

Chapter 1 : Publications Authored by Dermot Maher | PubFacts

present an opportunity to provide better care through increased case detection activities, improved clinical management and better access to care for both tuberculosis and non- communicable diseases.

Discussion India accounts for about one-fifth of the global burden of TB [6]. This is further evident from the fact that out of the total market of USD 94 million for the first-line anti-TB medicines in India, the public sector purchases drugs worth USD 24 million while the private sector accounts for the remaining USD 61 million [15]. The RNTCP has made several attempts to engage the private health sector in general and private practitioners in particular in TB care and control [2] , [16]. Based on numerous successful projects with documented evidence on feasibility, effectiveness and cost-effectiveness [17] , [18] , the RNTCP has designed and promoted public-private mix schemes that define the input of the public sector and expectations from the private sector and offer financial and non-financial incentives [2]. Several thousands of private practitioners as well as non-governmental organizations are reported to have been collaborating under the various schemes [5]. However, they comprise only a miniscule of the large private sector in the country and their precise contribution to detecting and treating TB cases is not known. In the study of prescribing behaviour of private practitioners, doctors reported to have provided 80 different prescriptions [1]. A similar study undertaken in Mumbai and rural Pune, a neighbouring district and published in , reported private practitioners giving 79 diverse prescriptions [11] and in this study, doctors wrote 63 different prescriptions. Can this be called progress? An analysis of the prescriptions may provide some measure of consolation. Seventy three doctors used four-drug fixed dose combinations and 53 wrote prescriptions of drugs for longer than six months suggesting an overkill rather than under-treatment of their TB patients. If the patients did take their medicines as prescribed and did adhere to treatment, a large majority were less likely to develop multidrug-resistance. However, the above referred study that followed up patients diagnosed in the private sector showed that patients did not generally take all the medicines as prescribed by their doctors and that their treatment completion rates were very poor [11]. There were several reasons for doing this. The actual levels of MDR-TB may be much higher than those projected by national estimates as the patients diagnosed and managed in the private sector never get reported. Only 5 of the respondents could write an appropriate prescription with a minimum of 3 new second-line drugs in the right doses for a right duration. This combination of MDR and additional fluoroquinolone resistance “ pre-XDR TB ” is a direct result of inappropriate and indiscriminate fluoroquinolone use. A majority of the prescriptions reported by the practitioners would serve only to amplify resistance. An important limitation of this follow up study, especially with regards to its comparability with the original study, needs to be acknowledged. The original study was a one-on-one study conducted among a randomly selected cohort of physicians chosen from a list of physicians, while the present study used a CME session for the purpose. It includes doctors with large as well as small practices. Also, our conducting CMEs generally on a Sunday facilitates attendance of doctors who are otherwise busy with their practices on week days. Furthermore, conducting one-to-one interviews with practicing doctors is much more time and resource intensive than it perhaps was two decades ago. Finally, even if we restrict the comparability of the two studies to simply drawing a sample of doctors from the same geographical area with predominantly slum population and a very high prevalence of TB, the findings are still worrisome and demand attention of all those concerned with TB control in the city and the country. Another limitation of this study, as it was of the original study, is that what the doctors reported could only be said to reflect their knowledge and not necessarily their practices. It may be unreasonable to expect the RNTCP to effectively reach hundreds of thousands of practicing doctors. How can this worrisome situation be addressed? Training and orientation of practicing doctors by both RNTCP experts and private chest physicians who believe in evidence-based practice is of course essential but may not be sufficient. Some of the recommendations of a recent joint monitoring mission of the RNTCP are also worth reiterating. Assessing ways to set-up a system of mandatory

notification is also recommended. Given the magnitude of the problem of TB and MDR-TB and the size of the private sector in India, ignoring the private sector or dealing with it in a superficial manner cannot be an option. Evidence from numerous successful small projects shows that local public-private initiatives do work well [17]. Willingness on the part of the RNTCP staff to initiate and foster collaboration is a key requirement. A local intermediary organization acceptable to both parties, if available, hastens the process. A logical first step that each public sector tuberculosis unit can take would be to identify willing practitioners and support development of a few best practice clinics and hospitals in the private sector for management of TB and MDR-TB. Using the private sector to help achieve universal access to rational and standardized TB care can be a win-win situation not only for programme managers and private providers but also for patients with TB and people at large. Furthermore, some thorny issues must be addressed as a priority. Currently, the RNTCP tends to collaborate only with those individual and institutional providers who agree to follow the programme recommendations. As a result, those who follow appropriate, rational, internationally recommended practices that do not exactly match the programme guidelines cannot receive any support or recognition from the programme. Specifically, as the programme uses intermittent treatment regimens, physicians using daily regimens correctly to treat their patients cannot hope to collaborate with the programme. Considering their large numbers and diverse backgrounds, it would simply be not possible for the RNTCP to adequately orient, support and supervise hundreds of thousands of private practitioners. Parallel mechanisms should be developed within the private sector to support itself to manage TB patients properly and pass on all the relevant information essential for surveillance to the RNTCP. Measureable progress will be possible only with the creation of structures and staff to work with the private sector at the national, state and district levels. Half-hearted approaches are unlikely to make any significant change in the plethora of treatment regimens proffered by private practitioners even after two decades hence.

Acknowledgments The authors are thankful to Dipika Agarwal for her help in collecting the data, Franzina Coutinho for her help in analyzing the data, Knut Lonnroth and Leopold Blanc for their review and thoughtful comments. He alone is responsible for the views expressed in this publication and they do not necessarily represent the decisions or policies of the World Health Organization. The authors have declared that no competing interests exist. The authors have no support or funding to report.

Treatment of tuberculosis by private general practitioners in India. Directorate General of Health Services. Ministry of Health and Family welfare. **Private practitioners and public health: Engaging all care providers in tuberculosis care and control: Multidrug-resistant tuberculosis in Mumbai: Int J Tuberc Lung Dis.** Incidence of multidrug-resistant tuberculosis in urban and rural India and implications for prevention. International standards for tuberculosis care. Tuberculosis patients and practitioners in private clinics in India. Private patient perceptions about a public programme; what do private Indian tuberculosis patients really feel about directly observed treatment? Global Alliance for TB drug development. TB Alliance, New York; J Indian Med Assoc. Improving tuberculosis control through public-private collaboration in India: Economic evaluation of public-private mix for tuberculosis care and control, India. High levels of multidrug resistant tuberculosis in new and treatment-failure patients from the Revised National Tuberculosis Control Programme in an urban metropolis Mumbai in Western India. Increasing incidence of fluoroquinolone-resistant Mycobacterium tuberculosis in Mumbai, India.

Chapter 2 : Publications Authored by Katherine Floyd | PubFacts

Contents: The global TB epidemic / Christopher Dye and Philippe Glaziou -- The epidemiology of tuberculosis / Megan Murray -- Pathogenesis of tuberculosis: new insights / Nicholas A. Be, William Bishai, and Sanjay K. Jain -- Diagnosis of pulmonary and extrapulmonary tuberculosis / Phung Lam, Antonino Catanzaro, Sharon Perry -- Treatment of.

