Improve Biosafety (Renovation of Culture/DST Lab to meet BSL 2 plus standard)	-	4 labs completed 2 labs inprogress
6	Implementation of LPA	-	3 labs
7	Implementation of GeneXpert	-	5 labs (up to March)

The National TB Lab Action Plan, 2011-2014, prepared as a complement to the national strategic plan to control TB includes the introduction of liquid culture and LPA and roll-out of Xpert MTB/RIF. The current status is as follows:

- Two out of five certified DST laboratories are applying liquid culture (MGIT 960 and manual MGIT): Microbiology UI, Jakarta (MGIT 960) and NEHCRI Makassar (Manual MGIT).
- Expand TB plan will support MGIT 960 and HAIN for 2 labs (BBLK Surabaya (NRL for culture/DST) and Persahabatan Hospital (MDR TB Treatment Centre).
- Three laboratories are already implementing the LPA (Hain test) (Microbiology UI, Jakarta; NEHCRI Makassar; Soetomo Hospital, Surabaya).

- GeneXpert: 17 GeneXpert machines and 1700 cartridges have been procured. Implementation of GeneXpert will be done in a step-wise manner. Five initial sites are operating as of March 2012. The placement of the GeneXpert machines is shown in Figure 6.

Figure 6: Placement plan of 17 GeneXpert machines



Dr Dyah concluded by saying that the TB laboratory plays a main role in MDR-TB diagnosis to support the scale-up of PMDT. The expansion of quality assured culture/DST laboratories and MDR-TB treatment centres are crucial to achieve national targets for TB control. Utilizing new TB diagnostic tools is a breakthrough to avoid delays in treatment. However, it is imperative that the increase in diagnosis capacity is followed by an increase in the treatment capacity as well.

4. Overview of the Global Fund transformation

The Global Fund (GF) strives to be an effective, efficient and transparent public health donor. It is no secret that the past two years, coinciding with

the global economic turn-down, have been difficult. The GF experienced the first budget shortage in its history and responded by focusing on its core mission: "impeccable grant management." In so doing the GF will continue to emphasize the:

- Impact of its interventions;
- Effectiveness of its programmes; and
- Efficiency of its investments.

In 2012 the GFs' Grant Management Division has been staffing up significantly in order to ensure this "investment for impact," as defined by:

- Strategic monetary investment (by focusing on high impact countries);
- Support for successful grant implementation (through "performance-based funding");
- Promotion of human rights (and universal access to services);
- Resource mobilization (with public and private partners alike); and
- Evolution of the funding model (moving away from "zero sum" rounds to joint programme development with annual incremental commitments.

In perhaps the largest potential departure from past practice (i.e. in lieu of rounds-based proposals), the GF is discussing compression of proposal development and grant negotiation into one step. Beginning in 2013 -- and on a continuing basis -- the GF would invite "concepts" developed jointly in-country by stakeholders, including implementers, partners and the GF country team itself. The resulting short papers would be reviewed by the TRP and, following appropriate clarifications and/or modifications in concept, country stakeholders (again, including donor and technical partners, as well as the GF country team) would be asked to jointly develop programmes suitable for funding. In this manner the GF would seek to remove the "game theory" from Global Fund investments, making funding decisions a function of sound epidemiological analysis, financial forecasts and programmatic capacity.

This process will also facilitate rational work-planning and cash flow forecasting for both countries and the GF. For any given programme design, stakeholders would be able to determine not only resource needs but also

their availability. Performance frameworks could be established to reflect these realities and all sides would be able to accurately estimate probable funding levels over a multi-year life of a grant. The GF will simultaneously adopt an operational risk management framework that will safeguard the investments.

5. Planning and accessing high quality technical assistance to implement country national strategic plans

5.1 Linking national strategic plans, operational plans and TA planning

The session started by a description of the justifications for the development of a national strategic plan (NSP). This includes, but is not limited to, facilitating for the NTP to reach goals and strategic objectives; to determine strategic interventions; to specify activities to be implemented; to develop a budget; identify available funding; and to monitor and evaluate the implementation of the strategic interventions.

Subsequently, the five key components of a NSP were outlined: the core strategy; the budget plan; the monitoring and evaluation plan; the operational plan; and the technical assistance plan. A good NSP will allow resource mobilization, can be an early warning for GF grant implementation, allows country ownership, helps to prioritize TB control and prevention, and facilitates effective involvement of all partners.

5.2 Overview of technical support provided to the countries.

The SEA Region has five high TB burden and five high MDR-TB burden countries. All countries in the Region except Maldives have grants for TB control from the GF.

The key principles of TA were highlighted, including long-term capacity building and intensive technical assistance focusing on increasing case detection and improving treatment outcomes in line with global strategies. One of the key challenges to timely and effective TA is the very limited formal joint TA planning and implementation involving various

partners. A new direction has been suggested including TA planning based on a systematic analysis of the country situation. Countries should be planning TA needs in collaboration with national and international partners. The importance of the quality of the TA was highlighted. Good TA also includes good collaboration between the consultant and the clients. An excel sheet for country-specific TA planning was presented as well as a quarterly TA monitoring sheet. This quarterly monitoring has been utilized by the Regional Office to monitor implementation of TA to the countries. The importance of coordinated TA planning and implementation as the means to avoid duplication of TAs from various partners was stressed.

5.3 TBTEAM trends globally and in SEA Region

TBTEAM (the TB Technical Assistance Mechanism) is a global coalition of partners, countries and funding agencies. It aims to build up national capacity and ownership of countries' own technical assistance plans and implementation, and to help countries and international agencies coordinate their technical assistance through a well-organized network of technical partners. It facilitates implementation of the Stop TB Strategy, achievement of the 2015 Millennium Development Goals, and enables the most effective use of Global Fund and other external resources. The objectives of the TBTEAM are:

- to facilitate access to high-quality technical assistance;
- to encourage planning at national, regional and global levels, but most importantly at national level;
- to improve the efficiency of TA by ensuring that needs are met while minimizing redundant TA; and
- to promote capacity-building at all levels in terms of TA planning and training of consultants according to international standards.

