

**Strategic Plan to Control Tuberculosis
Somalia
2010-2014**

Equitable Access to Quality Diagnosis & Treatment of
TB

version 17 March 2010

Foreword

A Few wise words on behalf of the Ministries if possible, if not on behalf of the NTPs/WVI.

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Acronyms & Abbreviations

ACSM	Advocacy Communication and Social Mobilization
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CCM-Italy	Comitato Collaborazione Medica-Italy
DCT	Diagnosis Counseling and Testing
DOT	Directly Observed Treatment
DRS	Drug Resistance Survey
DST	Drug Susceptibility Testing
ENRS	Electronic Nominal Registration System
GDF	Global Drug Facility
GFATM	Global Fund Against AIDS TB and Malaria
GLC	Green Light Committee
HIV	Human Immunodeficiency Virus
HSC	Health Sector Committee
IDA	International Dispensary Agency
IPT	Isoniazide Preventive Therapy
ISTC	International Standards for TB Care
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MDR-TB	Multidrug-Resistant TB
MOH	Ministry of Health
NGO	Non-Governmental Organization
NRL	National Reference Lab
NTP	National Tuberculosis Program
PAL	Practical Approach to Lung Health
PHC	Primary Health Care
PLWHA	People Living With HIV/Aids
PPM	Public Private Mix
PR	Principle Recipient
TB	Tuberculosis
TB/HIV	HIV-Related TB
UNHCR	United Nations High Commission on Refugees
VCT	Voluntary Counseling and Testing
WFP	World Food Programme
WHO	World Health Organization
WVI	World Vision International Somalia (GFATM Principle Recipient)
XDR-TB	Extensively Drug Resistant TB

I. Executive Summary

1-2 pages maximum, this section shall be written after finalizing other sections.