They may have different meanings in other contexts. DRS Drug resistance survey is a discrete study measuring the proportion of drug resistance among a sample of patients representative of an entire patient population in a country or geographical area. DST Drug susceptibility testing defined as the testing of a strain of *Mycobacterium tuberculosis* for its susceptibility or resistance to one or more anti-TB drugs. MDR-TB Multidrug-resistant tuberculosis defined as TB caused by strains of *Mycobacterium tuberculosis* that are resistant to at least isoniazid and rifampicin. Previously treated case A newly registered episode of TB in a patient who, in response to direct questioning admits having been treated for TB for one month or more, or, in countries where adequate documentation is available, there is evidence of such history. Chemoprophylaxis should not be considered treatment for TB. Relapse case A patient previously treated for TB who was declared cured or successfully completed treatment, and is again diagnosed with bacteriologically positive smear or culture TB. New case A newly registered episode of TB in a patient who, in response to direct questioning, denies having had any prior anti-TB treatment for up to one month , and in countries where adequate documentation is available, for whom there is no evidence of such history. Some countries are making progress by implementing policy changes that rationalize the use of hospitals, such as South Africa, or treating patients through community-based models of care, such as the Philippines. However, diagnostic capacity remains limited. Furthermore, the price of some quality-assured second-line drugs has not fallen, and shortages of drugs still occur. Overall, there is recognition that the response to MDR-TB must be built across health systems, and corresponding plans have been made. Human and financial resources are grossly insufficient and frequently inadequate. MDR-TB results from either primary infection with resistant bacteria or may develop during the course of treatment. Five candidate anti-TB drugs are being evaluated in clinical trials, and preliminary results are encouraging: However, no technological or managerial innovation will make a meaningful difference to the response if access to care for the poorest and most vulnerable groups is not increased through strengthened and properly funded health-care systems. Beyond more rapid implementation of available tools, there is an urgent need to fully fund a robust and comprehensive research portfolio that ranges from basic science to efforts to develop new vaccines, diagnostics and treatments. New and more effective tools will likely facilitate care and control of MDR-TB, as long as they become accessible to the poorest populations worldwide. Besides scaling up implementation of available and new tools, research providing evidence that countries can use to reach the global target of achieving universal access to MDR-TB care in line with resolution WHA While there is clarity and consensus on what to do, as the 62nd WHA resolution indicates, the international community should no longer hesitate to fully implement the resolution. In Estonia, Latvia, the Russian Federation and South Africa, domestic sources will provide most if not all of this funding. WHO has set a target of having at least one laboratory with capacity to perform culture per 5 million population, and one laboratory with capacity to perform drug susceptibility testing DST per 10 million population. Laboratory networks are established in all 27 countries; all have capacity to perform DST of at least first-line anti-TB drugs at the central or national reference laboratory and at regional level in some countries. This substantive progress in expanding diagnostic capacity should now be reflected in increasing numbers of patients being enrolled on treatment in the next years. Improving drug resistance surveillance. In the 27 high MDR-TB burden countries, the number of new drug resistance surveys under way or planned increased from 1 in to 10 in ; the number of countries with representative drug resistance data increased from 19 to It is expected that by mid, all 27 countries will have representative information on drug resistance. This finding is likely to be associated with the growing HIV epidemic in the subregion. Ensuring access to

quality-assured anti-TB drugs. The number of finished second-line anti-TB pharmaceutical products available for procurement through the Global Drug Facility increased from 11 in to 25 in ; the number of suppliers of second-line drugs SLDs increased from 5 in to 15 in Further progress could 2 WHO PROGRESS REPORT Towards universal access to diagnosis and treatment of multidrug-resistant and extensively drug-resistant tuberculosis by be achieved in many countries by facilitating registration and importation of drugs, conforming to quality assurance standards set by WHO, strengthening national drug management, and increasing production capacity of quality-assured products. There is wide variation in the performance of the programmes as far as treatment is concerned. Fourteen countries reported no data on outcomes. If reports correspond to what is happening in reality, it may be that most people affected by MDR-TB are not diagnosed and that only a small proportion of those in whom the disease is diagnosed are enrolled on treatment. Engaging all health-care providers. Countries such as Bangladesh, Pakistan and the Philippines are forging successful partnerships, demonstrating both the feasibility and necessity of engaging all health-care providers. Promoting regulated access to anti-TB drugs. Inappropriate or incorrect prescribing practices increase the risk of treatment failure and drug resistance and its amplification. There is increasing evidence to suggest that, under appropriate conditions, countries may restrict dispensing practices to qualified providers only. Efforts are under way in Cambodia, India and the United Republic of Tanzania to promote the rational use of anti-TB drugs by engaging pharmacists and their associations. Most countries are at a preliminary phase in implementing policy and have yet to begin national assessments or draft national action plans. Incidence rates have been declining globally and in all subregions except in certain African countries since Reflecting that notion, this report has two parts: However, national budgets do not always follow need. India, with the second highest burden of MDR-TB, has achieved major progress in expanding laboratory capacity and is hailed as an example of the progress being made globally. It needs careful planning, intensive technical assistance and mentoring during implementation, as well as regular monitoring. It requires countries to mobilize resources, build capacity and properly coordinate operations within the health-care system. Part II describes and analyses the progress, remaining challenges and next steps in some elements of the health-care system as applied to prevention of TB and strengthening of basic TB control, including DOTS, role of all health-care providers, access to drugs, collaboration with HIV programmes, and infection control. Other elements relevant to the prevention of TB, though not discussed in this report, include co-morbidities that are emerging as major risk factors for TB and contributing to poor treatment outcomes, such as smoking, diabetes, and alcohol or substance dependency. WHO is working with partners to develop policy for collaboration with national TB control programmes NTP and groups addressing these conditions. Options are also being explored with some countries to pilot-test interventions that may contribute to tackling social and economic determinants that prevent access to diagnosis and treatment of MDR-TB and simultaneously increase the risk of TB. There is compelling evidence that the publichealth sector is not the first choice for those seeking care. The same applies to those affected by TB. Uninterrupted access to the right combination of anti-TB drugs meeting international quality standards is fundamental to prevent creation or amplification of drug resistance. Successful implementation of these policies will stop the practice of irregular and self-prescribed treatment. Methods, sources of data and derivation of indicators The data used for this report were based on the most recent information made available by countries to WHO until 22 February The sources of this information were the following: Since July , the department has been collecting these data through a web-based system www. All these profiles were cleared by individual countries ahead of finalization of this report. These updates and accompanying budgets, are essential to identify gaps, mobilize additional resources and monitor implementation progress. The analysis of updated country plans shows promising governmental commitment and financial contributions to ensuring sustainable scale-up of MDR-TB diagnosis, treatment and care; however, not all MDR-TB components are adequately financed. Five training courses for global and local consultants to further develop the necessary skills to support the planning, implementation, and monitoring and evaluation of the MDR-TB component of TB control programmes have been conducted. From the five

DOWNLOAD PDF ACHIEVING HIGHER CASE DETECTION KNUT LONNROTH, MUKUND UPLEKAR, LEOPOLD BLANC

main groups of funding sources, namely government, loans, grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria Global Fund , other donors and patients themselves, it is clear that out-of-pocket payments by TB patients are not a solution for financing the scaleup of MDR-TB diagnosis, treatment and care. It may also lead to treatment of unknown quality, delivered in the private sector without a link to the national TB control programme, which in turn can increase the risk of emergence of further drug resistance, poor treatment outcomes and increased transmission of MDR-TB strains. MDR-TB care and treatment costs by sources of funding. Excludes 4 countries 1. How the required funding will be mobilized in While domestic funding for MDR-TB has increased since , it is not expected to further increase in In the Democratic Republic of the Congo, Indonesia, the Philippines and Ukraine, more than half of the funding needs will not be covered Table 1. These are compared with the Global Plan funding estimates. Enrolled on MDR treatment Notified; no information on enrolment No information on notification or enrolment Azerbaijan 2.

Achieving Higher Case Detection, Knut Lonnoth, Mukund Uplekar, and Leopold Blanc Anti-TB Drug Resistance in the World, Abigail Wright and Matteo Zignol Programmatic Control of Multidrug-Resistant TB, Michael Kimerling, Ernesto Jaramillo, and Kitty Lambregts.