TBTEAM operates at global, regional and national levels. Global/central TBTEAM complements regional and national TBTEAM, which take the lead on partner coordination, TA planning and identification of funding for TA. Where a national partnership or similar collaborative entity exists, national TBTEAM functions as a mechanism for TA coordination among these partners

At the global level close coordination is ensured with partners and donors especially with the GF secretariat. An online coordination platform has been developed and is available. The TBTEAM is also managing a roster of technical experts. There are currently 239 experts online. The total number of TA missions to date through the TBTEAM is 2938. The number of missions peaked in 2009 at around 66 per month and by 2011 the number of missions had dropped to 50 missions per month. For technical areas such as MDR/XDR TB and laboratory capacity strengthening, mission numbers peaked in 2010. Paediatric TB, operational and basic science research and infection control, show a recent continuing upward trend.

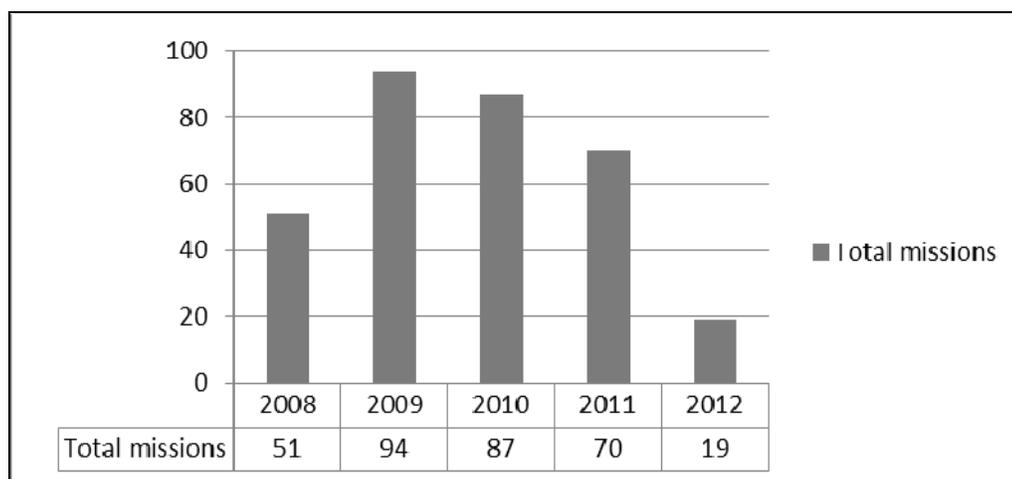
The major contributors to the TBTEAM database have all had reductions in the number of missions between 2009 and 2011. For KNCV, this fell from 123 to 63 missions/year; the Union from 100 to 87, the Global Drug Facility (GDF) from 86 to 44. Some new partners are getting active like CDC and the International Council of Nurses (ICN).

The US Government (USG)/TBTEAM was the largest funding source of missions recorded on the TBTEAM website, supporting 25 (25%) of the 101 missions in the last quarter of 2011.

TBTEAM offers an opportunity of ensuring storage and control, with easy access to previous mission reports by experts/agencies who need them. Only 11% of missions resulted in a mission report in 2011 (either confidential or public) leaving a large scope for improvement. Overall, only 39% of reports of USAID/TBTEAM-funded missions were uploaded by partners in 2011.

The picture in SEARO is similar to what has been observed. The peak in the requests for TA was observed in 2009. However, in subsequent years the trend has been gradually decreasing (Figure 7).

Figure 7: Total completed missions in SEARO since 2008



The number of completed missions per country recorded during the last year and a half can be seen in Table 2. Bigger countries are, with the exception of Nepal, getting more missions.

Table 2: Completed missions by country in SEA Region

	2011				2012		Grand Total
	♂	♀	♂	♀	♂	♀	
Indonesia	5	1	4	2	4		16
India	5	1	7			1	14
Nepal	1	1	5	4	1		12
Bangladesh	2	4	1	1	4		12
Thailand	3	3	1	1	3		11
Myanmar	1	1	1	2	3		8
Bhutan	2	1		1	1		5
Democratic Republic of Timor-Leste		2		1	1		4
Democratic People's Republic of Korea		1	2				3
Sri Lanka		1	1		1		3
Maldives		1					1
Grand Total	19	17	22	12	18	1	89

	2011				2012		Grand Total
	Q1	Q2	Q3	Q4	Q1	Q2	
Indonesia	5	1	4	2	4		16
India	5	1	7			1	14
Nepal	1	1	5	4	1		12
Bangladesh	2	4	1	1	4		12
Thailand	3	3	1	1	3		11
Myanmar	1	1	1	2	3		8
Bhutan	2	1		1	1		5
Democratic Republic of Timor-Leste		2		1	1		4
Democratic People's Republic of Korea		1	2				3
Sri Lanka		1	1		1		3
Maldives		1					1
Grand Total	19	17	22	12	18	1	89

The issues related to the uploading of mission reports seen from a global perspective can also be seen in the SEA Region. In 2011, only 7% of all missions resulted in a report being uploaded (Table 3).

Table 3: Mission report uploading in SEA Region

	2008	2009	2010	2011	2012
No report uploaded	45	87	80	65	19
Report uploaded	6	7	7	5	
Total missions	51	94	87	70	19
% of missions with an uploaded report	12%	7%	8%	7%	0%

In conclusion, much more needs to be done to encourage all "mission information" to be shared and especially all mission reports to be uploaded to be available to all partners.

5.4 Education and training package on TBTEAM

The TBTEAM secretariat has developed an education and training package on how to manage the TBTEAM at national and regional levels. The package consist of two modules. The goal of Module 1, education, is to educate on the mission and purpose of TBTEAM. The goal of module 2, training, is to increase capacity around utilization of TBTEAM tools. The development of the package is part of the TBTEAM strategy to develop capacity at country level.

