

**How the Stop TB Strategy can contribute to
Health Systems Strengthening:
Reinforcing collaboration and impact**

A discussion paper for initial discussions of the WHO Task Force on Health System Strengthening and TB Control, 19-20 January 2006

We intend for this discussion paper to facilitate discussions on challenges in health system strengthening and in TB control in low and middle-income countries, and to help orient discussions on WHO's related work programme, the work of partners, and areas for further collaborative work in TB control and within the wider health system strengthening field. The themes presented below may also be reworked, with full references to the evidence base, in preparing a paper for submission to a peer-review journal. Several sections, as noted, need further elaboration.

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We greatly appreciate comments received on an earlier draft from: Rifat Atun, Sara Bennett, Francois Boillot, Karen Cavanaugh, Rena Eichler, Gijs Elzinga, Peter Iveroth and Yelena Yorasova. Some concerns related to structure and the analytic framework could not be addressed fully in this revision but will be used to stimulate further discussion at the Task Force meeting.

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1. Introduction

WHO has proposed a new Stop TB Strategy to reach the 2015 TB-related Millennium Development Goal (MDG) # 8 and Stop TB targets, and to move towards TB elimination. It aims to enable universal access to quality TB diagnostic and treatment services, reduce suffering and socio-economic burden due to the disease, build on the successes of the DOTS strategy, face the large challenge of expanding access, address threats and opportunities not explicitly considered under DOTS, and enable rapid development of new tools in the fight against TB. This Stop TB Strategy has been endorsed by WHO's Strategic and Technical Advisory Group (STAG-TB), by the Stop TB Partnership Coordinating Board, and by the Working Groups of the Stop TB Partnership.¹ The vision, objectives, targets and specific components of the strategy are presented in the summary in Table 1.

The success and sustainability of TB control interventions, like other public health priorities, will depend on the capacity of the general health systems within which they are delivered. Therefore, the third component of the Stop TB Strategy is "contribute to health system strengthening." The Global Plan to Stop TB, 2006-2015 which will be launched in January also addresses health system strengthening as an explicit objective within the Plan, particularly in relation to the Stop TB Partnership's DOTS Expansion Working Group. Therefore, National TB Programmes and their partners must be pro-active participants in harmonized efforts to improve policy and stewardship, financing, human resources, management and other core system elements aligned within national health system and development strategies.

Programmes also should help increase sharing and adaptation of innovative approaches to improving access and quality of services.

This note aims to provide: (a) background on existing synergies across TB control and health system strengthening aims and efforts; and (b) a framework on how the Stop TB Strategy should help build stronger links with other broad health system strengthening approaches, while also reducing the potential negative externalities of intensive attention to control of major epidemics.

¹ Seven working groups: DOTS Expansion, TB-HIV, DOTS-Plus, New Drugs Development, Diagnostics, Vaccines, and Advocacy, Communications and Social Mobilization.

Table 1. The Stop TB Strategy (January 2006)

THE STOP TB STRATEGY	
VISION	A world free of TB
GOAL	To dramatically reduce the global burden of TB by 2015 in line with the Millennium Development Goals and the Stop TB Partnership targets
OBJECTIVES	<ul style="list-style-type: none"> • Achieve universal access to high-quality diagnosis and patient-centred treatment • Reduce the human suffering and socioeconomic burden associated with TB • Protect poor and vulnerable populations from TB, TB/HIV and multidrug-resistant TB • Support development of new tools and enable their timely and effective use
TARGETS	<ul style="list-style-type: none"> • MDG 6, Target 8: Halt and begin to reverse the incidence of TB by 2015 • Targets linked to the MDGs and endorsed by the Stop TB Partnership: <ul style="list-style-type: none"> – by 2005: detect at least 70% of new sputum smear-positive TB cases and cure at least 85% of these cases – by 2015: reduce TB prevalence and death rates by 50% relative to 1990 – by 2050: eliminate TB as a public health problem (1 case per million population)
COMPONENTS OF THE STRATEGY & IMPLEMENTATION APPROACHES	
<ol style="list-style-type: none"> 1. Pursue high-quality DOTS expansion and enhancement <ol style="list-style-type: none"> a. Political commitment with increased and sustained financing b. Case detection through quality-assured bacteriology c. Standardized treatment with supervision and patient support d. An effective drug supply and management system e. Monitoring and evaluation system, and impact measurement 2. Address TB/HIV, MDR-TB and other challenges <ul style="list-style-type: none"> – Implement collaborative TB/HIV activities – Prevent and control multidrug-resistant TB – Address prisoners, refugees and other high-risk groups and special situations 3. Contribute to health system strengthening <ul style="list-style-type: none"> – Actively participate in efforts to improve system-wide policy, human resources, financing, management, service delivery, and information systems – Share innovations that strengthen systems, including the Practical Approach to Lung Health (PAL) – Adapt innovations from other fields 4. Engage all care providers <ul style="list-style-type: none"> – Public-Public, and Public-Private Mix (PPM) approaches – International Standards for Tuberculosis Care (ISTC) 5. Empower people with TB, and communities <ul style="list-style-type: none"> – Advocacy, communication and social mobilization – Community participation in TB care – Patients' Charter for Tuberculosis Care 6. Enable and promote research <ul style="list-style-type: none"> – Programme-based operational research – Research to develop new diagnostics, drugs and vaccines 	

2. Background

This is not the first time that the fundamental importance of viewing and advancing TB programmes within larger health systems has been recognized. TB control integration within primary health care was a major consideration for WHO and Member States in the 1980s. Former approaches to TB care with hospitalization in TB-dedicated institutions were supplanted in much of the world by ambulatory services and shorter-course treatment, enabling TB care to be integrated into general primary care.

2.1. Launching and measuring cost-effective DOTS efforts within established programs and health systems

DOTS programs to combat TB began to scale up in earnest from the mid-1990s. The DOTS approach was built on primary care TB treatment experiences in several settings including India, the US, Chile and most importantly the IUATLD-assisted programmes in Tanzania, Malawi, Mozambique and Nicaragua. The Chilean and IUATLD supported programmes were large-scale national programmes that provided solid data for the measurement of the high cost-effectiveness ratio of the approach now known as DOTS. One of the groundbreaking works in the 1990s to highlight the urgent need for health system strengthening across the developing world was the World Bank's World Development Report 1993: Investing in Health. In that report, data from the cost-effectiveness analyses enabled TB treatment to be noted as among the most highly cost-effective interventions available.

