

CHAPTER 3

Political commitment and coordination

3.1 Chapter objectives

Sustained political commitment is a prerequisite for control of drug-resistant TB. This chapter considers how political commitment can be translated into practical measures to support all aspects of the framework for control of drug-resistant TB, and the practical implications for national TB control programmes. The main elements are described and a checklist for programme managers is provided.

3.2 General considerations

Sustained political commitment and leadership are the foundation for any sound programme to control TB. The legal and regulatory context defines the potential as well as the structure and policies of the national TB and DR-TB control programmes. Political commitment is expressed through adequate financial support and appropriate infrastructure, including facilities and trained human resources. Coordination among the different components of public and private health programmes and organizations is essential for successful programme implementation. Sufficient training and retention of medical and public health personnel depend on long-term government planning and support.

3.3 Political commitment

Political commitment must be expressed at all stages of the health intervention process, from planning and implementation to monitoring and evaluation. Political support needs to be garnered from sources including government ministries and regional departments responsible for TB control, nongovernmental organizations and the private sector, the pharmaceutical industry, academic and research institutions, professional medical societies and the donor community. This commitment takes the form of financial and human resources, training, legal and regulatory documents, infrastructure and coordination of all stakeholders involved in all aspects of the framework for control of drug-resistant TB.

3.3.1 Sufficient economic support

The national TB control programme budget must be sufficient to develop and retain an adequate workforce with interest and expertise in drug-resistant TB without weakening the workforce of the national programme as a whole. The financial resources needed to support the framework should be provided. There should be no financial barriers to patients' accessing appropriate care for drug-resistant TB. Human resource needs are discussed in Chapter 16.

3.3.2 Regulatory and operational documents

Before embarking on a DR-TB control programme, national and regional authorities need to develop policies as a foundation for any subsequent legal, administrative and technical support necessary for the initiation, implementation and monitoring of the programme. Regulatory document(s) should consider how the programme will be integrated into the national TB control programme. The following are examples of the use of regulatory and operational documents:

- Legislation can be drafted to ensure proper registration, availability, quality, safety and distribution of second-line drugs. (Often, strict control of second-line drugs is possible only after establishment of the programme to provide quality-assured drugs free of charge to patients.)
- A local steering committee or expert committee can be formed to meet periodically to consult on individual patients and to address programmatic problems.
- A memorandum of understanding delineating responsibilities and funding is often necessary if multiple organizations are involved. In settings where programmes involve different ministries or departments (including, for example, the prison system or the social security system), an interministerial or inter-departmental agreement should be signed that codifies the mechanism for coordinating services for TB diagnosis and treatment between all authorities.
- A programme manual can be the vehicle for disseminating operational and clinical protocols to ensure consistency. It should be officially endorsed by the relevant authorities. The manual describes treatment protocols, defines responsibilities for different health-care providers and delineates the human resources that will be needed. It specifically defines how patients will be diagnosed, registered, reported, treated and followed up, in addition to programme monitoring and evaluation. Items to be included in the programme manual are proposed in Box 3.1.

3.4 Coordination

Coordination needs to include the contributions of all the key stakeholders, organizations and external partners, as considered below.

BOX 3.1 PROPOSED ELEMENTS OF THE DR-TB CONTROL PROGRAMME MANUAL

- Background on the DOTS programme and its integration with treatment of drug-resistant TB
- Organization and management of the DR-TB control programme
- Case detection, diagnosis, classification of and reporting requirements for drug-resistant TB
- Organization of the laboratory network, including quality control procedures for laboratories providing culture and DST
- Treatment regimens for drug-resistant TB
- Management of adverse effects caused by antituberculosis drugs
- Management of drug-resistant TB in special populations and situations (including children; pregnant or lactating women; diabetes mellitus; HIV; renal or hepatic insufficiency; the elderly; alcohol and drug-dependent patients; prisoners)
- Case management system including DOT, transition to ambulatory care, patient assistance and defaulter tracing
- Standards for evaluation and monitoring of treatment and of overall project performance
- Plan for infection control in health facilities and other methods to prevent drug-resistant TB

