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DEWG *focus*

QUARTERLY NEWSLETTER OF THE DOTS EXPANSION WORKING GROUP (DEWG) OF THE STOP TB PARTNERSHIP

An OVERVIEW

DOTS Expansion Working Group

The Stop TB Partnership established the DOTS Expansion Working Group (DEWG) to address the major challenges facing control of tuberculosis (TB). This working group represents an inter-institutional arrangement between the World Health Organization (WHO), major financial and technical partners, national TB control programmes (NTPs), the Global Drug Facility (GDF), and community representatives to expand access to TB diagnosis and treatment in line with the Millennium Development Goals and the Stop TB Partnership targets.

Since its inception in 2000, the DEWG has established a core team, a secretariat and five subgroups. Each subgroup focuses on specific elements of DOTS expansion and enhancement: public-private mix (PPM), childhood TB, poverty, advocacy, communication and

social mobilization (ACSM) and retooling. In addition to expanding and enhancing DOTS, the DEWG contributes to implementing other components and sub-components of the Stop TB Strategy.

Members of the working group include NTP managers from 22 countries with a high-burden of TB. Among its achievements, the DEWG has helped in developing detailed plans for DOTS implementation at the country level as well as monitoring and evaluating progress; fostering coordination among partners; supporting technical and financial agencies in their efforts to control TB; and mobilizing resources for DOTS expansion. The main pillars of its activities have been enhancing DOTS activities in countries, preparing national plans to control TB and forging national TB partnerships.



EVENT WATCH

The tenth annual meeting of the DOTS Expansion Working Group will be held on 13-14 October 2009 in Geneva, Switzerland. The focus of this year's meeting is increasing case detection. The meeting will serve as a platform to share a range of new interventions and approaches in TB control among NTP managers, PPM focal points in the NTP, and major Stop TB partners, and discuss ways to accelerate progress in TB control, in particular case detection.

DEWG Subgroups

The five branches of the DOTS Expansion Working Group

PPM Subgroup

WHO established the PPM initiative in 1995 to develop effective mechanisms and approaches for involving and linking relevant public and private health-care providers in the delivery of TB care and control services. The global Subgroup on Public-Private Mix for TB Care and Control (the PPM Subgroup) builds on this work in order to address the issue urgently and effectively.

Public-private mix implies public sector driven engagement of all health care providers -- private, voluntary, corporate -- for the purpose of TB care and control. The objectives of the PPM subgroup are: to promote systematic engagement of all relevant health-care providers to improve access, equity and quality in TB care; to develop evidence-based strategies related to PPM, to coordinate development of generic tools and materials to facilitate PPM implementation; to assist regions and countries in planning and implementation of PPM interventions; to coordinate provision of technical assistance for PPM planning and implementation; to promote the use of PPM as a comprehensive approach for strengthening of health services and to monitor global progress in expansion of PPM for TB care and control.

Childhood TB Subgroup

Decreasing the burden of TB in children demands urgent and effective action. However, the management of childhood TB is not systematically included as part of the routine operations of many NTPs. Improved care and prevention of TB among children depend on: (i) intensified efforts to ensure implementation of national guidelines on managing TB in children; (ii) mobilization of human resources; (iii) ongoing policy development; and (iv) research.

At the request of key partners, the DEWG approved the establishment of a subgroup to focus on childhood TB in October 2003.

The objective of the Childhood TB Subgroup is to promote research, policy development, the formulation and implementation of guidelines, the mobilization of human and financial resources, and collaboration among partners working in relevant fields (including maternal and child health, the Expanded Programme on Immunization and HIV) to achieve the goal of decreased mortality and morbidity from childhood TB.

ACSM Subgroup

The Experts' Consultation on Communication and Social Mobilization (held in Cancun, Mexico, in June 2003) and the Stop TB Task Force on Advocacy and Communication (Johannesburg, September 2003) strongly recommended that a formal entity be established within the Stop TB Partnership to facilitate the development, implementation and evaluation of TB advocacy and communication interventions under the Global Plan to Stop TB. An external evaluation of the Stop TB Partnership conducted in mid-2003 similarly recommended that serious consideration be given to establishing such a body to better support the needs of the Stop TB movement. In response to these recommendations, the Stop TB Coordinating Board authorized the creation of an advocacy and communication subgroup in March 2004, previously part of the (now disbanded) ACSM Working Group. In October 2008, the Stop TB Coordinating Board recommended that this subgroup be moved into the DEWG, to enhance its work in countries and strengthen support for strategic implementation of component 5 of the Stop TB Strategy.

With more than 100 country-level partners, the ACSM Subgroup provides guidance and support for country-level ACSM. Key areas of work include strengthening ACSM capacities of NTPs and other country-level partners, and facilitating the formation of national partnerships to generate greater civil society support for TB control.