In addition, important data from a World Bank-financed project in China were also already available at that time to demonstrate how quickly TB results could change with the adoption of this TB approach. DOTS was built on this evidence of the critical role of national commitment to a programme, smear microscopy for diagnosis, free treatment for infectious patients, a regular system of drug supply and standardized reporting and recording systems that enabled routine and regular documentation of results of all patients treated. Documentation of the size of the TB epidemic, the cost-effective response available, together with disturbing re-emergence of TB in the US and Europe stimulated major new investments for TB control response. The situation in the US was associated with the breakdown of public health structures, HIV/AIDS, a heavy burden among foreign-born individuals, and the emergence of multidrug-resistant TB.

2.2. Scaling up DOTS within reforming health systems - perils and promise

Also emerging in the 1990s were important efforts to reform failing health systems with laudable objectives including increasing effective delivery of cost-effective health interventions, efficient management, and equitable access and responsiveness of health systems. These were reflected in policies and processes, such as decentralization, integration, privatization, and sector wide approaches to planning, resource mobilization and allocation. Unfortunately, some rapid reform experiences led to severe crises for public health functions and public health programs, such as immunization, reproductive health and TB control in countries such as Bangladesh,

Zambia, Brazil etc. This was reflected in several areas, including a loss of management staff at central and intermediary levels, devolution of financing responsibilities but no concurrent increase in local revenue generation. This frequently resulted in reduced capacity in core functions such as training, quality control and supervision, and reduced funds for key inputs such as drugs and reagents and transport logistics required to ensure safety and quality. The challenge was severe for TB programs that had just begun to adopt the DOTS strategy and needed to not just help maintain capacity, but build it.

These reforms spurred analysis and policy guidance on how to protect public health safety, and ensure effectiveness and sustainability of disease prevention and control under reform processes. WHO produced a guide on *Expanding DOTS in the context of a changing health system (WHO/CDS/TB/2003.318)* that built on some national-level analysis of the impact of reform on TB control and role of NTPs in some reform programmes. The guide sought to highlight ways to build synergies, rather than barriers, across disease control and broader systems reforms. It addressed the major health system reform objectives and then looked across core functions of health systems (e.g., strategic planning; normative functions; financing; human resource capacity; drug supply; service delivery; monitoring and evaluation; IEC, social mobilization and advocacy; and operational research). These are roughly equivalent to the health systems building blocks described in the next section. Under each of these approaches, the guidelines suggested what were key health sector reform issues related to that function and then noted how the functions are likely affected under several reform processes: decentralization, integration, increasing role of private sector and NGOs, and how TB control programs and partners could position their work under these policy and management changes. Examples were provided of active engagement of National TB Programs in reform processes, monitoring and evaluation of processes, problem-solving and system innovations. This paper draws heavily on such experiences and the 2003 guide should still prove useful in discussions with partners on TB control and health system strengthening.

2.3. Joint global efforts to support national action

The Stop TB Partnership was established in response to the successes in some countries in TB control scale-up in the 1990s, as well as in response to slow global progress and daunting challenges. Over-arching efforts to respond to general health systems challenges, to harmonize development aid, and to advance global public goods, underpinned objectives of the Partnership - such as coordinating donor and technical assistance to support national strategic plans for DOTS expansion, stimulating research, mobilizing resources for all facets of TB control, devising mechanisms to make drug procurement more reliable and cost-efficient, and sharing surveillance and evaluation methods and results. Later some of these concerns were mirrored in the HIV/AIDS community's call for the "Three Ones" (one national plan, one coordinating body, and one M&E system).

2.4. Health system bottlenecks and the urgency of improving health outcomes equitably

In the last five years, it has been widely recognized (eg, in the World Health Report 2000, in the WHO Commission on Macroeconomics and Health (CMH), in the Millennium Development Goals (MDGs), in Poverty Reduction Strategies, and the World Bank's World Development Report 2004 on Getting Services to the Poor), that health goals would only be advanced if there were dramatic increases in global investment in poverty reduction, debt relief, health systems and human development. Efficiency-focused actions and decentralization alone could be deleterious without increased financial resources dedicated to health systems and to social protection. Fundamental to such work was also recognition that health reforms in the 1990s focussed predominantly on processes rather than measurable health outcomes for which health services, authorities and donors could be held accountable. Along with new financing, fundamental strengthening of good governance, public health stewardship, institutional management and incentives systems were recognized as ongoing concerns in countries as diverse as Russia, Pakistan, Nigeria, Bolivia and Cameroon.

2.5. New disease-specific initiatives

Given global concern over worsening killer diseases and missed opportunities in using or developing the best available tools, The Global Fund to Fight AIDS, TB and Malaria and the Global Alliance for Vaccines and Immunization (GAVI) were established, as were public-private partnerships for development of new tools. These, along with other forms of increased bilateral, multilateral and foundation support have led to a sea-change in the resources available for HIV/AIDS, malaria, TB and immunizable childhood killers. While bringing very welcome new resources and political attention to urgently needed public health interventions, some of these global financing mechanisms impose substantial new burdens on applicants and recipients. There is substantial concern that these advances are having unintended negative effects, principally given human resources required to manage, use and report on these funds, national fiscal space issues, and risks of creating parallel logistics structures without concurrent improvement of existing systems. There has not been a similar growth in resources for primary care, health system infrastructure in general, and some other priority public health concerns worldwide (eg, reproductive health and child health beyond vaccines). Furthermore, there is fear that advances made in building a stronger balance of vertical support systems and horizontal service delivery approaches may be at risk in some countries.

Over the last few years, some case studies were attempted in East/Southern Africa as well as in Nepal and in East Asia to document how/when effective National TB Programmes were especially well-integrated within national health systems and reinforced these system objectives and processes. Other analyses have attempted looking at any deleterious effects of investments in selected disease control efforts vs. comprehensive systems reform. Unfortunately, none of these have been published and most had difficulty with methods through which to attribute health system gains and/or losses to programmatic inputs and actions. This is not to say that there are not

associations or causal links, but that more policy analysis design and impact measurement is needed to document where and when they exist.

2.6. Regaining a balance to advance both systems and specific health outcomes

The 2nd ad hoc Committee on the TB Epidemic and the U.N. Millennium Project's working group report on TB control both recognized the critical importance of increased and capable human resources and stronger health systems, particularly at primary care level, to achieve progress against TB. They also noted the benefits to health system of the public health strategy and service innovations offered by TB. These are now also reflected in the new Stop TB Strategy and the Global Plan to Stop TB, 2006-2015.

