PLAN OF ACTION 2008-09

DOTS EXPANSION WORKING GROUP

DEWG action plan for 2008-09

Introduction

According to the 2007 Global TB control report, the treatment success rate in the 2004 DOTS cohort was 84% on average, just below the 85% goal and TB cases notified under DOTS programmes in 2005 represented 60% of estimated new smear-positive TB cases. This document lays out the activities and the costs, that the partners of the DOTS Expansion Working Group (DEWG) of the Stop TB Partnership plan to conduct in 2008 and 2009. It includes both the technical assistance to countries and operations of the WG and its subgroups.

The DEWG Strategic Plan[1] is the main pillar of the second Global Plan to Stop TB (2006-2015). The DEWG aims to assist countries in improving access to quality DOTS. This serves as a foundation for the implementation of the Stop TB Strategy including activities of the TB/HIV and the MDR-TB Working Groups. Implementation of the DEWG Strategic Plan also includes operational research for effective implementation of the new tools that are expected to become available through the efforts of the Working Groups on new diagnostics, new drugs and new vaccines.

This plan has the endorsement of the DEWG core group and forms the basis to operationalize the DOTS Expansion component of the Global Plan to Stop TB 2006-2015.

The two main objectives of the DEWG action plan are:

Outcome objective 1: To achieve and sustain performance beyond the "70/85" targets.

Outcome objective 2: To further advance towards universal access to quality TB care for all people with TB, adults and children especially the poor and vulnerable, in line with the STOP TB strategy and the Second Global Plan to Stop TB (2006-2015).

The overall need for countries to implement and improve quality of DOTS and expand activities of laboratory, involvement of all health care providers (PPM), health system strengthening (HSS), Practical Approach to Lung health (PAL), Human resources Development for TB control (HRD), monitoring and evaluation and operational research amount to 3 billion in 2008 and 3.15 billion in 2009. The estimated gap for High Burden Countries (HBC) alone was estimated at 250 million in 2007.

The total estimated needs for technical support to countries and related activities by the WG partners amount to US$ 65 million per year (without funding needs for laboratory). The amount received by different partners for DOTS Expansion activities is estimated at USD$30 million in 2007, the funding gap is about US$ 35 million.

Cost of operations of the WG and the four sub-groups are estimated in US$ 2,2 million, with a funding gap of USD$1,6 million.

[1] DEWG strategic plan 2006-2015: WHO/HTM/TB/2006.370

Main activity areas for DOTS Expansion in 2008-2009

The combination and mode of implementation of activities will be tailored to address specific local challenges. Detailed country planning in line with the Global Plan to Stop TB, local targets and implementation will be tailored to country situation in order to address barriers and exploit opportunities. Implementation of the activities will have to be coupled with operational research and careful monitoring in order to fine-tune approaches before scaling up. DEWG has identified five main priorities in different areas:

1. Strengthening quality of DOTS implementation.

2. Laboratory strengthening to expand quality assured microscopy, culture and drugs susceptibility testing (DST).

3. Human resources and in particular human resource development (HRD) plan including mapping of existing resources from different health care providers and a focus on the services to the poor.

4. Linking existing health care providers to NTP including promotion of international standard for TB care (ISTC).

5. Monitoring and evaluation including impact measurement.

Strengthening of laboratory capacity

Laboratory capacity strengthening will be key to all components and implementation approaches outlined in this action plan. Specifically, laboratory capacity strengthening will address the following:

- DOTS expansion and enhancement through optimized and quality assured sputum smear microscopy;
- Accelerated access to culture and drug susceptibility testing to help address TB/HIV and MDR-TB;
- Engaging all care providers through broad-based partnerships and novel models of integration (e.g. private laboratory services);
- Increased involvement of patient and community constituencies in laboratory advocacy initiatives through education and information;
- Enable and promote research through increased utilization of the supranational reference laboratory (SRL) network in programme-based operational research and basic research on new diagnostics.

Resource mobilization and coordination of laboratory activities will be essential in mounting an effective global response, which should be underpinned by solid technical guidance and targeted training initiatives. To effect this challenges and address the demands of the global response, a strategic plan for laboratory capacity strengthening is under final preparation, outlining strategies, gaps and resource needs.

Highlights of expected outcomes of this plan (See Annex 1 for details)

2008:

- 67 countries achieve at least 85% success rate (2007 cohort) and at least 4 more high burden countries HBC achieve 70/85 targets.
- Laboratory (to be defined in laboratory strategic plan).
- TB programmes in 15 HBC have an HRD plan for TB control based on guidelines for HRD.
- PPM started in 20 HBCs and scaled up in 6 additional HBC; ISTC promoted in all HBC.
- 3 HBC will conduct prevalence survey and 5 HBC/RPC (regional priority countries) will perform special studies to measure impact (the task force on impact measurement may change the targets after its meeting in December 2007).