The objectives of Module 1 are that the national TBTEAM coordinators will be able to;

- (1) describe TBTEAM and its messages;
- (2) define their role in the overall mission of TBTEAM;
- (3) define TA;
- (4) access TA through TBTEAM;
- (5) describe the importance of a country taking ownership of the TA plan development process; and
- (6) list the steps of TA plan development.

The objectives of Module 2 are that the national TBTEAM coordinators will be able to:

- (1) navigate the TBTEAM website and utilize it as a planning tool; and
- (2) update and revise a TA plan.

Both the training modules are available on the TBTEAM website: <http://www.stoptb.org/countries/tbteam/default.asp>.

6. TBTEAM regional and country plan development

This part of the workshop consisted of two group work sessions with subsequent presentations of the outcome of the group work. The first group work aimed to give countries a possibility to review their national strategic plans; review progress in 2011, assess strengths, weaknesses, gaps, issues, and challenges of their plans; and to identify the lessons learned. The second group work aimed at giving countries a possibility to, based on the presentations, discussions and previous group work during the workshop:

- Discuss and identify actions needed to strengthen the components of the national strategic plans;
- Prioritize and plan for next steps (what, when, where, by who); and
- Strengthen collaboration and coordination with partners.

In general, countries in the SEA Region are well advanced with regard to strategic planning. All countries have the core component of the strategic plan. In general the plans cover a five- year period, are linked to national health plans based on MDGs and the Stop TB Strategy and targets and have firm political commitment.

Most countries have operational plans that are in line with the national health plans and policies and consistent with the strategic core plan and the budget plan. Most of the operational plans available cover a two-year period of. However, operational plans are incomplete in some countries or available for specific components only. In some countries the operational plans do not account for inputs by all partners. In general implementation of activities are listed on a quarterly basis with timelines and identification of the source of funding. However, sub-national plans are not well linked and the HR development component not developed. The HR component also needs to be linked with the health master plan.

Most monitoring and evaluation plans are independent plans, based on the core component of the NSP. Impact, outcome, output and process indicators are in line with country core strategic plans.

The TA plan is the weakest component of the NSP in all countries. If they exist they are in general incomplete and are not regularly updated.

Following the group presentations the participants concluded with the following key issues and challenges:

- Management of human resources to ensure a competent, motivated and available workforce at all levels.
- Complex logistics management.
- Preparation of comprehensive TA plans.
- Decentralized decision-making often complicates implementation.
- Big countries have different situations requiring different strategies and approaches.
- Commitment from local government is often suboptimal and difficult to influence.

The group listed the following lessons learned:

- The NSP is a very important document and crucial to guide the programme.
- Good strategic planning takes time.
- Links with national health strategy and national development plan for long-term commitment and sustainability are essential.
- Good plans increase the possibility for donor support and sustainability.
- Involvement of all stakeholders is important, difficult and time-consuming.
- The NSP needs to be dynamic – new gaps emerge as plans are implemented.
- NSPs need to be comprehensive and complete – including monitoring and evaluation.
- Important to take cost effectiveness and operational feasibility into account.

During the second group work countries identified the next steps to update or complete their existing NSPs based on the analysis and discussions during the workshop. The conclusions are covered in the next section.

Prior to concluding the session the following information was provided to participants:

- Six months before Phase II renewal, countries that wish to ensure continued funding should discuss gaps and solutions with partners in the countries, including WHO. Strong arguments are needed to convince the panel to sustain funding.
- SEARO is organizing an urgent meeting in Colombo, 21-22 June 2012. All CCMs are invited to gear up the Region. Board member from Sri Lanka is hosting this meeting.
- SEARO is organizing another meeting on 17-18 July 2012 in the Regional Office with WRs and other WHO staff to discuss roles and responsibilities to assist countries in the Regions with GF grants.

The session ended with very positive developments from India. The Government of India (GOI) has banned the use of serological diagnostics for TB. Secondly, TB has become a notifiable disease by law; and, through an agreement with the Pharmaceutical Federation, restrictive measures for the 600 000 drug sellers are being put in place (e.g. keep copy of prescriptions, have someone with pharmacological skills in the shop, in this way they could even become a DOTS centre, etc.). These new measures by the GOI are in line with the discussions and recommendations of the SEAR Technical Working Group on Tuberculosis (TWG-TB), that held its fourth meeting on 11-13 April 2012 in New Delhi. India was encouraged to inform other countries by publishing an article on the new developments in an international journal.

7. Conclusions and recommendations

Conclusions

- (1) Countries in the WHO South-East Asia Region have made significant progress towards achieving the TB-specific targets of the MDGs. The estimated incidence of all forms of TB, estimated prevalence of all forms of TB, and the estimated TB mortality all continue to show a downward trend. The treatment success rate among new smear-positive pulmonary TB cases has remained above 85% since 2005, and was 88% in 2010.
- (2) Comprehensive national strategic plans (NSPs) in accordance with national health plans are available in India, Indonesia and Myanmar and are under development/revision in all other countries of the Region. However, technical assistance planning, implementation and monitoring as well as the use of the TBTEAM and available tools (such as TBTEAM website) is sub-optimal.
- (3) All countries in the SEA Region, except the Maldives, are benefitting from TB grants from the Global Fund making it the biggest external funding source for TB control activities in the Region.

- (4) The Governments of the United States of America (USG) and Japan as well as other bilateral donors also provide substantial funding for TB control in the Region.
- (5) In the current period of transition from the Global Fund's round-based application process to a new funding opportunity, good communication between national TB control programmes (NTPs), local fund agents (LFA), principal recipients (PRs) and WHO and the Global Fund secretariat is essential to enable timely preparations of applications for the new funding opportunity. Countries which have already prepared for the cancelled Round 11 will likely be able to use this work for applications when the new funding mechanisms are finalized.
- (6) Exchange of experiences on the preparation and implementation of comprehensive NSPs in the Region is important.