2004-2005 saw a dramatic increase in governments' demands for health system strengthening support as well as in global inter-agency collaboration in this area. There appear to be substantial new opportunities for constructive joint action to strengthen systems, including scale up of priority public health interventions, to meet fast approaching targets for improved health outcomes.

2.7 The Stop TB Department's Health System Strengthening and TB Control Task Force

In order to optimize the contribution to health systems strengthening globally by WHO's Stop TB Department, by national TB programmes and partners, STAG-TB recommended that the Stop TB Department establish a time-limited Task Force on Health Systems Strengthening and TB Control.

This task force should:

- define STB's role vis-à-vis priority areas of work in health system strengthening
- further engage in health system strengthening efforts and partnerships
- expand the adoption and impact of TB control innovations that strengthen health systems
- increase the impact of health systems innovations on TB control
- increase communications on these areas of work, remaining gaps and opportunities and means for engagement of more TB control partners

The following sections propose a structure for looking at potential areas of interaction across health system strengthening and the Stop TB Strategy and some lessons learnt to date on the interface of innovations and interventions within TB control and the broader health system context.

The note also seeks to dispel perceptions that public health practitioners and/or supporters are divided into two camps - those that apply a disease control or public health programme "lens" and those that use a broader health systems "lens." in the way they work and seek to overcome obstacles. It is the premise of this paper that there are many stakeholders that integrate these perspectives in their work. They promote objectives such as decentralization to create local ownership and accountability as well and further integration of services to enhance efficiency and patient-centred care. However, they also recognize that how you pursue these aims

effectively are critical questions. Tuberculosis control is a good field to demonstrate this required balance, with its global relevance, its required engagement of all spheres of the health system in ensuring safe and effective care, and the need for a sustained response to achieve disease elimination targets.

3. New actions to advance health systems strengthening

Most developing countries are struggling or are off-track in their progress towards the health-related Millennium Development Goals. There are a number of ways to look at the challenges, but they are generally seen to include:

- Going to scale - safe, proven and cheap interventions are not reaching those in need
- Distribution - those with unmet needs are disproportionately those with lesser means
- Protection /safety - too many are worse off through encounters with the health system

To alleviate poor results and to achieve the MDGs, there is widespread recognition that coordinated action is needed to strengthen systems as a whole, as well as address remaining challenges in framing and applying specific health interventions. What is meant by health system strengthening is described in Box 1.

Box 1: What is health system strengthening?

Building on WHO's definition of the goals and core functions that all health systems should perform regardless of how they are organized, health system strengthening is defined as building capacity in critical components of health systems to achieve more **equitable and sustained improvements across health services and health outcomes**. It includes the following dimensions:

- **Policy:** defining sector strategies, clarifying roles and managing competing demands
- **Financing:** ensuring fair and sustainable financing
- **Human resources:** creating a sufficient and productive workforce
- **Supply systems:** ensuring supply, maintenance, proper use of drugs, equipment
- **Service management:** improving organization, management and quality of services
- **Information and monitoring systems**

Building capacities may involve actions at **one or more levels**, from households to national and global level. It may involve changes in **skills** and knowledge; in key **support systems**, or in institutions, **structures and policies**. It almost always involves many different actors. Creating a strong sense of in-country ownership is a key element of capacity building.

Source: EIP background brief for GAVI and Montreux meeting documentation

For the purposes of this paper, a conceptual framework is proposed in Figure 1 which shows the relationship of health system elements of government policy, planning and financing; resources, structures and systems needed for effective service delivery; service providers and outcomes. The main purpose of this framework is to identify health systems components, which may be affected by TB control planning, implementation and monitoring on local, national and global level (see table 2 in next section).

The framework does not incorporate the larger frame of the biological, socio-economic and political determinants of health nor the household dynamics that contribute to health- and help-seeking behaviours. These must inform the design of financing, stewardship, inputs and service delivery approaches. The framework does not attempt to show the incentive dynamics needed among clients, government stewardship and providers as suggested in the World Bank's World Development Report 2004. However, these are absolutely critical and inform the TB control intervention approaches presented in the next pages.

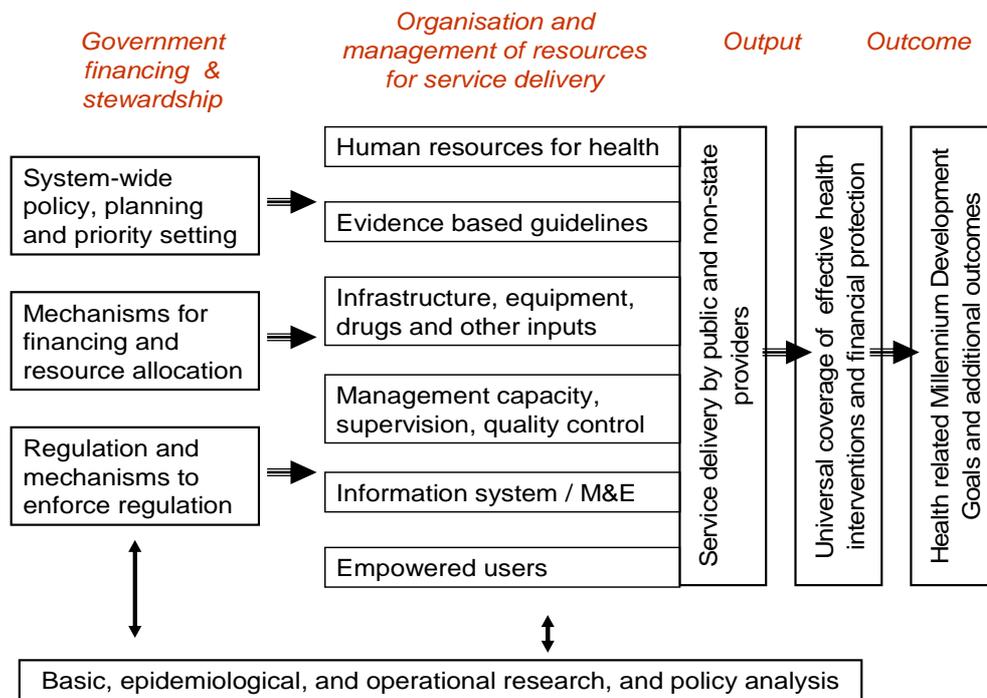


Figure 1. Framework on components in health system strengthening

4. Areas where the Stop TB Strategy can contribute to HSS

Contributions, complementary action and collaboration can be pursued on four levels:

1. National TB programme policy design and management can contribute to overall national public health policy and stewardship functions (section 4.1.)
2. Provincial and district TB programme implementation can strengthen local health systems and service delivery (section 4.2.)
3. TB control innovations can be adapted and inform development of generic tools and strategies in HSS on global (section 4.3.)
4. Linkages across initiatives in health system strengthening, global TB control, and other global health initiatives (section 4.4.)