2009:

- 75 countries achieve at least 85% success rate (2008 cohort) and at least 3 more HBC achieve 70/85 targets.
- Laboratory (to be defined in laboratory strategic plan).
- TB programmes in 18 HBCs and 10 RPCs have an HRD plan for TB based on guidelines for HRD.
- PPM scaled up in 8 additional HBC, and initiation in all relevant RPCs, ISTC promoted in RPCs.
- 3 HBC will conduct prevalence survey and 5 HBC/RPC will perform special studies to measure impact (the task force on impact measurement may change the targets after its meeting in December).

Resource availability:

Major funding sources (not exhaustive) for technical support to countries and related activities on policies and human resources development are the following:

- USAID through its umbrella grant to WHO, support to the UNION, KNCV, PATH, MSH etc…
- TB CAP plan with an annual budget of US$ 4 million for technical assistance and coordination.
- OGAC support to technical assistance to countries for the implementation of GF grants (US$ 2.5 million).
- SIDA in technical assistance to countries for the preparation of GF proposals (US$ 100,000 for 2007).
- France in the form of 4 senior TB experts seconded to WHO and support to the Union.
- Gates foundation to support TA related to the GF (US$ 100,000 per year for 3 years).
- Netherlands through a grant to KNCV.
- Italy in support to global, regional staff for coordination and technical assistance.
- And others ….

In the costing below, table 1 shows costs for the DEWG and sub-groups coordination (running costs) and table 2 shows the summary plan and the costs to undertake activities by different partners.

Table 1: Coordination work of WG/ Sub-groups and cost (in US$ 1000s). This table does not include laboratory sub-group.

ACTIVITIES	Funding required	Funding available for 2008	Funding gap
DEWG coordination and annual meetings	350x2	180	520
1. Reinforcing support to countries and coordination (TBTEAM): 1 staff for central coordination	180x2	150	210
4. Lab capacity strength sub-group coordination and meetings (needs to be identified and listed in the lab strategic plan)	To be defined	(80)	To be defined
8. TB and poverty subgroup coordination and meetings Support for the Secretariat and meetings (1/year)	250x2	125	375
9. Childhood TB sub-group coordination and meetings Part time staff for coordination and annual meeting	130x2	30	230
10. PPM subgroup coordination and meetings Part time staff for coordination; Meetings of the sub-group (1/year) and core group (2/year), teleconferences	200x2	150	250
Total	**1,110x2**	**635**	**1,585**

Table 2: List of activities and costs to reach the desired targets. Staff cost not included except for coordination (secretariat of sub-groups and TBTEAM)

ACTIVITIES (costs in US$)	Funding required for 1 year in1000sUS$	Funding available in 2008	Funding gap
DEWG coordination and annual meetings	350		
1. Reinforcing support to countries and coordination (TBTEAM) Coordination at regional and central level Workshops GF Monitoring and Evaluation	1,380		
2. Monitoring of Global plan implementation and technical support to countries including impact measurement Regional meetings and workshops Missions in countries (including TBTEAM funded missions)	5,900		
3. Help countries in accessing funding for TB control Regional and global workshops Missions to countries	1,300		
4. Lab capacity strength sub-group coordination and meetings	To be determined		
5. Support countries in addressing HSS issues and PAL strategy Policy development, field test, tools development and production workshops Missions to countries	1,950		
6. Human resources Policy, tools development Missions to countries Global/Regional trainings	2,450		
7. Involve community and patients in TB control Tools development and production Missions to countries workshops	900		
8. TB and poverty subgroup coordination and meetings: Studies, policy development and other activities	750		
9. Childhood TB sub-group coordination and meetings Tools development, workshops Missions to countries	880		
10. PPM subgroup coordination and meetings Documents and tools, missions to countries Workshops/trainings	3,150		
11. Operational research. Linking research groups Doc/tools and missions to countries	1,000		
Total	20,010	10,000	10,010

Activities cost to provide support to countries (without laboratory):
needs estimated at 20 Million per year for 2008 and 2009.
available funding is estimated at 10 Million in 2007.
gap in funding is estimated at 10 Million per year.

Staff costs for the partners agencies to provide the support (without the laboratory):
needs estimated at 45 Million per year for 2008-2009.
available is estimated at 20 Million in 2007.
gap in funding is estimated at 15 Million per year.