TB and Poverty Subgroup

The subgroup on TB and poverty was created in response to the launch of the Network Secretariat for Action on TB and Poverty at the UNION Conference in 2004 and was officially endorsed as a DEWG subgroup in 2005. This subgroup brings together a network of individuals and organizations committed to ensuring that the specific needs of poor and vulnerable populations are addressed in the delivery of TB diagnostic and treatment services.

The objectives of the TB and poverty subgroup are: to provide a forum for discussion and an opportunity for sharing knowledge and experience among members; to promote and publish best practices in the field of TB and poverty; to represent and promote the poverty focus in the work of the Stop TB Partnership through active participation in DEWG and other relevant Stop TB Partnership working groups; to represent TB poverty concerns in international fora on poverty alleviation; to establish links with other health initiatives related to poverty; and to provide technical assistance to NTP managers, in collaboration with the WHO Stop TB Department, to address the needs of poor people as an integral part of TB control.

Retooling Subgroup

Considerable momentum has been building in recent years towards the development of new drugs, diagnostic tools and vaccines to facilitate the control of TB. While the promise of these new tools is encouraging, they must be utilized rapidly in programmes for public health benefits to be realized. Based on the experience of control of other communicable diseases and the recognition that considerable delays occur between new tools becoming available and their use at the country level, the Stop TB Partnership Board established a subgroup on Retooling in 2009 as a means of addressing this challenge across the working groups. The objective of the Retooling subgroup is to ensure that countries receive relevant and timely information and support >>

MESSAGE: DEWG Chair

Dr Jeremiah Chakaya



Important progress has been made in implementing and expanding DOTS. The working group has contributed to improvements in the care of TB patients in countries and has supported monitoring and evaluation by enhancing DOTS globally, by aligning and supporting country activities. Bringing together NTP managers from high-TB-burden countries and international partners has facilitated the adoption and implementation of DOTS by all 22 high-burden countries, and fostered a sense of commitment and accountability in countries. The DEWG is seen as a key driver of DOTS expansion because it has engendered commitment and ownership among NTP managers and members of working groups. Significantly, it has played a leading role in the creation, endorsement and promotion of the Global DOTS Expansion Plan in 2001, which has been adopted by all countries with a high-burden of TB. The DEWG also assists countries in efforts to improve access to, and effectively implement high-quality TB diagnosis and treatment for all, particularly poor and vulnerable populations. This group regularly holds annual meetings for NTP managers that provide an opportunity to monitor progress, share experiences and stimulate action where necessary. In addition, the DEWG fosters linkages with other working groups of the Partnership to ensure a cohesive and comprehensive response to TB care and control.

This newsletter is intended to showcase the efforts of the DEWG and facilitate the sharing of information, experiences and ideas on how to ensure equitable access to high-quality DOTS services for all people with TB.

>> to enable the rapid introduction of new tools, policies and approaches.

Early case detection

Rationale and Scope

Significant efforts by NTPs, WHO and partners, through the implementation of the Stop TB Strategy have helped slow down the TB epidemic. The global TB incidence has stabilized and is in slow decline. WHO estimates that rates of TB prevalence and deaths have declined from 296 prevalent cases per 100 000 population in 1990 to 210 in 2007, and from 29 deaths per 100 000 population in 1990 to 26 in 2007. Despite this progress, TB remains a formidable adversary and grows more lethal with the emergence of drug-resistant TB and its deadly combination with HIV. In 2007, there were an estimated 9.27 million incident cases of TB. Also of major concern is the stagnation in rates of TB case detection globally over the past two years.¹ Although the target for treatment success has been achieved globally, the global case detection target (>70% of estimated incidence of new smear-positive cases), set first for 2000 and then postponed to 2005, has not yet been reached. Early detection and diagnosis of individuals with active TB are essential to control the spread of this epidemic, and it will be necessary to go well beyond the 70% case detection rate in order to achieve sufficient epidemiological impact and to reach all those in need of TB cure.

From an equity perspective as well as a TB control perspective, it is essential to ensure that the poorest and most vulnerable groups have access to high-quality diagnosis and treatment. These populations are most likely to contract infection, develop disease, have poor treatment outcomes, and experience severe social and economic consequences of the disease. If TB is not effectively diagnosed and treated among vulnerable groups, it can perpetuate the epidemic and put the whole population at continuous risk of TB. Specific action is therefore required to ensure equity in access to high-quality diagnostic and treatment services. Targeted interventions to reach such groups may be necessary.

A major challenge for global TB control is therefore to resume the

acceleration seen in the early 2000s of case detection trends for all types of TB, while putting in place strategies that ensure equitable access to early diagnosis and initiation of effective treatment for all TB patients.