Chapter 3 Potential actions for overcoming barriers in accessing TB services This chapter proposes a range of potential actions to overcome the most common barriers faced by poor and vulnerable population groups in accessing TB services, as described in Chapter 2. Since there is overlap and interaction between the barriers presented in each group, addressing one set of barriers may also have additional impacts on others. Furthermore, since the barriers vary in type and importance in different settings, knowledge of the demographic, cultural and socioeconomic characteristics of the population is useful in planning ways to address barriers to access see also Chapter 6. Often, a multisectoral approach will be needed to deal with a combination of economic and social barriers faced by the vulnerable sections of the population. Long and complex diagnostic and treatment pathways are costly, especially for the poor sections of the population. Actions that will simplify and shorten these pathways will therefore benefit the poor. The basic organization of TB services can make a significant difference to the accessibility of the services. If, for example, TB diagnosis and treatment are available only in relatively centralized and specialized TB institutions, then integrating TB diagnostic services within public services at the periphery will significantly reduce the number of visits to health services. Engaging other partners in provision of TB services. If the poor preferentially consult private health providers, then integrating TB diagnostic and treatment services within this private provision as exemplified in pro-poor PPM DOTS initiatives will also shorten the pathways of TB patients to care. Another way of simplifying the pathway to cure for both diagnosis and treatment is to integrate TB control into the workplace, especially if the workplace in question provides employment for large numbers of poor patients on low incomes, as is often the case, for example, in mines and export processing zones. Engaging unions and employee organizations can also be constructive in this area of work. CHAPTER 3 33 Improving laboratory capacity, including quality-assured smear microscopy networks, transport of samples and mycobacterial culture. Requiring repeat visits to submit successive sputum samples complicates the care-seeking pathway and increases costs, which are particularly burdensome for the poor see Chapter 2. Increasing laboratory capacity for smear microscopy, integrating smear microscopy into primary health-service provision and building quality assurance mechanisms will promote overall health system responsiveness to the needs of the poor. Many countries are innovative in their use of private and public transport of sputum samples and slides from remote areas. Expanding regional and district laboratory capacity in sputum culture is a major challenge but will be needed to increase earlier diagnosis for all patients. New diagnostics may begin to replace smear microscopy or traditional mycobacterial culture with tools that are more user-friendly and efficient for patients and health workers. In addition to the costs of repeat consultations such as transport and lost income, user-fees present additional barriers to access to general health care for the poor. Managers of national TB control programmes may not be able to change user-fee policies in general health services, but they can advocate against their introduction at primary-care level and or advocate for health insurance schemes that mitigate the effects of such policies on the poor. Sputum examination provided free of charge should be strongly advocated as part of public health policy. In some countries, nongovernmental organizations NGOs and charity organizations may be involved in supporting the cost of the first examinations for diagnosis of TB in general and among the poor in particular. This removes a major financial barrier to accessing and completing TB treatment. This practice should be strongly discouraged. Other costs to patients, including transport costs to treatment centres, are often underestimated. Potential actions to reduce out-of-pocket costs vary in different settings. Treatment observation options can be designed to reduce costs to patients rather than to ease service delivery, e. Assistance in reducing costs for patients may

be arranged by national TB control programmes themselves or through partnerships with NGOs, including charity organizations. Experience is growing in several countries e. Cambodia, Peru and the Russian Federation with enablers such as food parcels, free transport vouchers or clothes. In some countries, with support from charity organizations, meals are organized for the poor in day-care centres, where patients may be referred for direct observation of treatment. It may be advisable to pilot-test these measures for feasibility and effectiveness before widespread use. In some settings, lowcost incentives to TB patients have been shown to improve early diagnosis and adherence to treatment, but evidence is still weak in most high TB burden countries. Decentralization and health sector reform are processes through which diagnosis and ambulatory treatment of TB may be brought closer CHAPTER 3 35 to where patients live. In some very remote areas, rather than take treatment observation and DOT support to patients, patients can be brought to treatment or observation centres. With the support of local governors, public transport vouchers are issued for TB patients in remote areas of India see page Primary health-care services play a crucial role in improving access to diagnosis and treatment, and TB services should be integrated within such services. Special attention should be paid to slum areas of big cities as well as remote rural areas where poor people tend to be concentrated. In some instances it may be worth re-examining the number of facilities offering TB services per head of population in order to plan the establishment of new diagnostic centres or more efficient referral systems. Community-based care offers another mechanism for improving access to TB services. In the late s, a major programme of work was begun to review community-based TB care models in use around the world and to pilot-test approaches in sub-Saharan Africa. The objective was to relieve health services overburdened by the dual TB and HIV epidemics and to increase effective case management through care in the community. The results were positive and demonstrate that communitybased care reduces costs and improves treatment outcomes. Follow-up work now focuses on scaling up models and examining their impact in improving case detection, and should include analysis of their impact on the poor. PLWHA are particularly prone to poverty and the burden of intercurrent infections. Stigma towards TB exists to differing degrees in most countries and may be particularly problematic among the poor. In some settings it is feasible to organize home visits by, for instance, nurses or former patients or to launch local TB health promotion activities. If carefully planned, these activities may improve awareness of TB services among the poor and vulnerable and help alleviate stigma. Where staff attitudes and behaviour reinforce stigma, particular attention may be needed through training and approaches such as total quality management. It may be useful to engage experts in personnel management for this. Fear of losing a job may pose a serious barrier to seeking diagnosis and is likely to reinforce stigma. Effective worker protection is likely to require a legal framework that can be developed from these discussions. Diagnosis and treatment of TB may be brought to the workplace, so that patients who do not pose a significant risk of infection to others may follow treatment at their workplace without fear of losing their jobs. Awareness campaigns should, however, be launched only after quality-assured services have been established. The optimal means of communicating this vital information in a manner that suits the needs of the poor is best determined locally. Surveys and qualitative studies are often arranged, and carried out with collaborating partners as necessary, to assess the knowledge, attitudes and practices of the population KAP surveys , and specifically of the poor, regarding TB. It is important to use these surveys to determine the most influential and usable sources of information for the poor in order to CHAPTER 3 37 inform local health promotion and communication strategies. A comprehensive TB health promotion plan should be developed to raise awareness and knowledge about TB and the services available. Educational levels play an important role in the ability of patients to understand the treatment of TB. A nurse or physician in a TB or general health facility may conclude that patients who do not follow instructions are being uncooperative. In fact, the patient may fail to follow the treatment because of lack of understanding of the medical terms, unfamiliarity with medical systems or inability to read the materials provided. In some settings, minority groups need special attention: Identifying and overcoming gender-related barriers are extremely important for TB control programmes. Poor men and poor women each face different barriers in different contexts, which need to be

assessed and addressed locally. It is therefore important to analyse specific gender-related barriers before planning interventions. Some general considerations are presented here. Women, particularly in poor or remote populations, very often consider their disease symptoms in terms of their reproductive health. They may therefore seek reproductive health services where awareness of TB may be low. In such instances it may be important to increase awareness of TB among staff in maternal and child health clinics. Alternatively, women may be reluctant to present their symptoms to for example male health workers in general health services. Men tend to consider their disease symptoms in terms of their ability to perform manual labour. They may therefore be very reluctant or unable to seek health services until very ill. In such cases it may be necessary to take diagnostic and treatment services to the places where poor men work, such as mines, export processing zones or estates requiring large seasonal 4 One example is An IEC strategy for Orissa: Patient support groups have also been helpful in supporting men through treatment in the workplace and community. Managers of national TB control programmes should assess awareness of gender-related issues among their staff and plan appropriate training. However, training alone, unlinked to specific, integrated and ongoing activities may be of limited benefit. Health promotion campaigns should be planned to include specific consideration of gender-related issues. Social mobilization plays an important role in ensuring the success of such campaigns. It may be possible, at least in some settings, to arrange alternative working hours for health-care facilities to allow better access particularly for women but also for all whose work limits their access. Communication skills, staff attitudes and practice in relation to the poor. Special attention should be paid to the development of communication skills of the health-care staff. Training in effective communication should be included in training curricula for example by introducing role play and group discussion in the training of staff. Supervisors should monitor the effectiveness of staff communication with patients during their visits to TB facilities. It is important to eliminate any practices that may discourage the poor from seeking diagnosis and treatment. National TB control programmes may include inspection systems to ensure that patients and the community are able to express their opinion freely about the quality of the services and the existence of any discriminatory practices. CHAPTER 3 39 To maintain standards and promote public confidence in health facilities, a health quality-assurance system addressing the needs of the poor must be in place and functioning effectively. Quality assurance is a planned, systematic approach to monitoring, assessing and improving the quality of health services on a continuous basis within the existing resources. Motivation of staff is a key factor in their performance. Incentives may be introduced to reward performance, such as the possibility to attend training courses, performance-based salary payments, or other measures which may be considered. Giving a voice to the poor. It is important to seek and understand the views of the poor about service provision. It is also important for maintaining staff motivation and satisfaction. However, as already discussed, national TB control programme managers should also be able to remind reformers about the need to be objective in introducing critical health sector changes, particularly in health systems that are already weak. Continuous monitoring of TB services using appropriate indicators, as described in Chapter 6, is essential to assess the impact of the services provided, including their responsiveness to the needs of the poor sections of the community. This will depend on the assessments of barriers made through the action points in Chapter 2. Consider engaging trades unions or employee support organizations. Consider innovation in the transport of samples, specimens and results. Pro-poor interventions form an integral part of the programme, which attempts to address inequities in health care by eliminating physical, financial and social barriers that affect the poor and vulnerable groups. Direct costs to patients are reduced by the provision of both diagnostic and treatment services free of charge under the programme.