The potential contributions by different Stop TB Strategy elements to HSS at national and local level are summarized in **Table 2. Annex 1** provides a table (adapted from the DOTS Expansion Strategic Plan 2006-2015), which presents the benefits that TB systems and innovation can offer the overall system as well as the potential benefits of health system strengthening to TB control. **Annex 2** provides a summary table on some of the predominantly global health system strengthening initiatives and how TB partners are, or could, contribute.

Potential contribution by the different elements of the Stop TB Strategy to overall HSS is conditioned upon the way which Stop TB Partners and NTPs pursue various activities. Efforts focused on strengthening the health system's capacity to deliver high quality TB diagnosis and treatment - such as focused interventions to strengthen human resources for TB control, improve laboratory capacity for sputum smear microscopy, or improve anti-TB drug management - need to consider the opportunity cost of strengthening alternative components of the health system as well as possible additional transactional costs of targeting particular health systems elements in isolation from general HSS activities. Sections 4.1.- 4.3 outlines the potential contributions to HSS by different Stop TB Strategy elements. It also identifies the basic requirements for these elements to have general HSS effects, rather than isolated effects on the health system's ability to deliver quality TB care. In order to further highlight the conditionality of positive general HSS impact of TB control efforts, Annex 3 provides a summary "Do and Don't" matrix. This matrix may be further developed into a simple HSS check list for Stop TB Partners and NTPs, when planning, implementing and monitoring TB control efforts.

Table 2. Stop TB Strategy components' contribution (see sections 4.1. to 4.3. below for explanation)

	National level Stop TB Strategy contributes to <i>national level HSS</i>	Local level NTP implementation contributes to <i>local health systems</i>	Stop TB health systems innovations contribute to <i>HSS globally</i>					
			Expanding and enhancing DOTS	Responses to special challenges: TB/HIV and DOTS Plus	Public-Private Mix DOTS	Practical Approach to Lung health	Community DOTS	Global Drug Facility
Government financing and stewardship								
Policy, planning and priority setting	X		X	X	X	X	X	X
Regulation and enforcement	X		X		X			X
Financing mechanisms and resource allocation			X			X		
Organisation and management of resources for service delivery								
Human resources for health	X	X	X	X	X	X	X	
Evidence based guidelines	X		X	X		X		
Infrastructure, equipment, drugs and other inputs	X	X	X	X				X
Management capacity, supervision, quality control	X	X	X	X	X	X	X	X
Health information system / M&E	X	X	X	X	X	X	X	
Empowered users			X				X	

4.1. Contributing to HSS at national level

The following section outlines how national-level Stop TB strategy development and implementation can contribute to the following components of health systems strengthening on national level (see column 2 of Table 2).

Government policy, planning, priority setting and financing:

Many of the greatest challenges in health system strengthening are beyond the influence areas of individual priority public health programmes. They relate to fiscal space issues for expanding resources in the health sector, building development planning and budgetary frameworks that prioritize poverty reduction and human development objectives, civil service structures and reforms and government-wide decentralization policies. In these fields, NTPs and partners can add value most likely through documenting the public health impacts of failure to improve systems, financing, and HRH frameworks etc. They can also pro-actively engage with the partners, including donor agencies, that have influence in some of these arenas, and can actively promote new sector-wide planning and policies that aim to enhance capacity to reach the MDGs. The Do's and Don't's Table (Table 3) provides guidance on engagement.

Through experiences of rigorous TB programme planning, central managers and policy makers can improve their capacity to prioritize and plan health care delivery based on clear objectives, evidence-based guidelines, measurable indicators and routinely collected health information. A range of global guidelines are available for adaptation and use at country level, related directly to DOTS implementation and new

strategies as well as addressing the links between TB and poverty in reaching and serving patients.

Conditions for such processes to strengthen the health system include:

1. Maximising use of common sector-wide planning frameworks, MTEFs, poverty reduction strategies and opportunities for sharing best practices in building core public health functions, effective financing schemes and service delivery strategies
2. Minimising parallel administration, reporting and monitoring systems for external funding
3. Devising common responses to challenges and opportunities associated with civil service reform, decentralization and civil society engagement and accountability.

Designing and enforcing regulations: A Stop TB national strategy can contribute to a stronger platform for designing and enforcing health care regulations: (1) Through establishing a broad partnership with stakeholders in the public and private sector that can help facilitate implementation of policy and legislation (e.g. on case reporting requirements, free care and use of drugs); (2) Through developing routines to disseminate and enforce clear quality standards (such as the International Standards for TB Care); and (3) Through improving capacity for advocacy and communication towards health providers and consumers.

Human resources: National Tuberculosis Control programmes (NTPs) are a critical part of a well balanced approach to health workforce development . NTPs can support the political and technical actions needed for a more substantial and balanced response to health workforce development. Using a systematic approach based on job descriptions to: (a) clearly determine HR needs (competence and staffing) for comprehensive TB control; (b) develop long term strategic plans and (c) medium term implementation plans to enable greater alignment with national policies and systems helps develop routines for improved general human resource development.

Conditions for such processes to strengthen the health system include:

1. Recognizing that TB control interventions are delivered by the same – often limited – group of health workers and facilities that deliver other health interventions
2. Using a systematic approach based on job descriptions to: (a) clearly determine HR needs (competence and staffing) for comprehensive TB control; (b) develop long term strategic plans and (c) medium term implementation plans to enable greater alignment with general human resource development.
3. Collaborating and coordinating with other specific disease programmes, with other departments and services in the MOH as well as other units and services in the provincial/district health services to ensure synergy and consistency with overall local health sector plans and capacity-building frameworks
4. Avoid developing programme specific solutions to speed up implementation of TB interventions without considering implications for other programmes, e.g. intervention specific incentives, or increasing number of emergency or longer-term staff
5. Avoid developing single solutions, such as in the job training, or training large numbers of staff without considering educational quality and without considering other HRD needs, e.g. basic training curricula

6. Avoid developing implementation plans for HRD without being realistic about the time needed for many changes in HRD structures to bear fruit

Evidence based guidelines: Through applying the Stop TB Strategy and related clinical and managerial guidelines, which have been widely endorsed by technical agencies worldwide, policy makers and central managers gain experience in how to adapt and apply Evidenced Based Medicine and Evidence Based Public Health Approaches in practice.