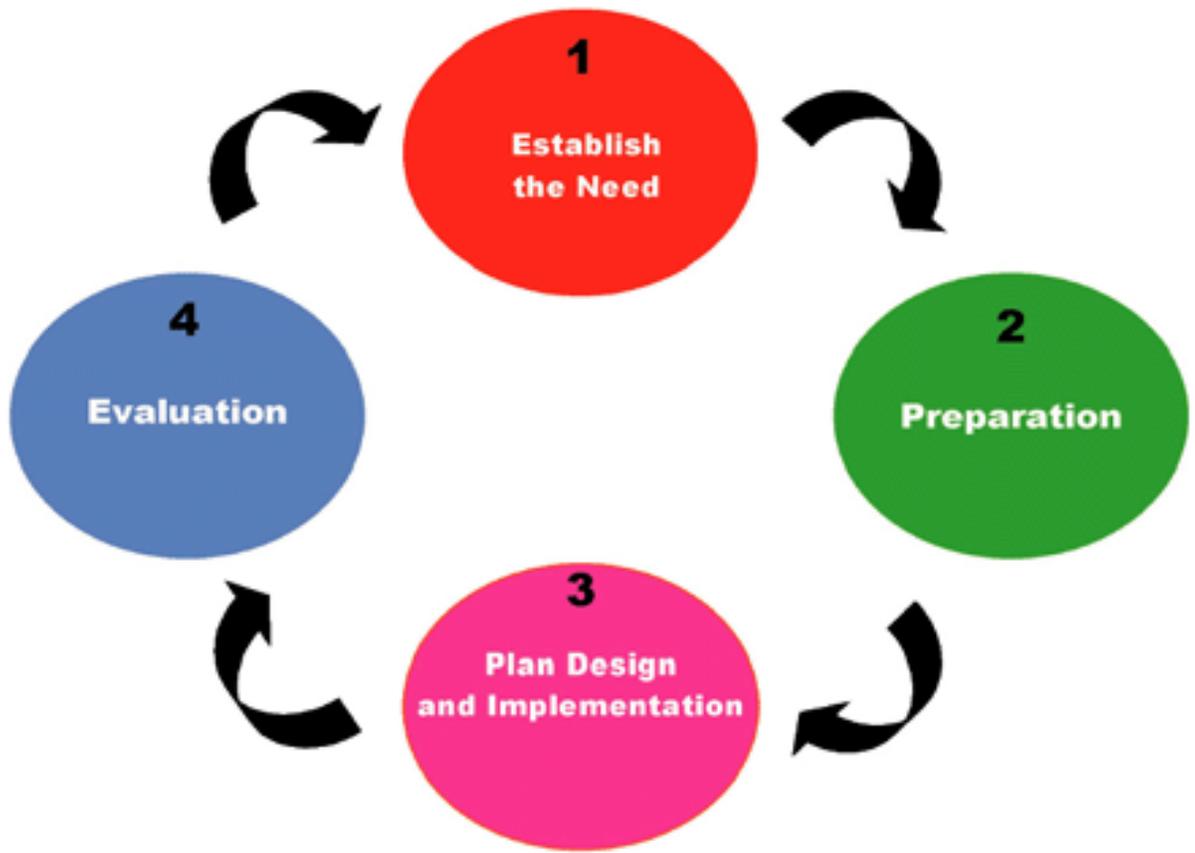
II. Scope & purpose of Strategic Plan

The aim of this document is to present the strategic approach to tuberculosis control in Somalia, for the period of 2010-2014. This document is largely based on the Global Stop TB Strategy (2006-2015)¹ developed by the Stop TB Partnership, which describes the main challenges, strategies, and activities for TB control considering the specificities of Somalia. The GFATM project has facilitated development of this document with valuable inputs of a wide-variety of national and international partners.

The current document is to serve the National Tuberculosis Control Program (NTP) and the Ministries of Health, national and international partners as a roadmap and guide to define the objectives, activities and means to progress towards the targets build up on strengths, and address the weaknesses while taking into account the opportunities and threats. The plan is based on six elements of the global Stop TB (STB) strategy tapered to specific context of Somalia. This document also includes the time plan of activities and funding resources.

In order to develop the current strategic plan, a need assessment was conducted by seeking inputs of stakeholders. The partners follow the below cycle in order to make sure the plan is up to date and modified based on the result of the evaluation of the TB control programme.

¹ <http://www.stoptb.org/globalplan/assets/documents/GlobalPlanFinal.pdf>



III. Background information

I took information in this section mostly from GFATM proposal round 7 as well as WFP and Health Sector Document and WHO report 2009 Please advise if there are needs to update some. Thanks and regards,

Somalia has population of 8,196,000 with 145 in 1000 under-5 mortality rate. Total health expenditure in 2008 is reported as 8 USD per capita.

The national health system is divided in the zonal areas with a Ministry of Health and Labour in Somaliland, a Ministry of Health in Puntland and a Ministry of Health of the Transitional Federal Government located in Central-South. In both Puntland and Somaliland, efforts have been made to put in place the basic elements of a health care system which are delivered by the Health authorities and NGOs with technical support from UN agencies. In the Central-South, public health services are provided mostly by NGOs. Overall, the public health network is largely fragmented, given the divisions and the variety of agencies and programs. The package of services provided by health facilities is conditioned by the external support received. Few national strategies and policies, such as the Health Sector Strategy have been developed in more than a decade. Most health infrastructures were seriously damaged and looted during the civil war. Inventories report 86 hospitals (with 24 functional public hospitals) and just under 200 health/MCH centres and 470 health posts, though the functioning status of many health facilities is unknown. Overall, the public health care network is small and concentrated where security conditions allow. Facilities are generally poorly equipped and private health care outlets have proliferated, and their features are poorly documented. Overall, the quality of the provided care is a source of concern and needs improvement.

The health workforce is small and relatively under-skilled. Skilled cadres in Puntland are fewer than 200, while in Somaliland this figure is around 400. No reliable counts are available for Central - Southern Somalia, and the number of workers operating private outlets is unknown. The ranks of laboratory technicians, pharmacists and midwives are also diminutive. The performance of health workers is considered poor, as they are often not properly supported. Many were trained before the war and are irregularly supervised or not supervised at all (with the exception of the GFATM TB and Malaria, existent but under-resourced).

There is a lack of national resources to finance anti-TB drugs and laboratory supplies. GFATM supports the supply of drugs needed by disease-control programs including TB, Malaria and HIV/AIDS. Many NGOs in health care acquire drugs through their own channels; however, anti-TB drugs supplied by the GFATM are available to all TB service points. Unregulated drug selling outlets are commonplace, and anti-TB drugs of uncertified quality and source have also been found in selling outlets in some areas. The TB programme has worked with local health authorities, and bans on the sale of anti-TB drugs have been declared in some zones but are yet to be fully enforced.

There is no consolidated estimate of the resources allocated to healthcare provision in Somalia from public and private sources. Most public financing to healthcare is provided by the international community, with the GFATM presently as one of the largest donors. External contributions were below US\$5 per head in 1993. Many of the public facilities run a cost-recovery system; however, TB care services are provided for free.