Chapter 4 : Read Addressing poverty in TB control

The authors are thankful to Dipika Agarwal for her help in collecting the data, Franzina Coutinho for her help in analyzing the data, Knut Lonnroth and Leopold Blanc for their review and thoughtful comments.

It includes data on case notifications and treatment outcomes from all national TB control programmes that have reported to WHO, together with an analysis of plans, budgets, expenditures, and constraints on DOTS expansion for 22 high-burden countries HBCs. During , a standard form for reporting surveillance and financial data was sent to countries via WHO regional offices. The form requests information about policy and practice in TB control, about the number and types of TB cases notified in , and about the outcomes of treatment and retreatment for smear-positive cases registered in . It also asks for information about NTP budgets, expenditures, and funding sources, and about the way in which the general health infrastructure is used for TB control. National programme managers in the 22 HBCs were also asked, via a separate questionnaire and interviews, to summarize plans for TB control from onwards, focusing on activities to improve political commitment, expand access to DOTS, strengthen diagnosis, improve treatment outcomes, ensure adequate staffing, and improve programme monitoring and supervision. Improving the detection and treatment of TB cases 4. Using trends in case notifications to update estimates of incidence, we calculate that there were 8. The global incidence rate of TB per capita was growing at approximately 1. The growth in case notifications has been much faster in African countries with high HIV prevalence, and in eastern Europe mainly the former Soviet Union , but growth has been decelerating in both these regions since the mid s. The number of countries implementing the DOTS strategy increased by 25 during , bringing the total to out of DOTS programmes notified 3. A total of The increment in smear-positive cases notified under DOTS between and was greater than the average from “ The acceleration in notifications was more pronounced for all TB cases, which increased by between and , as compared with the average annual increment of in the interval “ Twenty-eight percent of the additional smear-positive cases reported under DOTS in were found in India. Low treatment success in these two regions can be attributed, in part, to the complications of HIV co-infection and drug resistance, respectively. Equally important, though, is the failure of NTPs to monitor the outcome of treatment for all patients. Based on case reports and WHO estimates, 18 countries had reached the targets for case detection and cure by the end of . However, Viet Nam was the only high-burden country among them. Planning and DOTS implementation Detailed plans for major improvements in DOTS coverage, case detection, and programme quality had been made by several countries, including India and Indonesia. However, strategic planning to overcome the constraints to TB control remains weak in several countries with low case detection or cure rates. The six most common constraints identified were: The remedies required to overcome these constraints include: Intersectoral cooperation 2 will be critical in overcoming constraints that lie beyond the full control of NTPs. The effectiveness of DOTS, and the prospects for expanding the strategy, are also limited by the failure of drug supplies, inconsistent drug quality, and inadequate drug policies. A consequence is the spread of drug resistance. Part of the remedy will be to establish testing for drug sensitivity as an integral part of DOTS programmes, to standardize treatment regimens for patients that have failed treatment, and to ensure that second-line drugs are available and properly used for patients with MDR-TB. In all HBCs that reported data for both years, the cost per patient increased between and . The reasons were made clear in some budgets e. Brazil , and tended to be greater in richer countries. Financing DOTS expansion Financial data were received from countries, 77 of which provided complete data on budgets including 17 HBCs , and 74 of which provided complete, disaggregated expenditures for including 15 HBCs. Between and , the funding gap narrowed in seven countries, mainly because more funds were promised by governments including loans and the GFATM. The gap increased in five countries because more unfunded activities were planned to accelerate DOTS expansion. Beyond , and preferably sooner, DOTS programmes and public health authorities must begin to recruit patients from nonparticipating clinics and hospitals, notably in the private

sector in Asia, and from beyond the present limits of public health systems in Africa. A special effort must be made to improve cure rates in Africa. To achieve these goals, governments and NTPs will need to take a more strategic approach to planning, match budgets more closely with plans, and match fundraising activities to realistic budgets. This is already happening in several HBCs, but not in all. If disbursements from the GFATM and other donors can be made more expeditiously, these funds will make a major contribution to TB control in several of the poorer HBCs whose governments cannot adequately support TB control. Parmi les solutions permettant de surmonter ces obstacles, on peut mentionner: Las causas de este aumento estaban claras en algunos presupuestos por ejemplo, una encuesta de prevalencia en Viet Nam y compra de equipamiento en Myanmar , pero no en todos. El plan de Rusia para el quinquenio contiene cifras similares para Since these targets were not reached by the end of year as originally planned, the target year has been re-set to Framework for Effective Tuberculosis Control. Fifty-third World Health Assembly. Anti-tuberculosis Drug Resistance in the World. Although funding for TB programmes, and planning for DOTS expansion, had both improved during , deficiencies in staff and health infrastructure were identified as significant obstacles to DOTS expansion. In addition, NTPs were significantly underestimating the cost of rectifying these deficiencies. This 8th annual report provides an update of progress in TB control for most WHO member states and other territories. We present data collected during on case notifications for and treatment results for patients registered in , and compare the status of DOTS implementation within and among countries by the end of We also reassess plans for, and the major constraints to, TB control in the 22 HBCs, and analyse the latest available data on expenditures and budgets Methods Monitoring the detection and treatment of TB cases Data collection Every year, WHO requests information from TB control programmes or relevant public health authorities in countries or territories via a standard data collection form. The latest form was distributed in and the section dealing with surveillance asked for data on: TB control strategies implemented in , TB case notifications in , and treatment outcomes for TB patients registered during The form can be downloaded from www.who.int/tb. Good case management includes directly observed treatment DOT during the intensive phase for all new smearpositive cases, during the continuation phase of regimens containing rifampicin, and during the entirety of a retreatment regimen. Sputum culture is also used for diagnosis, but direct sputum smear microscopy should still be performed for all suspected cases. In countries that have consistently documented high treatment success rates, direct observation of treatment may be reserved for a subset of patients, as long as cohort analysis of treatment results is provided to document the outcome of all cases. Data verification Completed data collection forms are collected via WHO country offices, and the data are reviewed at all levels of WHO. EuroTB subsequently publishes an annual report with additional analyses, using data that are considered more final for the European region see www.euro.who.int. It is not simply a clinical approach to individual patients, but rather a management strategy for public health systems that includes political commitment, and the technical elements listed in Table 1. Numbers of TB cases are collected in terms of site of disease, history, and sputum smear status, but this report focuses on total and new smear-positive cases. All cases notified since are shown in Annex 2, together with new smearpositive cases notified since By convention, WHO does not include retreatment cases in the calculation of TB notification rates, assuming that these episodes of disease have been registered and reported during their first round of treatment. An exception is made for relapses, which may represent new episodes of disease, the previous episode of disease having been declared cured. European countries consider these numbers to be the total cases notified. They may differ from the total notifications reported by WHO because, by European convention, all types of TB cases are included in the notification rate, not just new and relapse cases. We ask for a breakdown of cases by age and sex for new smear-positive cases only, and these numbers, as well as age- and sex-specific rates per capita, are shown in Annex 2. Treatment outcomes are collected according to six mutually exclusive outcome categories Table 2. Diagnostic criteria should include: Diagnosis should be based on one culture-positive specimen, or histological or strong clinical evidence consistent with active extrapulmonary disease, followed by a decision by a clinician to treat with a full course of anti-tuberculosis chemotherapy. This report presents treatment