Recommendations

- (1) Member States should finalize, add missing components (or delete unnecessary ones), and update as necessary their comprehensive NSPs based on the existing TB burden and a thorough programmatic and financial gap analysis. The framework proposed during this workshop can be used for this purpose. All relevant stakeholders should be involved in the whole process.
- (2) Technical assistance planning, implementation, monitoring and evaluation should be based on country needs, should aim at local capacity building and prioritize the use of existing national and regional capacity to provide TA.
- (3) Member States should adopt and utilize the TBTEAM mechanism and use the mechanism based on the needs of the country. Timeliness of the requests for technical assistance from the Member States as well as that of the TBTEAM to provide the requested TA should be monitored.
- (4) Member States with the Global Fund TB grants entering into phase 2 renewal during the next 6-12 months, if in need of technical assistance, should seek necessary TA.

- (5) Countries planning to apply for Global Fund support in the future funding opportunity should, if not already done so, initiate gap analysis (including funding gap after recognizing contributions of domestic and external funding sources) and discussions with relevant Global Fund staff (respective Fund Portfolio Managers) and involve partners and other stakeholders from the beginning of the process. Countries will be encouraged to apply in line with their needs and are therefore encouraged to start preparing to avoid/minimize last-minute changes. However, the date of such future funding opportunity or the format for the application is not yet known.
- (6) In addition to sharing experiences during regional meetings and workshops, direct contact, including study tours, creation of virtual networks between Member States should be encouraged. WHO and other partners can facilitate such activities.

Annex 1

Welcome address by the Regional Director

*Message of Dr Samlee Plianbangchang,
Regional Director, WHO South-East Asia Region,
at the Regional Workshop on TB Control Planning, Implementation and
Monitoring, Jakarta, Indonesia, 29 - 31 May 2012
(Delivered by WHO Representative to Indonesia)*

Ladies and gentlemen,

I have great pleasure in conveying the greetings of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, and welcoming you on his behalf to this Regional Workshop on TB Control Planning, Implementation and Monitoring.

As Dr Samlee is unable to be here today, I have the honour to read out his address.

“The WHO South-East Asia (SEA) Region continues to bear more than one third of the global burden of tuberculosis, an estimated pool of nearly five million cases to which about 3.5 million are added each year. This is despite a more than 40% decrease in prevalence rates since 1990. The decrease in prevalence rates has been achieved due to a good case-notification and treatment success rate of more than 85% for the Region as a whole.

The progress in expansion and strengthening of DOTS services is quite visible from the increase in case-notification and success rates. The mortality rate among TB patients has also decreased by more than 44% for the Region although absolute mortality figures are still close to half a million.

Good performance of DOTS in the Region has also led to low levels of multidrug-resistant (MDR) -TB among newly-detected cases. However, given the large numbers of TB cases in the SEA Region, this translates to 105 000 MDR-TB cases accounting for nearly one third of the world’s total. However, many of the country-specific estimates are based on modelling.

National TB and AIDS control programmes in seven countries are jointly extending a comprehensive package of interventions for those affected by both HIV and TB. Currently, the total population having access to the comprehensive package of TB/HIV services in the Region is estimated to be 100 million.

Recognizing that TB services delivered through public health systems alone cannot reach all TB patients, national TB programmes (NTPs) in the Region began engaging with a wide range of partners starting in the early 1990s. As a result, several thousand private practitioners, 2 500 international and national NGOs, 1 500 large public and private hospitals, 500 medical colleges, the health services of defence forces, railways, state-run industries, 200 corporate houses and 900 prisons are now working with NTPs in the Region, through public-private initiatives. Where such measures are in place, the number of cases notified has increased by up to 25%, with treatment success rates of over 90%.

Ladies and gentlemen,

Central to all these efforts is the recognition that weaknesses in health systems must be addressed if we are to deliver an essential package of primary health care services. Primary health care is the best way to achieve concerted action by multiple sectors for equitable access to services, including TB services, and to reach the most vulnerable and those who find it hardest to seek care. The Practical Approach to Lung health (PAL) is a syndromic approach to the management of patients who attend primary health care services for respiratory symptoms. The PAL strategy targets multipurpose health workers, nurses, doctors and managers in primary health care settings with successful TB control programmes in low-and middle-income countries. Nepal is the first country in our Region to initiate this approach followed by India, Indonesia and Sri Lanka.

Community-based TB services are expanding and have demonstrated cost-effectiveness, higher utilization of services and better outcomes. Social support that entitles TB patients to community-based poverty alleviation schemes is beginning to address social and economic barriers to treatment access. The implications of social support programmes for TB, as a disease of poverty, are clear.

While much has indeed been achieved, national TB programmes still face several challenges. Expanding services to a population of 1.3 billion, with language and cultural diversities, and faced with poverty, rapid urbanization, and large population displacements in many countries, is a major task. At least one third of estimated cases remain unreported. These cases are of concern from the point of view of continuing disease transmission, risk of drug resistance, and higher TB mortality.

Almost all national TB control programmes have identified laboratory capacity as the major constraint to scaling up diagnosis and treatment of MDR-TB cases. Ensuring uninterrupted supplies of quality second-line drugs to treat patients with MDR-TB, especially in larger countries, is proving to be a difficult task.

Fortunately, TB control is receiving significant support, with increased funding currently available in several Member States. We acknowledge the commitment of several development and technical agencies, and national and international NGOs for the implementation of TB programmes in the Region. The Global Fund to Fight AIDS, Tuberculosis and Malaria is the single largest funding source for TB control programmes in 10 Member States. The Global Drug Facility is supporting countries through its direct procurement mechanisms.

Ladies and gentlemen,

The long-term goal is to eliminate tuberculosis as a public health problem. Given the nature of the TB epidemic, increased and sustained commitment will be needed, from all stakeholders, including national governments and national and international partners. Our continued collaboration is critical to deliver much-needed services more effectively and efficiently, to reach all population groups and to overcome the physical, social and financial barriers that prevent people from accessing care.