The TB program operates under the umbrella of the Global Fund and has recorded significant achievements since its inception. With 47 TB centres countrywide, there is at least one centre per region. However, there are gaps in coverage for some regions and in hard-to-access areas. Most TB centres use physical infrastructure that has not been rehabilitated for many years. The information system uses the standard WHO recording and reporting system, and inputs are provided under the GFATM R3 program. The local health authorities participate in the supervision, monitoring and evaluation of the program, but without a national budget, they depend on the GFATM resource.

Somalia, has been suffering some years of civil unrest with no functional central government. Somalia has a high incidence rate of Tuberculosis. The latest estimates in 2009 indicate that 21,634 people develop TB every year (249 per 100,000 population), and 8,500 of them are sputum smear positive (110 per 100,000 population). HIV/AIDS prevalence estimated at 3% (median value), though the prevalence is low compared to other countries in Sub Saharan Africa, this percentage represents a big threat to poor people both in urban and rural.

WHO estimated 6.8% HIV prevalence among TB incident cases. HIV/AIDS and TB are serious public health threat, particularly in the wake of collapsed health infrastructure due to economic crisis and civil unrest.

No national survey to first line and/or second line antiTB drugs have been conducted however 1.8% and 10% MDR-TB patients among new and retreatment patients are estimated respectively.

Because of the absence of the central government, TB care has been provided through a collaborative arrangement among international and national partners and local authorities. R3 support has laid the groundwork for TB care. The support has focused on the improvement of infrastructure such as renovation of 18 TB centres and recruitment of key staff. The support has also assisted the scale-up of DOTS through provision of laboratory training and materials, TB drugs from GDF, and improvement of M&E activities including quarterly supervision. A nationwide tuberculin survey was also conducted.

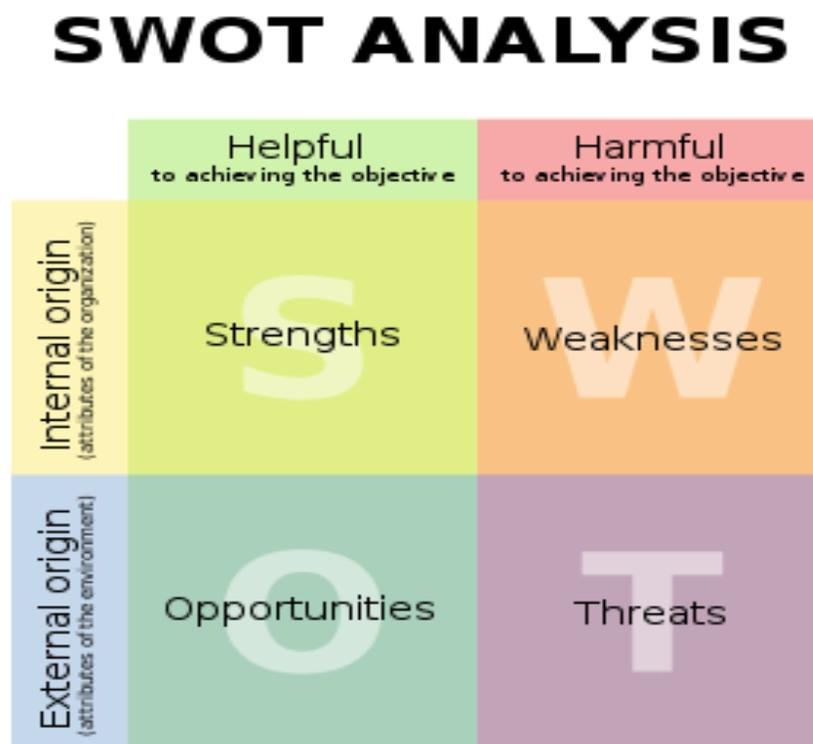
A tuberculin survey conducted in 2006² (funded by GFATM) also indicates the high prevalence of TB. The estimated annual risk of TB infection was 2.22% (0.58-3.18%). The latest TB case detection rate for new sputum smear positive pulmonary TB patients was 64% and for all smear positive cases 49%. The treatment success rate for new sputum smear positive pulmonary TB cases is maintained at over 89% (WHO Report, 2009); among retreatment patients, 78% are successfully treated.

² Risk Of Mycobacterium Tuberculosis Infection In Somalia: National Tuberculin Survey 2006, (07/61), EMHJ, Vol.14 No.3 July 2008.

IV. SWOT analysis

*. The process the SWOT analysis has been put together. **This section is very important** in order to develop the plan which is relevant to Somalia. The core group members shall review the SWOT analysis of all stakeholders and their inputs in the problem tree analysis. Based on these information and with reviewing other documents including performance of the programme a sound SWOT analysis for TB control programme shall be developed.*

Based on a series of national workshop and inputs from stakeholders the following areas are identified as strengths, weaknesses, opportunities and threats.