outcomes for The assessment of outcomes always lags by 1 year to ensure that all patients have completed treatment. A DOTS country must report treatment outcomes, unless it is newly-classified as DOTS, in which case it would take an additional year to report outcomes from the first cohort of patients treated. Special circumstances surrounding the data submitted by some countries e. Our estimates are based on a consultative and analytical process described elsewhere, and have been regularly updated since Journal of the American Medical Association ; The growing burden of tuberculosis: Archives of Internal Medicine ; In all calculations of TB indicators, we use population estimates provided by the UN Population Division,⁹ even though they sometimes differ from estimates made by the countries themselves some of which are based on more recent survey data. Where estimates of TB indicators, such as the case detection rate, are based on data and calculations that work with rates per capita, discrepancies in population estimates do not affect the indicators. Where rates per capita are used as a basis for calculating numbers of TB cases, these discrepancies sometimes do make a difference. Some examples of important differences are given in the country notes in Annex 2. Smear-positive cases are the focus of DOTS programmes because they are the principal sources of infection to others, because sputum smear microscopy is a highly specific if somewhat insensitive method of diagnosis, and because patients with smear-positive disease typically suffer higher rates of morbidity and mortality than smear-negative patients. The number of cases notified is usually smaller than estimated incidence because of incomplete coverage by health services, under-diagnosis, or deficient recording and reporting. Treatment success Focusing on new smear-positive cases, treatment success is the proportion of patients who complete their entire course of treatment, with or without bacteriological confirmation of cure Table 2. All registered cases should be evaluated, and the numbers registered and evaluated should therefore be the same discrepancies arise e. If the number registered is not provided, we use the number notified for the cohort year as the denominator. For retreatment outcomes, we cannot assess how many cases should have been registered on retreatment regimens. The units of population covered are usually the administrative units used for other purposes within countries e. World Population Prospects – the revision. The reason is that a proportion of patients given less than a fully-curative course of treatment remain chronically infectious, and continue to spread TB. Thus DOTS programmes must be shown to achieve high cure rates in pilot projects before attempting countrywide coverage. Standardized tuberculosis treatment outcome monitoring in Europe. European Respiratory Journal ; In general, the precise definition and assessment of DOTS population coverage is left to the NTP, and interpretations inevitably differ among countries. In the context of measuring access to DOTS, the ratio of DDR to population coverage estimates the case detection rate within DOTS areas as distinct from the case detection rate nationwide , assuming that the TB incidence rate is homogeneous across counties, districts, provinces, or other administrative units. Where the value of this indicator is much lower, it suggests that the DOTS programme has been poorly implemented.

DOWNLOAD PDF ACHIEVING HIGHER CASE DETECTION KNUT LONNROTH, MUKUND UPLEKAR, LEOPOLD BLANC

Chapter 5 : Global Tuberculosis Control: Surveillance, Planning, Financing - PDF Free Download

We acknowledge the contributions of staff of the Stop TB Department at WHO, Geneva, especially Leopold Blanc, Chris Dye, Katherine Floyd, Giuliano Gargioni, Haileyesus Getahun, Ernesto Jaramillo, Knut Lonnroth, Dermot Maher, Paul Nunn, Diana Weil, and Brian Williams.

The data collection forms long and short versions were developed by Philippe Glaziou, with input from a variety of other staff. Hazim Timimi organized and led implementation of all aspects of data management, with support from Tom Hiatt, Mehran Hosseini and Richard Maggi. The main report was written by Katherine Floyd and the Annex that explains methods used to produce estimates of disease burden was written by Philippe Glaziou. Karen Ciceri edited the report. Philippe Glaziou analysed surveillance and epidemiological data and prepared the figures and tables on these topics, with assistance from Ana Bierrenbach, Tom Hiatt and Charalambos Sismanidis. Mukund Uplekar contributed a summary of recent experience in implementing PPM. Data collection and analysis were also supported by funding from the government of Japan. We acknowledge with gratitude their support. We also thank Sue Hobbs for her excellent work on the design and layout of this report, and for designing offline versions of the data collection forms. Her contribution, as in previous years, is greatly appreciated. WHO Region of the Americas. The main purpose of this report update is to provide the latest data on the TB epidemic and progress in control of the disease, based on data collected in the round of global TB data collection and previous years. Data are supplied primarily by national TB control programme managers and their staff. Those who used the online data collection system to report data to WHO in are listed below, and we thank them all for their invaluable contribution and collaboration. Nkou, Grace Nkubito, D. Sunil de Alwis, L. Susan Barker, Risa J. It is designed to fill an month gap between the full reports of in March and in October , following changes to the production cycle of the report in that have been made to ensure that future reports in the series¹ contain more up-to-date data. The report includes the latest estimates of the global burden of TB incidence, prevalence and mortality. It also includes an assessment of progress in implementing the Stop TB Strategy and the Global Plan to Stop TB, which in combination have set out what needs to be done to achieve the global targets for TB control. These targets are that incidence should be falling by MDG Target 6. The latest data up to on financing for TB control are presented, and progress towards the targets at global and regional level is analysed. The report also features updates about the work of the Global Laboratory Initiative and the WHO Global Task Force on TB Impact Measurement, and highlights achievements in TB control during the period “ as well as the success of a new initiative in in which global TB data collection went online. In , there were an estimated 8. The number of notified cases of TB in was 5. The world as a whole is on track to achieve MDG Target 6. Six epidemiological subregions Central Europe, Eastern Europe, the Eastern Mediterranean, high-income countries, Latin America and the Western Pacific appear to have achieved the Stop TB Partnership target of halving the prevalence rate and four Central Europe, high-income countries, Latin America and the Western Pacific appear to have achieved the Stop TB Partnership target of halving the mortality rate, in advance of the target year of Prevalence and mortality rates are falling in all other regions with the exception of African countries with a low prevalence of HIV, although reaching the global target appears impossible in the African Region. Globally, the gulf between prevalence and mortality rates in and the target levels in African countries make it unlikely that prevalence and death rates will be halved by for the world as a whole. Reductions in disease burden achieved to date follow fourteen years of intensive efforts at global, regional and country levels to implement the DOTS strategy “ and its successor, the Stop TB Strategy “. Between and , a cumulative total of 36 million TB patients were successfully treated in DOTS programmes, and up to 6 million deaths were averted. To consolidate the major progress in global TB control achieved in recent years, intensified efforts to plan, finance and implement the range of interventions and approaches included in the Stop TB Strategy, according to the targets established in the Global Plan to Stop TB, are needed. The report was the 13th annual report in a series that started in The