Annex 1: DOTS expansion implementation status at 2005, tentative targets for 2008 and 2009

	2005 (baseline)	2008	2009
DOTS coverage	All HBCs covered except Brazil and Russia	100% DOTS coverage in Brazil and Russia	Full DOTS coverage in all HBCs and Regional Priority Countries (RPCs)[i]
DOTS quality improvement	• 26 countries achieved 70/85 targets incl 3 HBC • 57 countries achieved at least 85% success rate (2004 cohort) • 16 HBC have a functional NR Lab • 6 HBC have 100% functional EQA smear • 7 HBC reported shortage of drugs at periphery	• At least 4 more HBC achieve 70/85 targets • 67 countries achieve at least 85% success rate (2007 cohort) • Targets to be set in the laboratory strategic plan under development • No HBC report shortage of drugs at periphery	• At least 3 more HBC achieve 70/85 targets • 75 countries achieve at least 85% success rate (2008 cohort) • Targets to be set in the laboratory strategic plan under development • No HBC and less than 5% RPC report shortage of drugs at periphery
Culture, DST and other diagnostic tools	• 8 HBC report more than one lab per 5 M pop performing culture • 7 HBC report more than one lab per 10 M pop performing DST • MDR rapid test (no data)	• Targets to be set in the laboratory strategic plan under development	• Targets to be set in the laboratory strategic plan under development
Impact measurement	9 HBCs have undertaken prevalence surveys or special studies to measure TB impact	25 additional HBC/RPC will conduct prevalence surveys or perform special studies to measure impact of TB control	10 additional HBC/RPC will conduct prevalence surveys or perform special studies to measure impact of TB control
Special groups	20 HBC have a plan of action for TB control in prisons 11 HBC have action plan for TB in refugees	Revised guidelines for TB in prisoners and in displaced population used in all HBCs and RPCs All HBC have plan of action for TB control in prison and one for displaced population where relevant	Notfied TB cases and success rate for TB in prison and in displaced population available in all HBC
Health System Strengthening	Some information on how TB control can strengthen health system.	Use of HSS framework with concrete plan in 10 HBC/RPC	30 HBC/RPC implement HSS plan funded by a Global Fund or bilateral grant
HRD for TB control	• Basic training material and HR assessment tools available • 15 HBC reported having HRD plan • 15 HBC reported having one focal person for HR	• TB programme in all HBC have a focal person for HR • TB programmes in 15 HBC have an HRD plan for TB control based on guidelines for HRD	• TB programmes in all HBCs and 2/3 of RPCs have a focal person for HR • TB programmes in 18 HBCs and 10 RPCs have an HRD plan for TB based on guidelines for HRD
Community DOTS	85 countries mainly in AFR, SEAR and WPR, reportedly engage communities in TB care and prevention.	Guidelines to engage communities in TB care and prevention published and disseminated	Guidelines to engage communities in TB care and prevention used in 20 countries
PAL	20 countries implement to some extend PAL	Scale up in 2 countries in EUR and AMR. Simplified PAL strategy tested in 3 countries.	Scale up in 3 additional countries in EMR, EUR and AMR Simplified PAL strategy implemented in 5 countries

	2005 (baseline)	2008	2009
Childhood TB	Formation of Childhood TB sub-group	• All relevant material to guide NTP managers developed • Childhood TB notified in all HBCs	Childhood TB notified in all HBCs and 2/3 of RPCs
Addressing Poverty in TB Control	WHO guide developed (WHO/HTM/TB/2005.352) and distributed but few countries have actively used it and none report on the extent to which TB control reaches and serves the poor.	• WHO guide actively used to inform and modify national TB plan in at least 5 countries • Initial strategies for enhancing access to TB diagnosis available through new diagnostic tools and algorithms.	All HBCs will a) have developed the capacity to monitor the extent to which TB control reaches and serves the poor and vulnerable and b) have developed key strategies for improving access to TB control for the poor and vulnerable.
PPM DOTS	Initiated /piloted in 16 HBCs, and scaled up in a 4 HBCs	Scaled up in 6 additional HBC, and started in 20 HBCs ISTC promoted in all HBC	Scaled up in 8 additional HBC, and initiation/limited scale up in all relevant RPCs ISTC promoted in HBC and ½ of RPC
Operational research (OR)	No systematic global survey of operational research activities	Routine reporting of national operational research activities through global TB M&E system	TB programmes in all HBCs and RPCs incorporate OR and report activities through global TB M&E system

[i] AFR: 36 countries out of 46 (all countries except: Algeria, Angola, Benin, Cameroon, Comoros, Gabon, Mauritius, Niger, Sao Tome & Principe and Seychelles)
AMR: 14 countries (Brazil, Bolivia, Colombia, Domonican Rep, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay, Peru, Surinam)
EMR: 9 countries (Afghanistan, Djibouti, Egypt, Iraq, Pakistan, Somalia, Sudan, Yemen, Morocco)
EUR: 18 countries (Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Romania, Russian Federation, Tajikistan, Turkey, Turkmenistan, Ukraine, Uzbekistan)
SEAR: 7 countries (Bangladesh, India, Indonesia, Korea DPR, Myanmar, Nepal, Thailand)
WPR: 7 countries (Cambodia, China, Lao PDR, Mongolia, Papua New Guinea, Philippines, Viet Nam)