Ladies and gentlemen,

With increased financial resources in countries and efforts to implement all components of the Stop TB Strategy, there is both an increased demand for technical assistance and an increase in the number of TB partners available to provide support. The TB Technical Assistance

Mechanism (TBTEAM) coordinates technical assistance for tuberculosis control and engages the network of Stop TB partners including national TB programmes, local and international NGOs, financial partners, and WHO at country, regional and global levels to ensure a more coordinated and efficient approach to technical assistance . This mechanism includes building country capacity, technical assistance coordination, planning and resource mobilization and an international platform for supplying and coordinating the technical assistance required.

This workshop can play an important role in building capacity in appropriate planning, implementation and monitoring of technical assistance and harmonizing these plans at country level with all stakeholders. The process will involve reviewing the situation and achievements; exchanging experiences; identifying common challenges and actions to be taken; and discussing perspectives and plans of partner and donor agencies in an interactive manner that will allow us to prioritize required interventions and obtain agreement from partners on the support to be provided for these interventions to effectively address TB control in the SEA Region.”

In conclusion, I shall, of course, apprise the Regional Director of your deliberations and outcome which, I am sure, will be most fruitful. I also wish you a successful workshop and a pleasant stay in Jakarta.

Annex 2

Agenda

- Opening
- Progress in TB control: Global and regional overview
- Update on TBTEAM and technical assistance in implementation of the Stop TB strategy: focussing on TB laboratory diagnosis, universal access to quality diagnosis and treatment of TB, programmatic management of drug resistant TB and TB-HIV collaborative activities in the SEA Region
- Review of country and regional TBTEAM plans for technical assistance, identification of interventions and support required to address challenges and gaps and coordination of technical assistance TBTEAM and resource mobilization efforts for effective implementation
- Development of country-specific and regional plan on technical assistance by TBTEAM mechanism
- Conclusions and recommendations

Annex 3

List of participants

Bangladesh

Dr Mirza Nizam Uddin
DPM (Admn) & Focal Person
National TB Control Programme
DGHS, Dhaka
Email: mirzanizam@hotmail.com

Dr Md Nuruzzaman Haque
Deputy Director (MBDC) &
Programme Manager (TB)
National TB Control Programme
DGHS, Dhaka
Email: ntpban.pm@gmail.com

Mr Md Saidur Rahman
Senior Assistant Secretary
Ministry of Health & Family Welfare
Email: sayedsas20@yahoo.com

Bhutan

Dr Pandup Tshering
Registrar
Bhutan Medical Health Council
Thimphu
Email: pandup_tshering@yahoo.com

Mr Chewang Rinzin
Sr Programme Manager
Department of Public Health
Ministry of Health
Thimphu
Email: crinzin@health.gov.bt

DPR Korea

Dr Choe Kum Song
National TB Programme Manager
Ministry of Public Health
DPR Korea
Pyongyang

Dr Kim Hyon
Member of GF TB Programme Management
Unit (PMU)
DPR Korea
Pyongyang

Dr Kim Song Chol
Director
TB Preventive Institute
South Pyongan Province

India

Dr Ashok Kumar
DDG (TB)
Dte, GHS, MoHFW
Govt of India
Room o. 522 C, Nirman Bhawan
New Delhi - 110108
Email: ddgtb@rntcp.org

Dr Rakesh Dayal
State TB Officer
State TB Cell, JHS Building
Room No. 1 & 2 State RCH Campus
Namkum, Ranchi - 834010
Email: stojh@rntcp.org

Dr Asma Tabassum
District TB Control Officer
5th main, Ashok Nagar
Tumkur - 572103
Email: dtokatam@rntcp.org

Indonesia

Drg Dyah Erti Mustikawati
National Tuberculosis Programme Manager
Directorate of Communicable Disease Control
Ministry of Health
Republic of Indonesia
Email: dmustika_2007@yahoo.co.id

Dr Dyah Armi Riana
Section Head of Standardization
National Tuberculosis Programme
Ministry of Health
Republic of Indonesia
Email: dyaharmiriana@gmail.com

Drg Siti Nur Anisah
Focal Point for Human Resources of National
Tuberculosis Programme
Ministry of Health
Republic of Indonesia
Email: anisept_14@yahoo.com

Dr Saprina Maryani
Staff, Subdirectoate of Referral Health Service in
Speciality Hospital and other Health Facilities
Directorate of Referral Health Management
Ministry of Health
Republic of Indonesia
Email: rina_nur01@yahoo.co.id

Dr Triya Novita Dinihari
National Tuberculosis Programme
Ministry of Health
Republic of Indonesia
Email: tndinihari@yahoo.com

Dr Ratih Pahlesia
National Tuberculosis Programme
Ministry of Health
Republic of Indonesia
Email: ratihpahlesia@yahoo.com

Maldives

Ms Maimoona Aboobakru
Director
Centre for Community Health and Disease
Control
Male
Republic of Maldives
Email: maimoona@health.gov.mv

Ms Aminath Aroosha
Public Health Programme Officer
Centre for Community Health and Disease
Control
Male
Republic of Maldives
Email: aroosha.aminath@gmail.com

Myanmar

Dr Thin Thin Nwe (Ms)
Assistant Director
National TB Control Programme
Department of Health
Naypyitaw
Email: thinthinnwe.nwe@gmail.com

Dr Mar Mar Htay (Mrs)
State TB Control Officer
National TB Control Programme
Sittwe, Rakhaing State
Email: drmarmarhtay@gmail.com

Dr Khaing Sandar Aung (Ms)
Team Leader
National TB Control Programme
Patheingyi, Ayeyarwaddy Region
Email: k.sandarmay13@gmail.com

Nepal

Dr Sharat Chandra Verma
Senior Consultant, Chest Physician
National Tuberculosis Centre
Kathmandu
Email: verma.sharat@yahoo.com

Dr Rajendra Prasad Shah
Integrated Medical Officer
District Public Health Office
Lalitpur
Email: 222prakash@gmail.com

Sri Lanka

Dr D S D Samaraweera
Actg Director
National Programme for Tuberculosis and Chest
Diseases
Colombo 5.
Email: dd.nptccd@hotmail.com

Dr Thushara M Ambagahage
Medical Officer
National Programme for Tuberculosis and Chest
Diseases
Colombo 5
Email: tmambagahage@gmail.com