Strengths

- A. **Political commitment:** long-term planning, and financing to reach WHA and MDG targets.
- Established DOTS model of care **Standardized treatment**, under proper case management (**DOT**), to reduce acquired drug resistance and increase chance of cure
 - **An effective and regular drug supply system**, including drug management capacity

- Efficient **monitoring system for programme supervision and evaluation** including measurement of impact
- B. Sustained 95% DOTS application by all TB centers
 - C. Existence of Damiin (granter) system to which high treatment success rate attributable, is specific for Somali TB program
 - D. Sustained over 85% treatment success rate for new sputum smear positive pulmonary TB patients
 - E. Trained staffs in Somaliland TB Control Programme
 - F. Establishment of Satellite sites to expand the scope or the catchments area of the existing TB facility.

Weaknesses

- Inadequate distribution of the TB facilities throughout the country (e.g. only eight TB Microscopic units in Somaliland for 3,500,000 population
- Limited access to TB facilities (only 46% coverage). The majority of the unreached TB patients are in rural area or in the districts where is no TB center.
- Lack of access to culture and DST and other methods to diagnose drug resistant TB cases
- Management of TB suspects as well as TB contacts is not yet well established.
- Health care providers in other public sectors and private sector are not fully involved in TB control
- Limitations of the Planning – Programming – Budgeting –Spending - as part of MOH health planning
- Awareness of TB is not always high in the community because of low ACSM, and TB is often stigmatized.

Insufficient health system

- The NTP staff is limited to only two one doctor and one laboratory technician
 - No TB control innovation that strengthen health systems
 - No adaptation of innovations from others to TB control
 - No Practical Approach to Lung Health (PAL)
- A. Unsatisfactory empowering of patients and communities through ACSM
No community TB Care (CBTB)
 - B. Inadequate enabling and promoting researches

- C. Inadequate infection control measures (Lack of proper incinerators and safety cabinets, respirators and masks)
- D. Limited role of NTPs in the major activities such as budgeting and order of drug and other supplies.
- E. No mobile clinic to reach the unreached TB patients which could synergize the existing active case findings.
- F. Insufficient trainings or fellow ships;
- G. No established National partnership forum
- H. No comprehensive common supervision check list but there are various ones applied by the different organizations involved in the M and E section of this program
- I. Insufficient technical assistance in MDR-TB, TB/HIV and ACSM

Opportunities

- International community readiness to support further the TB control programme
- New GFATM grants can provide additional resources
- Health sector reform

Threats

- Lack of sustainability of the programme, the TB programme is donor dependant financially, and when it stops it will be difficult to get enough budgets.
- Insecurity can occur any time anywhere in the country: In addition to the political instability, common banditry affects access and operations in many regions, while organized large-scale piracy has escalated to unprecedented levels (according to the International Maritime Bureau, the coast of Somalia qualifies as the most dangerous in the world).
- Increasing rate of HIV in the community
- Increasing rate of drug resistant TB particularly MDR-TB and XDR-TB

V. Programme Goal

To decrease the burden of tuberculosis in Somalia, with emphasis on accessibility, affordability, quality, equity, sustainability, and patient satisfaction, in line with the MDGs and the Stop TB targets.

This goal is planned to be achieved with implementing the following policies:

- Integration of national TB control programme into health services
- Engaging all care providers including private sector
- Comprehensive diagnosis and treatment of all forms of TB in adults and children
- Patient-centered approaches
- TB/HIV policy for collaborative activities
- Maintenance of Quality Assurance system
- Free provision of equitable and universal access to health care services

VI. General Objectives

(Adapted from Stop TB components)

1. To pursue, optimize and sustain quality DOTS
2. To address TB/HIV, MDR-TB and other challenges
3. To empower patients with TB and communities

VII. Specific Objectives

1. To strengthen and maintain the supervisory capacity at all levels (central and peripheral level) to ensure proper implementation of TB control activities by 2011
2. To maintain a TB case detection rate of sputum smear positive pulmonary cases of 70% at least throughout 2010-2014
3. To achieve and maintain MDR-TB case detection rate of 65% of estimated MDR-TB cases by 2013
4. To establish surveillance of HIV among TB patients by 2011
5. To have established Three Is across Somalia by 2014
6. To achieve and maintain a treatment success rate of at least 85%, 75% and 65% for all new sputum smear positive pulmonary patients, retreatment patients and MDR-TB cases detected by 2014
7. To establish PPM model covering at least 50% of the population by 2012

VIII. Link to Health System & other development policies

Due to several years of civil unrest, access to general health services is low and uneven, particularly once the needs of the significant nomadic population and the extremely low population density are taken into account. Economic, cultural and gender barriers also play an important role in limiting the access to health services, in particular for the most vulnerable groups.