An analytical framework for early case detection

There are several possible reasons for low case detection rates and delayed initiation of treatment interventions, including poor understanding of TB and its symptoms in the general population; insufficient knowledge about where to seek care; weak health service infrastructures; barriers to access; poor diagnostic quality; limited human resources for health; lack of TB knowledge among health-care providers; and perverse incentive systems for providers that foster the use of

influencing health-seeking behaviours. A solid analysis of the existing case detection situation is required to devise locally-appropriate strategies and prioritize among possible options. The figure below presents a framework for analysis and identification of relevant entry points for improved early TB case detection.

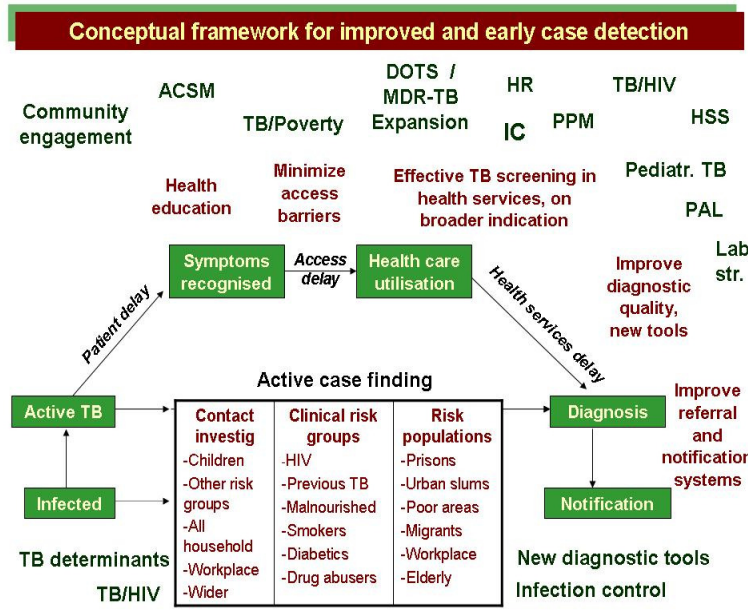
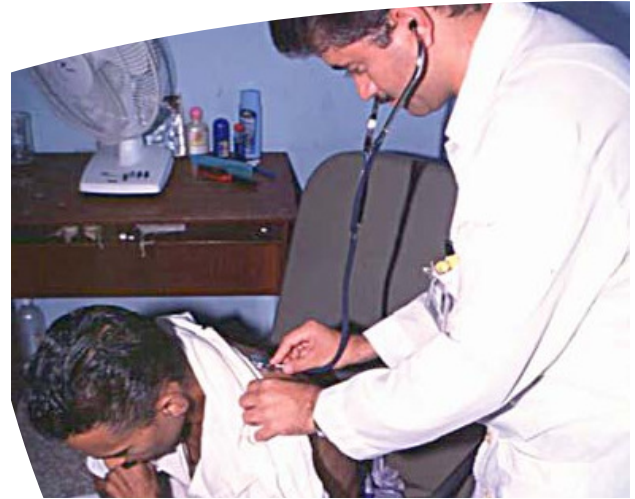
The upper part of the figure depicts the pathway to diagnosis and

waits for patients with TB symptoms to present at these facilities. However, the term may be misleading since this pathway requires a very active and alert health system with the capacity to identify people who should undergo TB screening when they present at health-care facilities.

The lower part depicts the pathway for "active case-finding", implying actions to screen high-risk groups who do not seek actively seek health care because of their TB symptoms. Contact investigation is the first logical extension beyond the passive case-finding approach. Active screening may also include routine screening of high-risk populations or clinical risk groups, but more research is needed on the effectiveness and cost-effectiveness of such approaches before they can be broadly recommended.

Appropriate strategies for improved early case detection will depend on the status and nature of the TB epidemic, the performance of the NTP, the capacity of the general health system, and the health-seeking behaviours of people with TB symptoms. A careful assessment of the situation with regards to these parameters is therefore required to prepare for local action. The framework in the figure may help to identify bottlenecks along the pathways to diagnosis, notification and initiation of treatment. Based on findings from such an assessment of current gaps in, and barriers to, case detection, various intervention entry points should be developed, considered and prioritized, depending on the country settings.