Thailand

Dr Chawetsan Namwat
Director, Bureau of Tuberculosis
Department of Disease Control
Ministry of Public Health
Email: chawetsan@yahoo.com

Dr Phalin Kamolwat
Medical Officer, Expert level
Office of Disease Prevention and Control
5 Nakorn Ratchasima
Department of Disease Control
Ministry of Public Health
Email: phalin1@hotmail.com

Mr Suksont Jittimane
Public Health Technical Officer, Sr Professional
Level
Bureau of Tuberculosis
Department of Disease Control
Ministry of Public Health
Email: ssthaitb@yahoo.com

Timor – Leste

Dr Constantino Lopes
NTP Manager
Ministry of Health
Timor Leste
Email: costa_tb@yahoo.com

Dr Tomas Basco
DPH Officer
Oecusse District

Technical Partners

Dr Neeraj Kak
Senior Vice President
University Research Co., LLC
Center for Human Services
7200 Wisconsin Avenue Suite 600
Bethesda, MD 20814, USA
Email: nkak@urc-chs.com

Dr. Refiloe Matji
Director
TB CARE II Project
7200 Wisconsin Ave, Suite 600
Bethesda, MD 20814. USA.
Email: RefiloeM@urc-sa.com

Dr Irene Koek
Director, Office of Health
USAID/Indonesia
Email: ikoek@usaid.gov

Mr Andreas Tamberg
Senior Fund Portfolio Manager
High Impact, Asia Team
Global Fund, Geneva
Email: Andreas.Tamberg@theglobalfund.org

Mr Kazim Hizbullah
Senior Programme Officer
High Impact, Asia Team
Global Fund
Geneva
Email: Kazim.Hizbullah@theglobalfund.org

Mr Philippe Creach
Senior Fund Portfolio Manager
South and East Asia Team
Global Fund
Geneva
Email:Philippe.Creach@theglobalfund.org

Dr. Sukumar Sarker
Senior Clinical Officer
Population, Health, and Nutrition
USAID Country Office
Dhaka, Bangladesh
Email:ssarker@usaid.gov

Dr Tara Singh Bam
Technical Officer – Tobacco Control
The UNION
Jakarta, Indonesia
Email: tsbam@theunion.org

Dr. M A Hamid Salim
Country Project Director
TB CARE I
Jakarta, Indonesia
Email: hamids@kncvtbc.nl

Dr Chawalit Natpratan
Deputy Director for Technical Support
Menara Salemba Building , 3rd Floor
Jalan Salemba Raya No.5, Jakarta Pusat,
Jakarta 10440, Indonesia
Email: cnatpratan@fhi.or.id

Dr. Bambang Hartono
Project Manager, Management & Technical
Assistance Facility
Jl. Cempaka I No. 259, Komplek Barata
Bekasi Utara 17124
Email: hartonoba@gmail.com

Dr.Haikin Rachmat
UNDP Advisor for SPER MTAF
Jl Percetakan Negara 29 Gd.B. Lt.3 R.UNDP
Jakarta Pusat
Email: haikin_rachmat@yahoo.com

Dr. Broto Wasisto
TB Expert Committee
Adhyatma Building, 5th Floor Room 501B,
Ministry of Health Republic Indonesia
Jalan H.R. Rasuna Said Blok X.5, Kav. No. 4 - 9,
Kuningan, Jakarta 12950
Email: brotowasisto@yahoo.com

Dr Carmelia Basri
C/o National Tuberculosis Programme
Ministry of Health
Republic of Indonesia
Email: carmeliabasri@yahoo.com

Dr Jan Voskens
KNCV
Jakarta, Indonesia
Email : voskensj@kncvhol.nl

Dr Andrew Marsden
Resident Drug Advisor
MSH
Jakarta, Indonesia
Email: amarsden@msh.org

WHO Secretariat

Dr Khanchit Limpakarnjanarat
WHO Representative
Jakarta, Indonesia
Email: limpakarnjanaratk@searo.who.int

Dr Malgorzata Grzemska
WHO/HQ
Geneva
Email: grzemska@who.int

Dr Karin Bergstrom
WHO/HQ
Geneva
Email: bergstromk@who.int

Ms Annemieke Brands
Technical Support Coordination
WHO/ HQ
Email: brandsa@who.int

Dr Md Khurshid Alam Hyder
Regional Advisor – TB
WHO/SEARO
New Delhi
Email: hyderk@searo.who.int

Dr Rim Kwang Il
Medical Officer – TB
WHO/SEARO
New Delhi
Email: rimkwangi@searo.who.int

Dr Md Kamar Rezwan
NPO – TB Control
Dhaka, Bangladesh
Email: rezwank@searo.who.int

Dr Vineet Bhatia
Medical Officer – TB (TIP)
Jakarta, Indonesia
Email: bhatiav@searo.who.int

Dr Sri Prihatini
National Consultant
Jakarta, Indonesia
Email: prihatinis@searo.who.int

Dr Setyawan Jati Laksono
Temporary National Professional
Jakarta, Indonesia
Email: laksonos@searo.who.int

Dr Erwin Cooreman
Medical Officer - TB
Yangon, Myanmar
Email: cooremane@searo.who.int

Dr Mukta Sharma
Technical Officer-HIV/TB programme
Bangkok, Thailand
Email: sharmamu@searo.who.int

Ms Tanushri Mitra
Secretary
WHO/SEARO
New Delhi
Email: mitrat@searo.who.int

Ms Nelsy Siahaan
Secretary
Jakarta, Indonesia
Email: siahaann@searo.who.int

Annex 3

Group presentations on national strategic plans

Group 1. India, Indonesia and Myanmar

**GROUP – 1
SESSION-2
(India, Indonesia and Myanmar)
31 MAY 2012**

Gaps/issues/challenges

- Unreached populations and incomplete access
 - Urban TB control
 - PPM
 - Migrant/ mobile population
- Weak drug regulation
 - Quality assured drugs
 - Drugs in private sector and OTC drugs
- Diagnostic capacity to cope with emerging needs
 - Culture & DST labs
 - Roll out of new tools
- Scaling up TB-HIV and PMDT
- Sustainable financing
- Human resource – quantity and quality
- TA: based on supply side/ available financing