main purpose of the report is to provide a comprehensive and up-to-date assessment of the TB epidemic and progress in controlling the disease at global, regional and country levels in the context of global targets set for The report the 13th in the series was published, as in all previous years, on 24 March " World TB Day. Despite its advantages, a major limitation of publishing the report on World TB Day is that much of the most important data are from two years prior to the year that the report is published. For example, with a production cycle of approximately nine months from the date of the original request to countries for reporting of data to the date of publication, with data validation, review, analysis, writing, layout and printing in between , the report included case notifications as well as estimates of disease burden incidence, prevalence and mortality from The latest year for which most of the data on implementation of the Stop TB Strategy were available was also To make the report more up-to-date, with an emphasis on data from the most recent complete calendar year, a decision to change the production cycle was taken by WHO in mid- From onwards, annual reports will be published around October. Publishing a report in October that includes data from requires two rounds of global TB data collection between the and reports. The round of data collection was conducted, as in previous years, from July to September. The main part of the report presents the latest data on the global TB epidemic and progress in TB control, up to and including data compiled in The following topics are covered in the order in which they appear: This report contains more up-to-date data than any report on global TB control previously published by WHO, with all of the key results based on data collected in Estimates of the burden of TB incidence, prevalence and mortality have been improved following 18 months of work by an expert group convened by the WHO Global Task Force on TB Impact Measurement as well as increased availability of data. The number of countries with direct measurements of HIV infection in TB patients has risen to up from 64 in the round of data collection , and TB mortality is now based on direct measurements from vital registration systems for 89 countries compared with three for which such direct measurements were used in previous reports. Estimates have also been updated using in-depth analyses and country consultations conducted during a series of regional workshops and country missions in All estimates are provided with uncertainty intervals; this will become routine practice in all future reports. Estimates of the number of TB cases occurring among women are also included. The report focuses on progress towards achieving the targets that have been set for within the context of the Millennium Development Goals and the Global Plan to Stop TB. This reflects the fact that the target year has now passed, that there are difficulties in measuring this indicator, and increasing emphasis on achieving universal access to health care. Besides reporting of data collected in , the report also highlights achievements in TB control during the period " , features updates about the work of the Global Laboratory Initiative and the WHO Global Task Force on TB Impact Measurement, and describes the success of a new initiative in in which global TB data collection went online. The exact timing will be defined after further consultations with those involved in reporting data. The report update also contains an annex that explains the methods used to produce estimates of disease burden. This annex has been included following important updates to the methods used to produce such estimates in Box 1. Methods For the round of data collection, data collection forms were updated from those used in Efforts were made to shorten the forms and to simplify the data being requested wherever possible. Two versions of the data collection form were developed a long form and a short form. In consultation with WHO regional offices, some countries that met the criteria for receiving the short form were instead requested to complete the long form. This included countries that had in previous years provided the more detailed financial data requested on the long form, and island states in the Western Pacific Region. Both forms requested data on the following topics: For the first time in , a web-based online system <http://> Following the deadline for reporting of data, all reports were carefully reviewed using a system of in-built validation checks also available to country-based staff reporting data , with any follow-up queries returned to respondents online. All data collected online in were imported to a master database that holds the TB-related data that have been compiled by WHO since Data from the two online systems used in the European Region² were uploaded to the master database separately. For the purposes of this report, all data in the global and European online systems as of 10

DOWNLOAD PDF ACHIEVING HIGHER CASE DETECTION KNUT LONNROTH, MUKUND UPLEKAR, LEOPOLD BLANC

November were imported to the master database and used, together with historical data reported in previous years, to produce analyses and related tables and figures. Country respondents continue to have the option of updating or adding data to the online system, which will be used for analyses conducted for the report. Three additional points should be highlighted: The new system allows representatives of NTPs as well as staff in WHO regional and country offices to complete the annual TB data collection forms online, replacing the previous system of recording data in spreadsheets and returning them to WHO by e-mail. The new system has the following advantages: All those using the system were able to assess progress in completing reports and had a common platform for reviewing data and resolving queries. The system was a great success: In , the system will be further developed, for example to allow easy downloading of data and the generation of country profiles. They are not recommended for collection of data within countries. A fuller explanation of the methods used to compile and analyse other data is provided in the report on global TB control. The global burden of TB 2. This is an increase from the 9. Estimates of the number of cases broken down by age and sex are being prepared by an expert group³ as part of an update to the Global Burden of Disease study,⁴ due to be published in Provisional analyses indicate that women account for an estimated 3. The five countries that rank first to fifth in terms of total numbers of incident cases in are India 1. WHO recommendations for recording and reporting within countries are described at: See also section 8 of this report. Global burden of disease and risk factors.

Chapter 6 : Global TB Control_Short Update Report by Anjan Amatya - Issuu

Mukund Uplekar, M.D., falling even faster. 1,6 This trend is the result of high-quality care and control practices that result in high rates of case detection and cure, drug-susceptibility.

Cross-project analysis of secondary data from separate project evaluations was used. Differences among PPM project sites in impact on TB control change in case detection, treatment outcomes and equity in access were correlated with differences in chosen intervention strategies and structural conditions. The analysis suggests that an effective intervention package should include the following provider-side components: Getting such an intervention package to work requires that the NTP be strongly committed to supporting, supervising and evaluating PPM projects. Further, using a local nongovernmental organization or a medical association as an intermediary may facilitate collaboration. Investing time and effort to ensure that sufficient dialogue takes place among all stakeholders is important to help build trust and achieve a high level of agreement. Introduction Government-run health-care services in low-income countries have been modestly successful in providing equitable access to high-quality care for diseases of public health importance. In many low-income countries, much of the population, across all socioeconomic strata, turns to individual or institutional private health-care providers PPs. PPs outnumber public health-care providers in some countries and often offer better geographical access and more personalized care than the public facilities. However, the clinical management practices of PPs are often inadequate. PPs have been shown to prescribe inappropriate treatment for diseases such as tuberculosis TB 8, 9, malaria 10, 11 and sexually transmitted diseases 12, 13, misuse antibiotics 14 and rarely monitor the effects of treatment or maintain records 4, 5. A second reason for growing interest in PPs is the need to address the potential negative impact of inadequate management practices such as the development of antibiotic resistance caused by the irrational use of antibiotics and the high costs of substandard care for poor people. Evidence of successful approaches to involving PPs in public health programmes is growing 7. Suggested approaches include a range of strategies focusing on demand, on supply and on policy-makers 3, 6, 7. Some evidence points to the need to use context-specific multifaceted interventions 3. Meaningfully involving PPs in TB control would be useful for two strategic reasons: The present study compared four such PPM projects. The objectives were to compare the processes and outcomes of the four PPM project sites, to correlate differences among sites with the intervention strategies chosen and the structural conditions and to identify the factors that make PPM work. All projects were launched in early and evaluated within a joint framework developed by the TB Strategy and Operations team of the Stop TB Department of WHO with the aim of enabling cross-project analysis. Evaluation was performed by external and independent resource people appointed by WHO in collaboration with academic institutions that had been involved in designing and implementing the PPM in the respective settings. These reports served as data sources for the present analysis. Data for the original evaluation were obtained through upgraded information systems within each PPM project. The information systems were based on specifically designed forms for referrals, treatment cards and upgraded reporting forms and registers. In addition, questionnaires to providers and patients were used. As a first step of the cross-project analysis, the impact of TB control was compared between the projects. TB control impact was measured through indicators of case detection, treatment outcome and equity in access Table 1. Equity in access was defined as equal access to treatment regardless of financial resources. Finally, the variation in TB control impact and PPM performance across projects was correlated with differences in structural conditions Table 2 and differences in operational intervention strategies for PPM Table 3 to identify possible relationships. Qualitative analysis was applied to identify plausible explanations for the variation in PPM performance and impact across projects. Results PPM settings and target groups The PPM projects were all launched in low-income settings with a high TB burden and a large private health-care sector with weak referral and notification links with the public sector. The Pune PPM project was based in a rural area; all others were in cities. In Ho Chi Minh City, the project was implemented