Equipments and drugs: Improved capacity for laboratory services for TB, including national reference laboratories and systems for lab quality assurance (ref on lab QA), provides examples for QA in general. Standardized drug management routines for TB, help improve general drug procurement management systems, capacity for drug quality assurance and systems to facilitate rational use of drugs.

Conditions for such processes to strengthen the health system include:

1. Avoiding that parallel systems developed to face urgent supply gaps, supplant or weaken general systems
2. Promoting financing for capacity-building and restructuring of basic logistical and quality control systems for all essential drugs and inputs.

Management capacity, supervision, and quality control: Through working with standardized (but locally adapted) approaches to TB programme management, the general capacity for management of health workforce, programme implementation, supervision, drug supplies, quality control on national level improves among central managers.

Conditions for such processes to strengthen the health system include:

1. Improving harmonization/coordination of external technical assistance for TB with other technical assistance
2. Ensuring that accountability for TB service delivery by all partners is to the Ministry of Health and to clients.
3. Integrate and harmonise management and supervision structures with general health systems managerial structures, including mechanisms for working with the non-state sector
4. Join efforts to build competencies that are common to all managers
5. Harmonise quality standards with general health system quality standards

Health information systems, M&E: Through implementation of standardized TB recording and reporting systems, national capacity for record keeping, referrals and reporting routines, and central data management and analysis can be improved.

Conditions for such processes to strengthen the health system include:

1. Ensuring that the recording and reporting system is harmonized with national health information systems

4.2. Contributing to HSS at local level

The following section outlines how local TB programme implementation can contribute to several components of health systems strengthening, noted in Table 2, on local level.

Human resources: Through coordinated, competency-based TB-specific training for provincial and district-level managers, clinical and managerial competence in the existing health work force can improve and general systematic approaches can be applied to the implementation of other health interventions.. This includes abilities to use a systematic approach to case management, training and supervision, logistics management, monitoring and evaluation and quality assurance schemes.

Conditions for such processes and activities to strengthen the health system include:

1. Recognition that TB control interventions are delivered by the same – often limited – group of health workers and facilities that deliver other health interventions
2. Close collaboration with other specific disease control programmes in "training, retaining and sustaining" the workforces to ensure a concerted action and minimize disruption in service delivery
3. Collaboration and coordination with other units and services in the provincial/district health services to ensure synergy and consistency with overall local health sector plans

Operations support: infrastructure, lab networks, equipment and drugs: Laboratory capacity for sputum smear microscopy, culture services, drug susceptibility testing as well as for new diagnostics under development. (this needs to be written out further - Diana to attempt on Wednesday....with KL and MA input)

Local management capacity, supervision, and quality control: Through working with a standardized approach to TB programme management and supervision, local managers (district medical officers etc.) gain improved general capacity for management of health workforce, programme implementation, supervision, drug supplies, quality control, etc.

Health information systems, M&E: Through implementation of standardized routine TB recording and reporting systems, local capacity for general recording keeping, referrals and reporting routines can improve, especially where TB information tools are within the overall package of national health information systems and inform other systems, such as new systems being developed for HIV/AIDS treatment and follow-up and other chronic care conditions.

4.3. Innovations in TB control that can contribute to HSS objectives

Below are some areas where innovations in TB control are relevant to larger health system strengthening components and processes at national and local levels. Each section looks at potential synergies, and as noted above, all need further monitoring and documentation of these linkages and impacts.

4.3.1 Expanding and enhancing DOTS

The Stop TB Strategy is an enhanced strategy building on the five core elements of DOTS. These elements have been "modernized" and modified in keeping with lessons learnt and new challenges to increase access, and new components reflecting additional needs and innovations are being added.

- **Political commitment** remains a cornerstone of DOTS but with reinforced emphasis now on the need for increased and sustained financing of national control programs and partnerships, as necessary to meet the MDGs and continue on towards TB elimination. Commitment to TB should be expressed through common development planning and budgeting frameworks.
- **Timely TB case detection through quality-assured bacteriology** is critical and now emphasis is given to all patients, not only smear-positive patients, in keeping with the changing patient profile, particularly in high HIV-settings and to increase equity in access to care and alleviation of suffering and costs to patients and families. With the focus on bacteriology, there is increased urgency to strengthen general laboratory networks for TB and other diseases.
- **Standardized treatment with supervision and patient support:** the emphasis is now enhanced on patient-centred care, full adaptation of DOT and patient support systems to enable adherence to cure and response to the varied needs of patients during treatment. This aligns well with larger health and human rights approaches, access and equity objectives in health service delivery and health promotion. It also relates to broader agendas to improve case management in HIV/AIDS and other chronic disease conditions, and builds on strengths of the DOTS approach and innovations over the last decade in implementation.
- **An effective drug supply and management system:** ongoing emphasis is given to the critical role of effective drug supply, and recognition is provided on the need to support overall strengthening of supply networks for essential drugs, from forecasting, procurement and financing, to quality assurance, storage, delivery and rational use.
- **Monitoring and evaluation system, and impact measurement:** Ongoing enhancements to routine M/E systems, information flow, integration in general health information systems, are supplemented by a focus on measuring epidemiological impact of TB control interventions. This requires substantial increases in competencies at country level and use of broader platforms for population-based or service-based surveys and coordination of partners with skills in this area.

4.3.2 Addressing TB/HIV and MDR-TB and other special challenges

Government planning, policy, priority setting and financing:

Collaborative planning and integrated implementation of TB and AIDS programme activities can promote more effective resource utilisation, information exchange and has potential to improve working conditions between different government bodies working on health policy development at all levels. It can provide focused approaches to programmatic collaboration and integrated service delivery models to reach special populations at risk for tuberculosis, eg. prisons, refugee support systems,

ethnic minorities and other vulnerable groups due to social or economic circumstances etc. Furthermore, it can forge partnership and ensure coordinated engagement of civil society organisations in the planning, implementation, monitoring and evaluation of activities.

Evidence based guidelines:

Implementation of TB/HIV collaborative activities as well as DOTS Plus programmes using available evidence based guidelines requires substantial human resources development and technical capacity among various health staff. Please refer to earlier discussion on human resource development

Equipments and drugs:

Implementation of DOTS Plus requires improved laboratory capacity for culture and drug susceptibility testing. This can strengthen general lab capacity, provided that the upgraded labs are part of the general primary health care network. Similarly, involvement of private laboratories in Quality Assurance schemes for culture and DST improves the quality of private lab services as well as the public sector capacity to oversee private lab functions. DOTS Plus programmes make quality assured 2nd line TB drugs available and foster their rational use. This can positively influence routines for procurement, prescription and dispensing of other essential drugs. Close collaboration between the TB and HIV control programmes contributes towards coordinated approach to ensure sufficient equipment and drug supply. Effective referral system between the two programmes and the general health system will ensure effective utilization of equipment and drugs.