Addressing gaps in plan

- India: Yes
 - Indonesia: Mostly yes, TA – Not completely addressed yet
 - Myanmar: Technical gaps: addressed, funding: not addressed
- Overall – Funding gaps have been identified but source of funding to bridge the gap not identified

Additional efforts

- Indonesia: develop comprehensive TA plan (supplement to current package) in coordination with MTAF support (UNDP)
 - Taking into account needs of different partners
 - Consultative process
 - Flexible for emerging needs
- India: Innovation to address gaps; bi-annual monitoring and review of district, state plan to update as necessary to reflect listed gaps

Additional efforts

Myanmar:

- Identified gaps (technical) addressed in plan
- Funding: ongoing consultation with donors (based on plan)
- TA: Need consolidation of components into the TA plan

Group 2: Bangladesh, DPR Korea, Nepal and Thailand

Group 2 Report National Strategic Plan Bangladesh, DPRK, Nepal, Thailand

1st component: the National Strategic Plan core

- Situation analysis:
 - TB burden analysis
 - Universal access
 - Magnitude of TB in the private sector (except DPRK)
 - Significant MDR-TB
 - TB control approach implemented to date
 - High case detection for smear positive
 - Good DOTS coverage
 - GO-NGO coordination
 - Lab capacity (microscopy and culture) improved

1st component: the National Strategic Plan core

- Situation analysis (continued):
 - Outcomes of the TB control approach:
 - o What has been achieved
 1. High TBR among the Treated patient
 2. MDR cases put on treatment
 3. DOTS coverage
 - What has not been achieved?
 - Inclusion of cases seen by private sector
 - Linkages between public and private sector
 - Access to culture and CBET
 - Capacity of people to manage MDR cases (access to SLDs)
 - Cases that do not interface with public system (migrants, hard to reach people, vulnerable groups/minorities, prisons)

1st component: the National Strategic Plan core

- Situation analysis (continued):
 - What are the strong elements in your NTP?
 1. Government commitment to the TB program
 2. Partnership with various stakeholders (service delivery, social support)
 3. Strong leadership of NTPs
 - What are the weak elements in your NTP?
 1. Drug supply chain management
 2. Supervision
 3. Quality assurance for labs and services
 4. M&E, use of data for decision-making, estimate of burden, policy making
 5. Skilled providers in all sectors
 6. Interface of TB program with other MOH programs (NCDs, MNCH, hospitals)

Are there any opportunities which your NTP should take advantage?

1. Engagement of other national/international partners
2. Improved TB-HIV collaboration (case finding, appropriate care and support for patients, dealing with stigma)
3. Increased donor support

Are there any social, economic or cultural factors that may have adverse effects on the efforts of your NTP?

- Stigma; funds for transportation, nutrition support; smoking; myths; gender-related barriers to access

1st component: the National Strategic Plan core

- Situation analysis (continued): Gap analysis
 - What are the gaps that need to be closed and the challenges that need to be addressed in your NTP? (please, clearly specify the most important gaps and challenges)
 - Training and TA plan
 - Reflection of contribution of other partners other than TGF
 - Good results framework - which should be then costed and supported by PSM, M&E and TA plan
 - QA and pharmacovigilance

1st component: the National Strategic Plan core

- Does your NSP have a goal (or goals)?
 - Yes
- If yes; what is(are) the definition(s) of this (or these) goal(s)?
 - Reduce TB related morbidity/mortality
- Does your NSP have strategic objective(s)? Yes
- If yes; what is(are) the definition(s) of this(or these) strategic objective(s)?
 - Achieving the MDG goals

1st component: the National Strategic Plan core

- What are the strategic interventions that are considered in your NSP?

(Please, only specify the most important strategic interventions included in your NSP)

 1. Strengthening the labs (microscopy, culture and DST)
 2. Introduction of new diagnostic tools

1st component: the National Strategic Plan core

- Among the most important strategic interventions you specified in the previous slide, identify, hereafter, one of them: Example: "TB laboratory strengthening"
- Please, specify the main activities that should be carried out to implement the strategic intervention identified above (example: "TB laboratory strengthening")
 1. Mapping of microscopy network
 2. Upgrading microscopy services (LED in high volume/high burden areas)
 3. Infrastructure improvement
 4. Introduce xPert
 5. Establish LPA and Liquid Culture
 6. Strengthen biosafety and infection control
 7. Strengthen QA/panel testing
 8. HRD – Training supervision/feedback, motivation at all levels
 9. Collaborative linkages with service delivery

2nd component: the budget plan

- Does your NSP include a budget plan?
 - Nepal, DRPK and Thailand has a well defined budget
 - Bangladesh has no detailed budget for labs in NSP
- If yes, provide the distribution of this budget by year and strategic interventions
 - Varies
- Specify the source of funding of your budget (by year)
 - Varies but could further improve on details
- Specify the funding gap inherent to your budget (by year)
 - Availability of funds for maintenance, replacement and consumables
 - Funding of new diagnostic tools and consumables

2nd component: the budget plan

- Provide, by year, the cost of each activity of the strategic intervention identified in the slide 8 (Example: "TB laboratory strengthening")
 - To be worked out

3rd component: the monitoring and evaluation plan

- Does your NSP include a monitoring and evaluation plan?
 - Yes for DRPK, Nepal and Thailand - Not for other countries
- If yes, please specify the key indicators you are using
 - Number trained: QA for sputum, number of functional lab centres
- Do you have any indicator for the strategic intervention identified in the slide 8 (Example: "TB laboratory strengthening")? If yes, specify
 - Various in different countries, details to be developed
- Is the process of data collection for the key indicators you use well specified in the monitoring and evaluation plan?
 - Need to be improved