DOWNLOAD PDF ACHIEVING HIGHER CASE DETECTION KNUT LONNROTH, MUKUND UPLEKAR, LEOPOLD BLANC

in 2 of the 22 districts, with a total project population of about 1. Private physicians and pharmacies were targeted in these districts. A group of TB specialists who catered to patients from all over the city was also targeted. In New Delhi, private nursing homes in two areas with a population of about 1. In Pune, allopathic and non-allopathic PPs from one rural TB unit covering about 1000 people were targeted. In Nairobi, chest specialists who catered to patients from all parts of the city were targeted. Structural conditions Table 2 shows the core structural differences between the projects. No new legislation or formal policy on the involvement of PPs in TB control was introduced in any project. The regulatory context was similar across the settings. TB notification was not mandatory in any setting. General policies on regulating and monitoring PP practices were similarly weak in all settings. The government stewardship role varied. In Delhi, the Ministry of Health also financed all activities, whereas external research funds financed the programme in Ho Chi Minh City. The project in Ho Chi Minh City started as a research activity; in New Delhi, the government took the first initiative and the research components were added to the project later. Project funding was limited and consisted mainly of drugs supplied by a donor agency. In Pune, a research institution planned and implemented the project. Although this was done in collaboration with the NTP staff, the project did not become clearly anchored in the public sector, which was demonstrated by some public sector managers hindering project implementation. The operational responsibilities for PPM also differed among projects. In Pune, the research institution had the central role both in initiating and conducting activities in the project. The duration and intensity of dialogue between stakeholders before and during the project varied. In New Delhi, the dialogue between NTP at the state and district level and the private sector was intense, complex and lasted for about 18 months before the project was launched. DMA is a strong body representing the interests of private allopathic practitioners in New Delhi. Their input and suggestions were seriously considered in the project development process. In Ho Chi Minh City, there were attempts to bring PPs into the dialogue early and allow their input into the development process. However, the participation and contribution of PPs was weak. A problem was the lack of a clear private sector counterpart for the dialogue, as no professional association represented PPs in Viet Nam. In Pune, the research institutions tried to institute a dialogue with the higher NTP management for support to make the PPM more sustainable, but there were few signs of a true joint development process. In Nairobi, a former NTP manager took the initial steps. PPs were invited to participate in the PPM in finalizing its structure. Intervention packages Table 3 shows the intervention components at each site. Educational activities for PPs were similar across projects and strongly emphasized adopting WHO-recommended diagnostic and case management principles. In all four settings, the intervention package included sensitization and training sessions in which the NTP case management guidelines were presented and discussed with PPs. Simple forms for referral, individual patient records and reporting forms were introduced in all projects to improve the information systems and the system for referring suspected cases and cases. This component was perceived as crucial in all projects to strengthen diagnostic procedures, to effectively transfer information between providers and to enable the treatment of individual patients and the project as a whole to be monitored. All projects introduced supervision and quality control at various levels of case management by PPs. Written consent for participation from PPs was obtained in Pune only, where this was not to be considered a binding contract. In New Delhi and Pune, the NTP provided drug boxes, each containing a full course for one patient, to PPs, who dispensed them to patients free of charge. This was contingent on the use of standardized regimens and directly observed treatment. In Nairobi, PPs had access to subsidized drugs for patients who agreed to receive a standardized regimen and directly observed treatment. No data were available for control areas in Nairobi and Pune, and controlled change in case detection could therefore not be estimated. In Pune, only three patients had been evaluated at the one-year evaluation, and all three were successfully treated. With regard to equity in access, the New Delhi project made quality treatment by PPs available to people with middle and low income by dispensing free drugs. Discussion Interpretation of differences across projects The sites differed in important ways in structural conditions and the processes of PPM. These differences mainly concerned the level of government commitment and the nature of dialogue

and partnership building between the stakeholders involved. Only in the Delhi project did the government directly take the first initiative. With the initiative came funding commitment as well as direct guidance on the conditions for PP involvement. The Delhi project was the most successful in contributing to three central objectives of TB control: No other project was successful in all these respects or had government commitment to the same extent. Strong government stewardship functions mean an opportunity to manage PPs and align their practices to public health programmes. However, a top-down strategy may fail if the interests of the PPs are not considered in planning and implementing PPM. This could especially occur in settings such as those in this study in which general private health care regulation is weak, the private sector is strong, the public sector is generally weak and demand for private health care is high. The process of developing a common platform for the projects was difficult at all sites, and conflicts between PPs, NTP and intermediary organizations were so severe at times that several of the projects risked failing even before starting. This reflects the common situation of distrust between PPs and government sector and also the mutual lack of experience in intersectoral collaboration. In the New Delhi project, stakeholders conducted active dialogue during the 18 months before the project was launched and throughout the project. The positive impact on TB control in New Delhi would probably have been difficult to achieve without spending time and effort resolving conflicts. The New Delhi project thus presents an interesting combination of collaboration between a strong professional association and a committed government sector. This combination was not present in any other project. One key to success could be involving strong stakeholders in the PPM development process while acknowledging potential conflicts between these stakeholders and investing time in resolving them through active dialogue. All four PPM projects used a common set of basic intervention components, including training, strengthened referral and information systems and strengthened supervision and monitoring. The similarities in these approaches across project sites made it impossible to analyse the impact of these factors on PPM performance and outcome in this study. Nevertheless, the experiences of applying these common-sense approaches were positive at all sites, and they are believed to be fundamental components. Differences across projects concerned mainly the use of free drugs and direct and indirect financial incentives. In Ho Chi Minh City, patients directly paid the prescribing physician for the full cost of drugs. In Nairobi, the treatment outcome was acceptable although the drugs were not free of charge. This probably resulted from prepayment, which led to the selection of patients who could afford a full course of treatment and also served as a motivating factor for patients to complete treatment. However, the prepayment scheme excluded poor people. Free drugs could also be seen as an indirect financial incentive for PPs that could contribute to their willingness to participate. Some participating PPs reported that the opportunity to provide some subsidized services for low-income patient groups was a business advantage, since it improved their reputation in the community and thereby increased attendance.

Chapter 7 : - NLM Catalog Result

Mandatory tuberculosis (TB) notification is an important policy under the End TB Strategy, but little is known about its enforcement especially in high TB incidence countries.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters. All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. Advising and counselling patients and their families on immunization Advising and counselling patients with acute respiratory infections Advising and counselling TB patients and their families Advising and counselling about HIV for patients with respiratory infections, particularly pneumonia or TB Advising and counselling asthma patients and their families Advising and counselling COPD patients and their families Chapter 1 Chapter 2 Chapter 3 Chapter 4. Formulating a PAL information system Essential information: To whom are training materials addressed? What are the objectives of a PAL training workshop? What documents are needed? The new Strategy was designed to deal with challenges and obstacles that slow the progress in achieving tuberculosis control goals. This initiative is aimed at managing respiratory patients in primary health care settings while expanding TB detection and good-quality TB services. PAL focuses on the most prevalent respiratory diseases at first-level health facilities – pneumonia, acute bronchitis and other acute respiratory infections, TB, and chronic respiratory conditions including chronic bronchitis, asthma and chronic obstructive pulmonary disease. PAL uses two main approaches to achieve integrated case-management of respiratory patients in primary health care: This manual was developed by WHO to assist country institutions – health and other government ministries, social security agencies, nongovernmental organizations – that want to introduce the PAL strategy into case-management practices in primary health care. It describes a phased process of promotion, technical guideline development and adaptation, pilot testing, managerial planning and implementation. The standards and recommendations represent a synthesis of the observations and experience gathered in primary health care settings in 10 countries in all regions of the world in the past six years. The manual provides practical guidance to health managers whose efforts are crucial to the achievement of global TB control goals and national targets for casemanagement of respiratory conditions. It will also be helpful for health care providers at both first-level health care facilities and the first referral level. The overall policy and guidelines development will rest at the central level of the ministry of health as the leading agency of the country health sector. Planning and implementation will be the responsibility of the district health level and the authorities of other institutions that provide primary health care services. The PAL strategy encompasses many managerial elements of the Stop TB Strategy in relation to training, logistics, patient education, community involvement, and information systems for monitoring and evaluation. Health workers need to be prepared to assess patients presenting with respiratory symptoms, some of whom will have TB but most of whom will have other respiratory conditions. They also need to be familiar with the criteria for referring respiratory patients or for treating them at home; supplies for case-management of respiratory conditions; and guidance on health education activities and on recording and reporting of data. The manual provides guidelines and tools for health managers to meet all the abovementioned needs. Countries are encouraged to follow a well-defined, stepwise process: Although PAL is still in the early stages of promotion and development, available information from country projects suggests that the strategy may improve TB