- **National TB control programme.** The national TB control programme is the central coordinating body for the activities described in the strategic framework. Commitment of the necessary resources, particularly for a strong central management team, ensures that all elements are in place, from the procurement of second-line drugs to the appropriate implementation and monitoring of the DR-TB control programme. As needed, the national programme may build partnerships with all relevant health-care providers.
- **Local health system.** DR-TB control programmes should be tailored to fit the local infrastructure. The precise organizational structure of the programme may vary greatly between different settings depending on how the local health care is provided. Transfer from hospitals to outpatient settings or between DOT centres requires care, advance planning and good communication. Given the type of care required during the treatment of drug-resistant TB, a team of health workers including physicians, nurses and social workers is often used.
- **Community level.** Community involvement and communication with community leaders can greatly facilitate implementation of treatment and respond to needs that cannot be met by medical services alone. Community education, involvement and organization around TB issues can encourage a feeling of community ownership of control programmes and reduce stigma. In some circumstances, communities have helped to address the interim needs of patients, including the provision of DOT, food and/or housing.

- **Coordination with prisons (1).** Transmission in prisons is an important source of spread of drug-resistant TB in some countries, and infection control measures can reduce incidence substantially. In many cases, inmates are released from prison before they finish treatment. Close coordination and communication with the civilian TB control programme, advance planning, targeted social support and specific procedures for transferring care will help ensure that patients complete treatment after release from prison.
- **All health-care providers (both public and private) (2).** In some countries, private practitioners manage most cases of drug-resistant TB. In these settings, it is important to involve the private sector in the design and technical aspects of the programme. Many PPM programmes have demonstrated effective and mutually beneficial cooperation (3). In PPM systems, patients and information move in both directions. For example, private providers can be compensated fairly through negotiated systems of reimbursement, and the public health system may provide clinic- or community-based DOT as well as registering patients and their treatment outcomes. Similar PPM mixes can be established for treatment of drug-resistant TB, but they require exceptional coordination.
- **International level.** International technical support through WHO, the GLC, supranational TB reference laboratories and other technical agencies is recommended. The national TB control programme should set up and lead an interagency body that ensures clear division of tasks and responsibilities.

3.5 Proposed checklist

From the earliest planning phase, the full range of issues encompassed in political commitment needs to be addressed. These include adequate financial support, an enabling regulatory environment, sufficient human resources, physical infrastructure and coordination. In addition, a communication strategy should be established to ensure that information is disseminated effectively from the central level to the periphery and that reports from the peripheral level are received centrally. Box 3.2 provides a checklist for programme managers, summarizing the key aspects of a DR-TB control programme.

References

1. Bone A et al. *Tuberculosis control in prisons. A manual for programme managers.* Geneva, World Health Organization, 2000 (WHO/CDS/TB/2000.281).
2. *Involving private practitioners in tuberculosis control: issues, interventions and emerging policy framework.* Geneva, World Health Organization, 2001 (WHO/CDS/TB/2001.285).

BOX 3.2 SUMMARY CHECKLIST FOR DR-TB CONTROL PROGRAMME MANAGERS**Laboratory**

- Specimen collection system for smears and cultures
- Dedicated laboratory space
- Adequate staffing and training
- Testing and maintenance of equipment
- Biosafety measures in place
- Reagents supply
- Supervision and quality assurance system (relationship with supranational TB reference laboratory established)
- Results reporting system to treatment care centre
- Laboratory for the free monitoring of electrolytes, creatinine, thyroid function and liver enzymes in place
- HIV testing, counselling and referral available
- Pregnancy testing

Patient care

- Council of experts or steering committee set up
- Adequate capacity and trained staff at the health centre for DOT and patient support
- Adequate DOT in place and plan to ensure case holding
- System to detect and treat adverse effects including appropriate medications
- Patient and family support to increase adherence to treatment, such as support group, psychological counselling, transportation subsidy, food baskets
- Patient, family, and community health education, including stigma reduction

Programme strategy

- Integration with DOTS programme
- Sources of MDR-TB control identified and shut off
- Legislation for treatment protocols accepted
- Project manual published and disseminated
- Strategies for prioritization of patient waiting lists
- Location of care defined and functional (ambulatory vs. hospitalization)
- Integration with HIV care
- Integration of all health-care providers into the DR-TB control programme

Prevention

- Sound implementation of DOTS programme
- Infection control measures taken where all MDR-TB will be treated
- Contact tracing for MDR-TB cases in place

3. *Towards scaling up. Report of the Third Meeting of the PPM Subgroup for DOTS Expansion.* Geneva, World Health Organization, 2005 (WHO/CDS/TB/2005.356).