4th component: the operational plan

- Does your NSP include an operational plan?
 - Yes, but room for improvement
- If yes, is it including all the years covered by the NSP?
- What are the details that are specified in the operational plan for the activities to be implemented in 2012 (or the first year of the plan)
- Could you provide these details for 2 or 3 key activities inherent to the strategic intervention specified in the slide 8 (Example: "TB laboratory strengthening")

5th component: the technical assistance plan

- Does your NSP include a technical assistance plan?
 - Incomplete for the lab component
- If yes, how was this plan established?
- Do you need any technical assistance for the strategic intervention identified in the slide 8 (Example: "TB laboratory strengthening")
 - Yes, will develop in the coming months with the partners
- If yes, could you provide details on this technical assistance as highlighted in your technical assistance plan?
 - Will develop while going through the detailed plan

Group 3: Bhutan, Maldives, Sri Lanka and Timor - Leste

BMST in SEAR

Regional Workshop on TB Control Planning,
Implementation and Monitoring
Jakarta, Indonesia, 29-31 May 2012

Epidemiology

- TB – a major public health problem in BMST
- NTP is implementing STOP TB Strategy since 1990s
- BMST has achieved global targets of case detection and treatment success
- there is decline in incidence, prevalence and mortality
- However....
- Vulnerable groups are not reached and therefore TB control outcomes are stagnating (migrants, prisoners, immuno compromised, children etc)

Outcomes of this TB control approach:

What has been achieved?

- 100% DOTS coverage: no shortages of FLDs, supervision, QA of labs

What has not been achieved?

- No regular supply of SLDs, PPM to strengthened, insufficient initiatives to address vulnerable populations incl. migrants

1st component: the National Strategic Plan core

strong elements in NTP

Government commitment to strengthen TB control

weak elements in NTP

So far no special efforts to reach migrants

Opportunities

Donors willing to support special efforts to reach migrants

BMST priority focus for migrants

Problems/Issues

- Large group migrating for employment from high burden countries
- Migrants come with TB and DR forms
- Many illegal and therefore do not present at public health care services
 - No proper registration system; screening difficult
 - Language/communication barrier
 - Stigma and discrimination: delay in seeking health care
 - Undernourished

1st component: the National Strategic Plan core

•Situation analysis (continued): Gap analysis

Screening and referral of migrants to DOTS centres; recording and reporting; follow up; contact investigation; collaboration and coordination with neighbouring countries on cross-border issues

1st component: the National Strategic Plan core

Goal

- To reduce the burden of TB among migrants

Strategic objective(s)

- To improve access to diagnosis and treatment among migrants

1st component: the National Strategic Plan core

Strategic interventions

- To promote TB services within the health facilities in high risk areas
- To strengthen the surveillance system
- To improve collaboration with the countries as per IHR rules

Main activities:

Promote TB services within the health facilities in high risk areas:

- Mapping of current services in high risk areas and identifying gaps and a meeting with all stakeholders (beyond health sector)
- Strengthen human resources to reach the migrants (developing skills of available staff and recruitment of additional staff)
- Strengthen facilities (additional diagnosis and treatment capacity)
- Development of IEC materials in appropriate language

2nd component: the budget plan

Migrants	NTP	Donors	Gap
2012	0	500,000 BMST RS	
2013	100,000	500,000	100,000
2014	200,000	300,000	100,000
2015	300,000	0	200,000

2nd component: the budget plan

- Provide, by year, the cost of each activity of the strategic intervention identified

Activity	2012: 500,000	2013: 700,000	2014: 600,000	2015: 500,000
Mapping	200,000			
Meeting	200,000		50,000	
Training		150,000	50,000	
Recruitment	100,000	250,000	350,000	350,000
Supervision		50,000	50,000	50,000
Supply & logistics		100,000	100,000	100,000
IEC materials		150,000		

3rd component: the monitoring and evaluation plan

- Key indicators:
- Number of DOTS centres involved
- Number of staff trained
- Number of suspects screened among migrants
- Case notification among migrants
- Treatment outcome
- Number of IEC materials developed and disseminated

4th component: the operational plan

Activity	Year 1
Mapping	Protocol and questionnaire & train people & data collection & analysis (Q1-2)
Meeting	Share experiences and agree on common approach (Q2)
Recruitment	New staff and reassignment from other areas (Q3-4)

5th component: the technical assistance plan

- TA is needed for protocol, guidelines, training materials, IEC materials

	Year 1	Budget	Source	Expert
Protocol & guidelines	Q1	10,000	Donor	From TBTEAM roster
Training materials	Q2	30,000	Donor	From TBTEAM roster
IEC materials	Q3	20,000	Donor	Local



Regional Workshop on TB Control Planning, Implementation and Monitoring
Jakarta, Indonesia 29 - 31 May 2012

Achieving TB control goals and objectives will require actions not only by and beyond TB control programs, but also by and beyond the health sector. To ensure active involvement of all stakeholders as well as other sectors beyond the TB control programs, strategic planning, implementation, monitoring and evaluation becomes increasingly important. Countries in the Region are progressing well in implementation of national strategic plans. However, with the increased complexity of many stakeholders as well as to ensure universal access to quality TB prevention, care and control, additional efforts are needed.

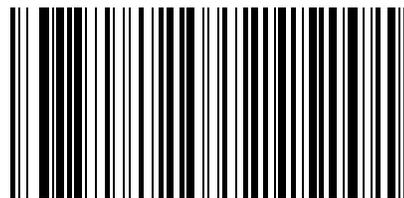
The general objective of the workshop was to strengthen country capacity to plan, implement and monitor technical assistance needs based on the revised or updated national strategic plan. The specific objectives were to update participants on latest developments in the Stop TB strategy and link to technical assistance, provide an overview of TBTEAM, and technical assistance planning, implementation and monitoring at country and regional level and review existing country and regional TBTEAM plans for technical assistance and develop/update country-specific and regional TBTEAM technical assistance.



**World Health
Organization**

Regional Office for South-East Asia

World Health House
Indraprastha Estate,
Mahatma Gandhi Marg,
New Delhi-110002, India



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