detection and diagnosis, drug prescribing, quality of care, criteria for referral, and follow-up of patients with chronic respiratory diseases. The committee outlined, discussed and agreed on the key elements to be included in the manual. Each chapter highlights an important step in the process of adaptation, development, implementation and expansion of the PAL strategy, considered in the light of the health system environment, as experienced in country projects. Selection of the references for each chapter was carried out using the Medline package. Existing PAL guidelines for countries were used for Chapter 4. Chapter 8 describes the protocol used in countries where PAL feasibility studies have been done, and Chapter 9 covers the development of a PAL implementation and expansion plan as established in countries that have implemented PAL. No references are cited for Chapters 8 and 9. The sixth draft was widely distributed for review to: The authors and contributors have no conflict of interest in the development of this document. In an effort to achieve those objectives and to provide all people with TB with access to effective diagnosis and treatment, the Stop TB Partnership developed a global plan to accelerate the expansion of the DOTS strategy and improve the quality of TB control services. Since the inception of the DOTS strategy, achievement of the treatment target has been given priority over the case-detection target, because detecting cases makes no sense if their cure cannot be assured. Thus, expansion of case-finding should be pursued only after cure rates have improved substantially. It is now recognized that the major deficiency in controlling TB worldwide is the lower than expected case-detection rates " and that the DOTS strategy alone is not sufficient to control and eliminate TB at the global level. The box below outlines this new strategy " its vision, goal, objectives, targets and six principal components. The Practical Approach to Lung Health PAL is explicitly identified in component 3 as an innovation within the TB control community that can contribute to strengthening the health system as a whole. PAL is a patient-centred approach to improving the quality of diagnosis and treatment of common respiratory illnesses in primary health care PHC settings. It seeks to standardize service delivery through the development and implementation of clinical guidelines and managerial support within the district health system. It is intended to achieve coordination between the different levels of health care and between TB control and general health services. By linking TB control activities to proper management of all common respiratory conditions through PAL, four main benefits are expected: To achieve universal access to high-quality diagnosis and patient-centred treatment. To reduce the suffering and socioeconomic burden associated with TB. To support development of new tools and enable their timely and effective use. Basis for development of algorithms for assessment, classification and treatment of respiratory illness in school-age children, youths and adults in developing countries. Severe asthma is an emerging public health issue among the poorest people, especially minorities, living in degraded areas of big cities of both developed and developing countries. The increase is linked to changes in exposure to environmental factors that may exacerbate asthma: Asthma prevalence has increased in most developing countries , particularly in Africa and Latin America. The epidemic of asthma observed in low- and middle-income countries may continue in the future with increasing urbanization and adoption of western lifestyles, which are factors that have been associated with the increasing trends. Chronic obstructive pulmonary disease Chronic obstructive pulmonary disease, or COPD, is a nonspecific term developed to describe chronic lung disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually both progressive and associated with an abnormal inflammatory response of the lungs to noxious particles and gases. The pathological conditions that contribute to COPD are chronic bronchitis and emphysema. Emphysema is a pathological term and describes only one of the several structural abnormalities present in patients with COPD. However, it may or may not be associated with airflow limitation, which is the essential characteristic of COPD. By far the most important cause of COPD is tobacco smoking. Other important factors reported to be associated with the condition include indoor air pollution, occupational exposure to irritants, and childhood respiratory infections. Cigarette smoking continues to increase in all low- and middle-income countries and will substantially increase the global COPD prevalence, particularly among certain subpopulations in Asia, who are becoming early and heavy smokers. In addition, increasing life expectancy is likely to be followed by higher COPD prevalence.

COPD is an important cause of restricted activity and chronic disability, with a consequent reduction in quality of life from adulthood to old age. In some high-income countries, such as the United States of America, the prevalence of COPD has shown a progressive decline in men during the past decade but a progressive increase in women. Unfortunately, different survey methodologies and variable definitions for COPD make inter-country comparison of epidemiological data difficult. Available data are likely to underestimate the total COPD burden. The estimated prevalence of COPD worldwide in was per population " males and females. These estimates include people of all ages and therefore underestimate the frequency of disease in adults, because COPD rarely occurs in young age groups. The disease is currently the fourth leading cause of death globally and may become the third by Lung cancer Lung cancer was a relatively uncommon disease at the beginning of the twentieth century. Since then, its incidence in the world has been steadily growing, more rapidly after than before, in both developed and developing countries. Global incidence has been rising at 0. Lung cancer is the most common cancer in males. The estimated incidence of lung cancer varies greatly with region and depends on age and population structure, prevalence of tobacco smoking and other risk factors, and opportunities for detection and treatment. Incidence in males is highest in the countries of Europe and North America, ranging from In females, the highest rate, Lung cancer incidence is lowest in Africa. Epidemiological studies have consistently shown that the majority of lung cancer patients have a history of cigarette smoking, and the highest mortality attributable to smoking corresponds to lung cancer. There are other risk factors, however, particularly exposure to asbestos. The falling incidence observed in developed countries in recent years seems to be related mostly to decreased cigarette smoking. Cough is one of the most common reasons for patients to seek care at first-level health facilities in both developed and developing countries. Sputum production and shortness of breath are frequently reported in these health settings. Data on prevalence of respiratory conditions among patients seeking care at outpatient services were collected by WHO, using the same protocol, in 76 health units in nine developing countries in different world regions. The data were collected from at least three typical PHC facilities in each country for a period of "3 months during the rainy season or winter period. The prevalence of outpatients with respiratory symptoms varied from The classification of outpatients of 5 years and over who had respiratory symptoms and attended first-level health facilities staffed with doctors is shown in Table 2. The prevalence of clinical pneumonia was 2. Tuberculosis was diagnosed in 1. B1 11 in Europe and 4 in Western Pacific, including China. B2 6 in Europe and 4 in Western Pacific. B3 14 islands in Western Pacific. Reducing risks, promoting healthy life. World Health Report, Geneva, World Health Organization,

DOWNLOAD PDF ACHIEVING HIGHER CASE DETECTION KNUT LONNROTH, MUKUND UPLEKAR, LEOPOLD BLANC

Chapter 8 : Worldwide: Incentives for Tuberculosis Diagnosis and Treatment - calendrierdelascience.com

Every second a new person is exposed to tuberculosis (TB). Each untreated TB-infected person will infect people every year. Following the success of its predecessor, this new edition of Tuberculosis: The Essentials scrutinizes the new discoveries and observations of the key aspects of the disease.

Page Center for Global Development www. Food packages from the World Food Program of canned fish, vegetable oil, and rice generally arrive on a monthly basis for eight months. In nearly 18, individuals benefited from this program. Until the end of , most TB patients were hospitalized for the first two months the intensive treatment. They received food packages weekly from the World Food Program if they remained in the hospital and continued to follow treatment. Outpatient patients received food support conditional on making required visits and adhering to treatment under DOT. Cambodia has since moved to a fully ambulatory system. Food packages are conditional on continued attendance at the clinic for treatment. Some programs distribute food every month, some every two weeks. Food Distribution The World Food Program handles procurement and first-level distribution, and the Ministry of Health handles distribution to patients. World Food Program staff deliver the food to outpatient departments, referral hospitals, and former district hospitals now health centers. Health centers along the delivery routes are sometimes serviced directly. The delivery point for food is not always the same as that for medicine, and thus accessing food support implies that the patients incur additional costs. When it does not have a provincial warehouse, the World Food Program delivers the food directly from the national warehouse to the outpatient departments and referral hospitals. TB staff at health centers and former district hospitals are responsible for collecting food from health service delivery sites. The delivery point for food is the same as for TB medicines. Monitoring Decentralization and an increased number of food service delivery points are challenges that merit careful attention. The World Food Program conducts monthly monitoring visits to check food distribution and stock levels, verify new patient lists, and review stock balance sheets. Field monitors make random spot checks during food distribution, at which time they check food ration cards against the TB register to ensure that false patients do not receive food supplements. Reporting systems related to food support that is, keeping track of beneficiaries and leakage follow World Food Program requirements. National coordination meetings are held on a regular basis to address operational and management concerns and to identify collaborative solutions. Mobilizing local resources to fund timely and efficient distribution of food to peripheral health centers has become more difficult in recent years. In one province Kampong Speu , a system has been established that uses Ministry of Health facilities and DOTS delivery points by allocating part of the budget for operating costs obtained through user fees. Health facility directors in other provinces have shown interest in this approach. Mookherji ; Mookherji and Weil ; Mookherji and others

Chapter 9 : Atencion Integral de Enfermedades Respiratorias (AITER PAL OMS - [PDF Document]

Mukund Uplekar. LÃ©opold Blanc. Over the past decade, there has been a rapid increase in the number of initiatives involving "for-profit" private health care providers in national tuberculosis (TB).