A detailed chapter on early case detection, is currently under development, for the forthcoming book - Tuberculosis: The Essential.



unnecessary medical technologies, and drug treatments that delay the correct diagnosis and waste resources. Efforts to improve early case detection therefore need to focus on both the demand and supply side. Main avenues to improve early case detection include improving the quality, outreach and access to diagnostic facilities (including new diagnostic tools) across the whole health system; improving mechanisms for referral and notification of cases already diagnosed with TB but who are managed outside the NTP; and

treatment based on active care-seeking by patients. The steps include recognition of symptoms by the individual (or caregiver), active health-seeking behaviours, diagnosis in a health-care facility, referral to the appropriate place of treatment, and/or notification of diagnosis and treatment. This pathway represents what is often called "passive case detection". It is the main approach applied by most NTPs in high TB burden countries. "Passive" implies that the NTP does not actively search for cases outside NTP-affiliated facilities but



Engaging professional associations in TB care and control

DEWG Annual Meeting 2008

In several countries, professional associations are a powerful ally of NTPs, exerting a broad sphere of influence among health-care providers and acting as a potential conduit through which private clinicians may be reached in a systematic way. Mobilization of professional associations in NTPs could facilitate in speeding up the process of linking of private practitioners with NTPs.

On 15 October 2008, on the occasion of the annual conference of the International Union Against Tuberculosis and Lung Disease, the DEWG, led by WHO and the American Thoracic Society, organized a meeting to sensitize and mobilize leaders of health professional associations for active collaboration in TB control. This is the first time a global effort has been undertaken to promote

collaboration between professional associations and NTPs. This effort builds on the PPM initiatives in

place in many countries and the International Standards for Tuberculosis Care as a useful advocacy and technical tool.

The meeting was well attended by around 170 participants including NTP managers, national PPM focal persons and representatives of national professional associations; patient and community representatives; representatives of technical, academic, corporate and donor partners; and WHO staff from regions and countries. The presentations included country experiences from the NTPs of Cambodia, Kenya and Mexico as well as those from professional associations in India and Indonesia.

The group work discussion topics included the types and current contributions of professional associations to TB control efforts; the potential roles of professional

associations in controlling TB; the ways in which professional associations could be strengthened to contribute to TB control; the support NTPs could provide to strengthen the efforts of professional associations; the role of professional associations in promoting the Patients' Charter for Tuberculosis Care and their potential engagement in rationalizing the use of anti-TB drugs. At the end of the group work session, a call for proposals was made for funding available to support professional associations in developing workplans for collaboration with NTPs. The meeting concluded with positive sentiments on all sides, with professional associations and NTPs expressing their strong support and willingness to work together in tackling the TB epidemic.

Professional associations and NTPs from the 22 high TB burden countries are currently developing joint workplans to facilitate collaboration in national TB control efforts.

FROM THE DEWG SECRETARIAT

Dr Léopold Blanc



Globally, TB case detection and treatment outcomes have improved substantially in the past decade. Still, much work remains to be done, within national TB programmes, and beyond. Early and effective diagnosis and treatment at low cost are essential for the well-being of individuals with active TB. Unfortunately, this is not guaranteed for all people with TB today. Poor access to quality services, diagnostic delays, complex and expensive care seeking paths, and inappropriate treatments produce poor health outcomes, and adverse social and financial consequences for TB patients, their families, and the wider community. In addition, early case detection and high treatment success rates are also essential for reaching epidemiological impact targets for TB control. High coverage of effective treatment can quickly reduce TB prevalence and death rates. Although, cure rates have approached the global goal, case-finding is still very low in many countries, and considerably below the rate needed to achieve the related MDGs. There is need therefore, to refocus and reinvestigate efforts to improve early case detection and ensure that all people with TB have access to quality diagnosis and treatment.

I would like to take this opportunity to encourage all of you to contribute and share your experiences through this newsletter.

CONTACT US:

We look forward to receiving your experiences, feedback and comments.

You can reach us at

dewg@who.int

TBTEAM

What is TBTEAM?

Created by the Stop TB Partners in 2007, TBTEAM (the TB Technical Assistance Mechanism) builds on the previously established Interagency Coordinating Committees, Stop TB Partnerships or otherwise named TB partner coordination bodies to help all stakeholders that implement TB control activities (e.g. NTPs, NGOs, patients groups, etc.) gain access to a network of technical partners and well-coordinated technical assistance (TA).

What can it do?

TBTEAM facilitates information-sharing among TA providers and recipients, filling TA funding gaps and encouraging TA planning through annual planning meetings.

TBTEAM Tools

TBTEAM offers an online Tool to make it easier for partners to deliver and receive quality assistance. This website, which is publicly accessible, helps partners to track missions and training



opportunities around the world, provides a roster of available experts, and contains a directory of the most active technical partners in each country of the world. Countries may apply for TA through standard WHO

channels, by submitting requests to country offices, or through TBTEAM focal points.

Achievements

Since its inception, 1272 missions and events have been entered into the Tool, with a significant increase in 2009 to date (nearly 50% increase). The annual number of missions entered in the first two quarters of 2009 (425) has nearly surpassed the number entered in all of 2008 (457). Of 113 requests for assistance ("open requests") made directly to TBTEAM, 102 (90%) have been successfully addressed. TBTEAM also facilitated TA for preparation of Global Fund Round 9 proposals through several regional workshops as well as in-country support.