Summary report on the

Fifteenth meeting of national tuberculosis programme managers in the Eastern Mediterranean Region

Cairo, Egypt
9–12 December 2012
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1. Introduction

Shortly after the introduction of the DOTS Strategy, the WHO Regional Office for the Eastern Mediterranean begun convening annual meetings of national tuberculosis control programme managers of all countries of the Eastern Mediterranean Region to review progress, share experiences, develop sustainable plans that focus on priorities and identify gaps.

The fifteenth meeting of the national tuberculosis programme managers was held in Cairo, Egypt, from the 9 to 12 December 2012 with a focus on strategic planning and management of multidrug-resistant tuberculosis (MDR-TB).

The meeting was attended by national tuberculosis programme managers and MDR-TB focal points from Afghanistan, Egypt, Iraq, Jordan, Morocco, Pakistan, Palestine, Somalia, South Sudan, Sudan, Syrian Arab Republic, Tunisia and Yemen, in addition to representatives from The Global Fund to Fight AIDS, Tuberculosis and Malaria and WHO staff from headquarters, the Regional Office and country offices.

The objectives of the meeting were to: review tuberculosis implementation status in the Region; follow up on the progress made in developing national strategic plans; and address MDR-TB management expansion, impact measurement and community involvement in tuberculosis control, including MDR-TB management.

The national tuberculosis control programme managers presented and discussed their national tuberculosis strategic plans, MDR-TB plans and tuberculosis control situation with WHO staff and
consultants. Gaps were identified and future plans developed according to recommendations.

The first day provided participants with an overview of the tuberculosis control situation, globally and regionally, and recent updates in tuberculosis control: the WHO post-2015 strategy, new WHO guidelines on tuberculosis contact investigations, and progress made in the area of tuberculosis control in complex emergencies. Participants were also briefed about the Global Fund new funding model.

The second day focused on methods for developing a strategic plan for tuberculosis followed by country presentations and review of strategic plans. On the third day, participants worked on addressing gaps in national strategic plans identified by the panel and peers during presentations and developing work plans for finalizing their plans.

2. Summary of discussions

In general, some national strategic plans were not composed of the five main components: core, monitoring and evaluation, technical assistance, operational and budget plans. These countries were advised to incorporate the missing component(s).

Some weaknesses were also identified in the formulation of gap analysis, goals and objectives, and strategic directions. Some incoherence was also identified between the different components of the national strategic plans.

The following issues related to specific country national strategic plans.
For Afghanistan, there was a need to increase demand to reach the 70% case detection rate and to address barriers to case finding and notification, including geographical problems impacting access to health services, gender issues, cross-border issues with Pakistan, and issues relating to certain high-risk groups (refugees, internally-displaced persons and prisoners).

Regarding Djibouti, the national strategic plan should not be formulated based on Stop TB strategy components, while the Capture-recapture (Inventory) study is needed to refine the estimates. Monitoring and evaluation, and technical support plans, should be incorporated in the national strategic plan.

In Egypt, the restriction of the sale of medicines over the counter is being considered. There are opportunities and threats from outside the programme and there is a need for clarity. It was noted that while a rate of 50% of tuberculosis patients testing for HIV was good for Egypt, the WHO recommendation is to test all tuberculosis patients.

For Iraq, there is a need to present relevant data in the national strategic plan. In complex emergency settings the focus should be on treating the current pool of tuberculosis patients.

In Morocco, there is an inconsistency between good performance and a decline in incidence, and the Capture-recapture (Inventory) study is needed to obtain accurate estimates, especially regarding the case detection rate. A column should be added in the register on whether the patient resides in the country or not. Extrapulmonary tuberculosis cases need to be investigated scientifically and LED microscopy should be introduced. There is a major problem with the laboratory network. The involvement of nongovernmental organizations is needed, including in the tracing of defaulters. A
process of decentralization is under way and regional teams need to be constituted.

In Pakistan, the incidence is higher than estimated and many cases present in the community are missed. A disease prevalence survey has been conducted and preliminary results are ready so the estimates will be higher in the next global tuberculosis report. At the current pace it will be hard to reach the plan’s goal. The current national strategic plan was developed in 2011 and will be more ambitious when it is revised with the rapid scale-up of the public–private mix (PPM) component of the strategy, improved suspect management, and improvements in the infrastructure, through Global Fund funding. However, the financial gap is still not filled. A quest for cost-efficiency should be incorporated into the national strategic plan, while high political commitment should be matched with higher investments by federal and provincial governments. Measures need to be taken to address the problem of unlicensed medical practitioners. Many private providers refer patients to the national tuberculosis programme laboratory network and these cases are not registered in the tuberculosis register.