Management capacity, supervision, and quality control:

Both TB/HIV and DOTS Plus programmes require sufficient management and supervision capacity, which can benefit general health system managerial capacity. The conditions for such processes to strengthen the health system are the same as listed under 4.1. above.

Health information systems, M&E:

Improved and integrated referral, recording and reporting benefits general health information systems.

4.3.2 Engaging all providers: lessons from Public-Private Mix DOTS (PPM DOTS)

Policies, planning and priority setting: Lessons from TB programme implementation based on mapping of state and non-state health providers for TB, can be used to improve tools for planning general health service delivery that requires utilization of the full range of available public and private health facilities. Furthermore, evidence-based policies and guidelines based on new International Standards for TB Care can provide a template to facilitate quality improvement among private sector providers.

Conditions for such processes to strengthen the health system include:

1. Ensuring that the stewardship function remain with Ministry of Health and that major financing and financial steering possibilities are not diverted to non-state sector providers.
2. Ensuring sufficient funds for supervision and quality control of non-state sector health services provision

Regulation and enforcement: Working with non-state health providers for TB control can help establish channels, routines and acceptance for surveillance and monitoring of these otherwise often hard-to-reach providers.

Financing: Building on PPM DOTS approaches, mechanism for public funding of private health provision as well as mechanisms for harnessing voluntary contributions from non-state providers, such as voluntary provision of time, facilities and equipment can be adapted for other health interventions.

Human resources Available tools and strategies for PPM DOTS can be adapted to help improve the general ability among non-state health sector work force to carry out public health related functions and thus optimally utilise the health work force in the non-state sector. Development of appropriate incentives for private providers can be informed by experiences of involving private health care providers in TB control which have used various non-financial incentives. The PPM experiences to link delivery of well defines and quality control TB services by private providers to social health insurance schemes, can serve as a basis to explore similar modalities for other health interventions.

Management capacity, supervision and quality control: Experiences from PPM DOTS on how to approach, involve, supervise and monitor a wide range of private health providers in public health initiatives can be used to inform strategies on how to improve management of the non-state sector in general.

Health information systems, M&E: Health provider mapping approaches developed as part of PPM DOTS can be adapted for improvements of general provider mapping systems. Using PPM DOTS experiences of how to improve referral routines and information exchange between public and private providers can help improve general health information systems and include private providers in disease surveillance.

4.3.3. Practical Approach to Lung Health (PAL) - extending TB care to respiratory care
Policy, planning and priority setting: Standardized and integrated management of respiratory illnesses, including TB, can help define the appropriate intervention in the national health policy for the first leading cause of demand of care in PHC setting. Evidence to date suggests that PAL is likely to improve resource planning as well as the efficiency of the utilization of the resources (drugs, HR, tests etc.) available within district health system.

Financing mechanisms and resource allocation: Given its characteristics of standardization of respiratory care and coordination among the various components of health care provision system in PHC, the implementation of PAL can contribute to improving and strengthening the resource allocation mechanisms within the health systems.

Human resources: PAL implementation can increase the competency of PHC workers through the application of standardized and evidence-based health care procedures. Also, the role of each health professional category in respiratory care provision is well defined by health care level.

Evidence-based guidelines: The implementation of PAL requires the adaptation and development of guidelines. These guidelines include evidence-based procedures to improve respiratory care and refer to well-established health intervention strategies such as DOTS, GINA for asthma or GOLD for chronic obstructive pulmonary diseases.

Infrastructure, equipment and drugs: The development of PAL needs to clearly specify the equipment and drugs necessary to ensure respiratory care services, as defined in PAL guidelines, at each level of the district health system.

Management capacity, supervision and quality control: PAL enlarges the spectrum of management capacity and increases the integration of health care provisions in PHC. It also increases the scope of supervision and quality control for TB control services, PHC services and general health services

Health information system, M&E: PAL promotes the utilization the existing health management information system as well as the recording and reporting system defined in DOTS strategy. It also promotes the information on respiratory patients referred for TB screening and on chronic respiratory cases within the district health system.

4.3.4 Pursuing Community DOTS

Policies, planning and priority setting: Experience shows that decentralizing provision of TB care beyond health facilities and into the community improves access to TB care (especially in rural districts) and guarantees significant gains in terms of access, equity, cost-effectiveness, and acceptability. Planning general health service delivery with civil society contribution will result in better delivery of those services, due to a shared responsibility for health through mobilized non-medical sector. National guidelines to implement and scale-up community TB care (CTBC) have been used to shape the approach to other health interventions and, likewise, community mobilization achieved with CTBC has been the platform for provision of additional services.

Human resources for health: Practical tools to help implementation are being developed in order to ensure quality contribution to care from the partner outside of the health sector, i.e. the community: training manuals for health staff need to be adapted, and information tools for community and treatment supporters need developing. Different approaches to building and sustaining motivation of community participation have been one of the common problems in implementation/scale-up; financial incentives may point towards a mere decentralization of services and not towards building a partnership with the civil society. The approach to establish community participation (and build the motivation that sustains it) is different from a plain decentralization process within the health services. It is important to explore existing systems involved in public health action, especially in HIV, and build on them in order to ensure sustainability.

Management capacity and quality of care: patients' ability, thanks to community support, to better cope with a disease which disrupts personal and family life is fundamental to personal health and can never be replaced by professional and/or government intervention. In fact, the more an individual can do personally and with

her/his community, the less health services will have to do by way of health management. If adequately supervised, the community can enhance the quality of personal care and reduce the workload of medical services.

Health information systems, M&E: District health services that have scaled-up CTBC have not only improved completeness of data, providing information about treatment outcome of every patient, but have strengthened health promotion messages at community level, improving case detection. Community surveillance of priority health problems has already been widely used (e.g. among others: early warning systems for nutritional status, polio eradication, dracunculiasis eradication).

Empowered users: By including TB in the essential package of PHC interventions, community members are increasingly empowered (through education) to assume greater responsibility for their health and are encouraged to participate in initiatives relevant for the quality of life of their families and communities.

Community participation contributes to affirming the right to health care, implied in the right to preserve one's life. This involvement is based on respect for the person and contributes to the provision of services that mirrors that respect. Community participation also facilitates the distribution of these services in an equitable manner to every member of the society.

4.3.5. Improving drug procurement and drug management: lessons from GDF and partners and future steps needed (To be completed based on the PPM-DOTS model)

- Reducing burdens for functions that can be efficiently supported at global level (economies of scale, prequalification functions of suppliers, information sharing, standardization of product presentations to meet diverse needs)
- Redirecting cost savings to other service delivery elements
- Supplying or facilitating support for general procurement and supply management improvements and integration of functions when foundations exist to do so

4.4. Complementary action at global and regional level

Partners committed to stopping TB, within and beyond National TB Programmes, can work closely with a range of other ongoing and very new efforts, including those listed below. Annex 2 summarizes the current and potential future contribution by Stop TB Partners to these initiatives.

The Stop TB Partnership: represents over 400 governments and partner agencies and institutions today. While some of the agencies are TB-specific in focus, the vast majority engage in a wider array of public health and development action in single countries or across countries. By using the internal networks of these agencies further (moving beyond the "TB specific" focal points to engage multiple teams), the Partnership can be an important lever for advancing health systems action. Its planning, resource mobilization and advocacy efforts are already integrating health system strengthening messages and proposals. Several of the Stop TB Working Groups are already involving "health systems" generalist experts and others beyond the "TB community". As noted above, the Stop TB Partnership has applied the principles now embodied in the AIDS community under the "Three Ones."

Furthermore, the Partnership has committed to adapt and apply Best Practice Principles for Global Health Partnerships²

WHO: The Stop TB Department is collaborating with several departments with the Evidence and Information for Policy (EIP) cluster on health system strengthening products (see annex 2 under development), including HSS technical framework working groups, and on a WHO institution-wide health system strengthening strategy. Collaboration is also increasing with other priority public health departments as well as those addressing pharmaceuticals on common system challenges and technical assistance needs. There is collaboration across the institution and with others in looking at inputs to achieve universal coverage/universal access to care objectives. WHO also hosting the Health Metrics Network, and the Global Health Workforce Alliance, both with health system strengthening objectives and range of partners. WHO is addressing particular attention to increasing country and regional capacity to support coherent planning and technical support on health systems.

The World Bank - anchor and regions: In the health anchor group as well as among health specialists in the Bank's regions and country offices, there are numerous collaborative efforts looking at reaching the MDGs, health system financing innovations, human resources, PRSP/PRSC and budgetary support approaches, contracting models etc, and relevance to public health priority interventions and outcomes. Potential and ongoing collaboration across sectors on common issues related to civil service reform, fiscal space concerns, decentralization and management capacity, and Medium-Term Expenditure Frameworks and budgetary support.

Bilateral agencies and foundations - A majority of the top funders in global health today are supportive of increasing funding streams for health system strengthening, as well as continuing increases in disease control support. Regional and country priorities also reflect attention to weaker and fragile states needing support. New aims in harmonization and alignment of financing streams and funding strategies and mechanisms are promoted, but ongoing domestic reporting requirements and political priorities remain challenges.

GFATM - Recently adopted (in Round 5) health system strengthening grant component that is now under review but overall commitment to contribute to health system strengthening continues as do efforts to minimize deleterious effects of GFATM proposal and implementation processes.

GAVI - Ongoing work on financial sustainability plans for governments for investment in immunizations which can provide a model for other public health fields, and new mandate to directly invest in health system strengthening.

NGOs, consulting firms and academic partners - There is an increasing number of technical NGOs and experts engaged in TB control as well as other public health program support and common system strengthening. Management consulting firms

² Developed for the High-Level Forum on the MDGs in 2005, modified and adapted from the Paris Principles on Aid Effectiveness. They relate to national ownership, alignment with national policies and plans, harmonization of support, accountability for results, good governance etc.

are also increasing engaged in looking at systems management and public health programs in developing countries and further sharing of best practice and coordination would be beneficial.

Activists and civil society partners - Many partners are broadening their commitment to advocacy, support and social mobilization across multiple public health fields, rather than single issue agendas in the past. An increasing number is also strongly advocating for investment in system that can make the difference in meeting very ambitious access and treatment targets.

4.5. Adapting innovations from other fields to enhance effectiveness, collaboration, integration or common platforms for HSS

To respond to all six elements of the Stop TB Strategy, TB programmes and their partners can adapt approaches that have been applied in other priority public health fields, and build further on some of the common systems that are already in place. This may include further integration of TB control activities within the community and primary care outreach pursued in maternal and child health programmes, social mobilization along the lines used by HIV/AIDS programmes, regulatory actions that have been used in tobacco control, financing initiatives and means to reach the poorest that have been developed by immunization services. It may also include establishing links with household-based surveys to further inform TB surveillance and programme monitoring. Effective integration of delivery systems depends on testing, adapting, scaling up and evaluating common approaches.

5. Potential opportunities and gaps for TF discussion

The following themes will be addressed in the meeting, especially through the breakout sessions. Other issues may also be prioritized for further consideration by the Task Force. Special focus will be given to identifying opportunities and gaps for action in the coming two years:

A. Aligning the STB/WHO work plan with HSS priorities and opportunities, and this includes also collaboration with WHO regional counterparts, Stop TB Partnership Working Groups and partners. There are many areas where STB/WHO is already engaged and these will be reviewed with reference to scope, nature of engagement and orientation and products expected.

B. Collaborating in HSS initiatives on national, regional and global levels. STB/WHO, regional offices and TB control partners are playing a role in some initiatives already and could engage in additional efforts or expand their involvement in some. There is need to brainstorm on prioritization of such engagement and likely outcomes.

C. Documenting experiences, conducting operational research, and evaluations. There are a range of opportunities and gaps in this area, particularly with regard to collaboration with governments, partner agencies, universities, and financing partners.