No gap analysis was shown in the presentation and threats are expressed as weaknesses (e.g. slums, security issues). The goals and objectives of the plan are not quantified. The confirmation rate of pulmonary tuberculosis is still low at 40%, despite the huge diagnostic capacity. This gap has not been adequately bridged and there is a need to be strategic after the transitional period of the past year and a half. The slums still have to be reached, which will increase case notification. The strategic plan should be more dynamic and information is still missing. There is good capacity in managing MDR-TB in Punjab but this capacity is lacking in the
other regions. An emergency preparedness plan needs to be identified.

In Palestine, tuberculosis is not a big problem and is on the way to elimination. However, the modalities of activity implementation need to be spelt out and active case finding is recommended.

In Somalia, there is extensive involvement of nongovernmental organizations which is a positive feature.

In South Sudan, there is a need to issue strong legislation regarding tuberculosis and to update the national plan according to the developments in the laboratory section. Funding issues have prevented the renovation of the national reference laboratory. The plan should focus on the basics such as clarifying its objectives. Experts in laboratory services may come up with new ideas to address the issues.

For Sudan, it is important to consider the results of the missions conducted in 2012 and adjust the plan accordingly.

For Tunisia, gap analysis should be done based on the SWOT analysis. The current targets are not ambitious enough and the operational plan should show how interventions will be implemented. The role of nongovernmental organizations was not clear enough and political commitment needs to be mentioned as an opportunity. The budgetary deficit needs to be clearly identified. There is a large proportion of extrapulmonary cases and this should be studied.

With Yemen, the objectives are not clear enough; there is confusion between objectives and interventions, and a lack of consistency
between the plans and interventions. It is unclear how the activities will be operationalized in the absence of an operational plan. The plan should be revised based on the latest assessment.

Issues related to the management of MDR-TB in countries were also discussed.

In Afghanistan, the guidelines are not in line with WHO recommendations. The method of transportation of sputum needs to be clarified.

In Djibouti, the short regimen can only be done within a research framework.

In Jordan, confirmation of tests from private laboratories requires quality assurance and supervision on a monthly basis. Drug susceptibility testing is conducted only in the national reference laboratory.

In Pakistan, cross-border MDR-TB patients are arriving from Afghanistan. Infection control guidelines for community-based interventions where patients are sent into the community, indicate that within households people should be made aware. There are 981 patients on second line anti-tuberculosis medicines and patients are hospitalized for 1–2 weeks to two months. The funding gap needs to be highlighted.

In Somalia, there are four GeneXpert machines and the opportunity this provides should be taken. Data should be disseminated for advocacy purposes. MDR-TB management planning started in Global Fund Round 7. Funds for R10 will only be released once the drug-resistance survey is conducted as part of R7.
In South Sudan, MDR-TB management was not included in the Global Fund R7 proposal, which does not allow for any added activity. The international community has a duty to find ways to raise funds for MDR-TB treatment. Capacity at state-level needs to be strengthened to increase case detection. WHO ethics guidelines say that it is appropriate to test even if there are no medicines, as patients have the right to know their status.

In Sudan, the MDR-TB management model of care is mainly an ambulatory one and the conditions for ambulatory care, including community-based treatment, should be met. The infection control committee at the Ministry of Health does not only deal with tuberculosis, but a sub-committee is to be established specifically for tuberculosis. The infection control plan has been endorsed and there is a plan to establish a centre of excellence.

In the Syrian Arab Republic, MDR-TB patients from Aleppo and Homs have been relocated as a provisional measure after the destruction of treatment centres and laboratories.

**Recommendations**

1. National tuberculosis control programmes should finalize their national strategic plans by addressing the gaps discussed during the meeting [Target: Q2, 2013: Afghanistan, Djibouti, Egypt, Iraq, Islamic Republic of Iran, Morocco, Pakistan, Somalia, South Sudan, Sudan, Tunisia and Yemen; Q4, 2013: Syrian Arab Republic].

2. National tuberculosis control programmes should incorporate their technical assistance needs in their plans for 2013. These technical assistance plans should be coordinated by the
national tuberculosis team focal points and submitted to the Regional Office [Target: 31 December 2012].

3. WHO should provide technical assistance to countries using the tuberculosis team mechanism through funding from different sources (Global Fund, tuberculosis team, others donors, domestic funds, etc.).

4. The Regional Office should consolidate the response received from countries on the WHO post-2015 strategy and provide feedback to countries [Target: 31 January 2013].

5. The Regional Office should organize a consultation to revise WHO guidelines on tuberculosis control in complex emergencies, including guidance on developing preparedness measures and contingency plans to address these emergencies [Target: Q2, 2013].

6. The Regional Office should organize a meeting on national strategic planning for tuberculosis elimination in low burden countries [Target: Q1, 2013; Gulf Cooperation Council countries, Jordan, Lebanon, Palestine].