Annex 1 Synergies between health systems strengthening and tuberculosis control

Work Area	Effect of health system strengthening on TB control	Effect of strengthening TB control on Health System
Programme planning and management	Availability of skilled managers and management routines for effective planning and management of a National TB Programme and primary care services	Transfer of managerial skills for strengthening general health policy planning and management
Health financing	Sufficient equitable financing of TB control implementation which enables TB control implementation while breaking the disease-poverty circle for patients. Financial steering mechanisms for aligning different health providers to TB control policy.	Working examples of introducing public financing of private health care provision, while harnessing private sector resources and reducing health care related costs to patients. Documented experiences of working with different types of incentives
Human resources	Availability of qualified and motivated staff for TB control coordination and implementation on all levels, together with other priorities	Improved technical and managerial skill among health staff for public health programme implementation
Laboratory Network	Capacity to undertake quality-assured sputum microscopy for all TB suspects and cases and increasing resources to enable effective expansion of culture and drug susceptibility capacity	Further strengthening of quality assured laboratory network for general health services and key disease control programmes
Drug Supply and Logistics	Timely procurement and uninterrupted supply of quality-assured anti-TB drugs at different levels of health services delivery through integrated systems	Systems, skilled work force and shared space for general drug supply planning, procurement and logistics management
Treatment supervision and patient support	Capacity to enable patients to continue treatment to cure, through measures to enhance access, supervision and support	Increased capacity of frontline workers and pool of community members who can be shared for managing a set of essential health tasks, including chronic care, outreach etc.
Improved referral system	Established basic channels for guiding TB suspects and patients in the health system and transferring relevant data	Refined strategies and tools for feasible and sustainable referral routines between different providers
Recording and reporting systems	Health information and infectious disease surveillance system provides infrastructure for TB programme recording and reporting	Practical experience of standardized monitoring of public health programme implementation, quality of care, outputs and outcomes
Harnessing available public, NGO and private resources for health	Policy, regulation, incentives and enforcement mechanisms for implementation of international standards of TB care across all government services as well as private sector providers	Experiences of pragmatic ways to involve a wide range of private and public health care providers in a public health oriented programme
Involvement of communities and civil society	Increased awareness and utilization of health services among people with symptoms of TB	Practical examples of ways to involve community volunteers, consumer organizations, national coalitions, and establishment of a pool of such partners for public health interventions
National and local partnerships for health	Network of partners and routines for collaboration available for TB control implementation	Pragmatic examples how to establish local and national partnerships
Improving performance through application of programme based problem-solving operational research	Capacity to analyse constraints to deliver quality TB care and address them through programme-based, problem-solving operational research	Potential to understand and health systems related constraints and address them

Annex 2 - Global Initiatives in Health System Strengthening and role for STB and partners (to be added)

Annex 3: What to do and not to do to ensure that national TB programme policy, planning and implementation contributes to general health systems strengthening.

	Do!	Don't!
Governance: Planning, policy, priority setting, financing	<ul style="list-style-type: none"> • Maximize alignment and integration of programme planning into common sector-wide planning frameworks and poverty reduction strategies • Align budgets and programme-specific financial flows within Medium-term Expenditure Frameworks and resource allocation tools and discourage parallel systems proposed by donors • Work collaboratively and integrate responses to challenges and opportunities associated with civil service reform, decentralization and civil society engagement. • Ensure adequate information on costs; programmatic spending; resource gaps; effects of spending on vulnerable and pursue policies that reduce out of pocket spending • Seek common public health policy platforms on which to promote programmatic policies and strategies 	<ul style="list-style-type: none"> • Develop national strategy and implementation plans in isolation from overall health systems planning • Cause additional transaction costs through, for example, unsynchronised planning • Create parallel administration, reporting and monitoring systems for different sources of external funding
Human Resources	<ul style="list-style-type: none"> • Recognize that TB control interventions are delivered by the same – often limited – group of health workers and facilities that deliver other health interventions • Use a systematic approach based on job descriptions to: (a) clearly determine HR needs (competence and staffing) for comprehensive TB control; (b) develop long term strategic plans and (c) medium term implementation plans to enable greater alignment with general human resource development. • Collaborate and coordinate with other specific disease programmes, with other departments and services in the MOH as well as other units and services in the provincial/district health services to ensure synergy and consistency with overall local health sector plans and capacity-building frameworks 	<ul style="list-style-type: none"> • Develop programme specific solutions to speed up implementation of TB interventions without considering implications for other programmes, e.g. intervention specific incentives, or increasing number of emergency or longer-term staff • Develop single solutions, such as in the job training, or training large numbers of staff without considering educational quality and without considering other HRD needs, e.g. basic training curricula • Develop implementation plans for HRD without being realistic about the time needed for many changes in HRD structures to bear fruit

	Do!	Don't!
Operations: infrastructure, drug & equipment supply	<ul style="list-style-type: none"> • Develop national procurement, distribution and stock management systems which are integrated with general supply systems and promote safe and efficient supply • If urgent temporary systems are required to ensure safe and timely delivery, ensure they are planned with central authorities and that support is provided to supplant them by integrated systems as quickly as possible • Engage in general efforts to improve national procurement/distribution systems • Promote financing for capacity-building and restructuring of basic logistics and quality control systems for all essential drugs and inputs. • Where stand-alone TB services remain in some countries, work to integrate hospitalization and ambulatory services 	<ul style="list-style-type: none"> • Develop parallel systems which supplant or weaken general systems
Management capacity, supervision, quality control	<ul style="list-style-type: none"> • Integrate and harmonise management and supervision structures with general health systems managerial structures, including mechanisms for working with the non-state sector • Join efforts to build competencies that are common to all managers • Harmonise quality standards with general health system quality standards • Ensuring that accountability for TB service delivery by all partners is to the Ministry of Health. 	<ul style="list-style-type: none"> • Plan and implement supervision and quality control in isolation from general health service supervision and quality control • Create incentives structures that distort priority-setting and/or performance in other areas of work among managers and supervisors
Health information, monitoring and evaluation	<ul style="list-style-type: none"> • Align monitoring requirements with overall health monitoring master plans in the country and work with donors to consolidate reporting demands • Ensure that the recording and reporting system is harmonised with national health information systems • Seek common platforms for any service- or population-based surveys 	<ul style="list-style-type: none"> • Create new indicators without careful consideration about overlap and inconsistency with general health systems performance indicators • Demand unnecessary process indicators or special reports on performance beyond routine reporting requirements
Empowered users	<ul style="list-style-type: none"> • Empower patients and communities to demand quality services across health problems and to positively influence and rationally use the whole health system • Integrate communications, education and social mobilization actions into larger platforms for public health promotion and/or combine efforts with any pre-existing effective campaigns or approaches(eg immunization, HIV/AIDS etc.) as well as known community leaders, CHW systems etc. 	<ul style="list-style-type: none"> • Focus on TB only when devising communication campaigns and mobilizing communities
External technical support	<ul style="list-style-type: none"> • Through dialogue with technical agencies, coordinate and harmonise all external technical assistance for TB • Through dialogue with relevant national and international health partners, coordinate external technical assistance for TB with other technical assistance 	<ul style="list-style-type: none"> • Accept the creation of additional and separate monitoring systems for similar activities, supported by different technical agencies