Regular supervision and surveillance activities are limited, given the lack of systems and infrastructure. In the absence of local health institutions, the formally known as Somali Aid Coordinating Body was set up in 1993 to coordinate international aid to Somalia. Based in Nairobi, there is an open forum of all relevant stakeholders and is supported by UNDP and major international donors including the EC, World Bank, DFID and the Italian Embassy.

It is composed of various sectoral committees, one of which is the HSC (Health Sector Committee), which has a specific mandate of addressing health sector issues. UNICEF, WHO and other partners are responsible for health programs and projects, whilst implementation of health interventions and services is through international and local NGOs as well as community based organizations (CBOs). Health strategies, programs and interventions in Somalia are made through consultative processes including HSC/SSS, NGOs, UN bodies and the local Somali authorities.

Technical working groups have been established via the SSS HSC and are open to all organizations working in Somalia. TB is among the active working groups and draws together implementing partners that meet bi-monthly. A TB Coordinating Team (TBCT) composed of the PR, WHO, representatives from local authorities, CCM Italy, and the SSS HSC Coordinator conducts regular meetings to discuss technical issues on TB and management issues.

Activities under this strategic plan will be closely coordinate with health sector reform.

IX. Activities

1. Pursuing, optimizing and sustaining quality DOTS

Under this component, the political and financial commitment needed for effective TB control in line with the Global Plan to Stop TB 2006-2015 and the MDGs will be raised and sustained. NTP will achieve complete coverage of DOTS for all TB cases, and all public health units provide TB care or referral of TB suspects according to the International Standards of TB care and the Stop TB strategy by 2011.

- ?? more TB Centres will be established based on population density and security.

2. Adapting DOTS to respond to TB-HIV, MDR-TB, and other special challenges

2.1 Prevent and Control multi-drug resistant TB:

GFATM project will proceed with a National Drug resistance survey to first line anti-TB drugs. A comprehensive model of care with patient-centered approach will be worked out. NTP will submit an application to GLC for a cohort of patients of 150 MDR-TB patients in 2010. With gaining experience scale up of MDR-TB project is foreseen from 2012 onwards. Prevention of further development of MDR-TB with emphasis on patients' follow-up and direct observation of treatment stay as cornerstones.

2.2 Implement collaborative TB/HIV activities:

In 2010, mechanism of collaboration between TB and HIV programmes will be fully established. The NTP strategy is to build strong collaborative bridges with the HIV/AIDS control program to identify and notify new cases of TB among HIV/AIDS and to address high risk groups, train the personnel on how to suspect and detect new cases, record and report all cases and ensure sustainable, regular and uninterrupted anti-TB drug supply. Three Is (Infection Control, Intensive phase case finding and Isoniazid prophylactic Therapy) will be implemented in a phased manner across the country in 2010-2012 and will be maintained 2012 onwards. To decrease the burden of HIV among TB patients, health education and provision of Antiretrovirals and cotrimaxazole preventive therapy among TB/HIV coinfecting individuals will be introduced and maintained from 2011 onwards.

2.3 Address prisoners, refugees, and other high risk groups:

NTP strives to enroll all TB cases in the program being a reference entity for TB control in the country. This means that all other partners involved in TB control report TB cases detected to NTP.

NTP will reinforce links with the focal persons in prisons carrying the responsibility to detect and treat TB cases and has been supplying prisons with the necessary anti-TB drugs. NTP prioritize collaboration with national and international NGOs for health education and social support.

Referral of TB suspect cases and ambulatory treatment of TB among refugees will be ensured through collaboration with UNHCR and other relevant agencies from 2011 onwards.

3. Engaging all care providers

Under this component, NTP promotes involvement of health care providers and standard approaches to TB control in other sectors, including universities and private sector.

3.1 Public-Public, and Public-Private (PPM)

The pilot project to work on PPM will be assessed in 2011 and based on the findings PPM will be expanded to other regions.

3.2 International Standards of TB Care (ISTC) will be shared with Universities and Association of Medical Doctors. NTP will distribute ISTC and catalyzes its endorsement by different associations.

4. Empowering patients and communities

4.1 Advocacy, Communication and Social Mobilization:

NTP builds up a strategy for Advocacy, Communication and Social Mobilization (ACSM) to pave the way to all stakeholders, decision makers and the civil society to contribute to TB control. Their involvement should cover planning, financing and implementation of different TB control activities.

The ultimate goal for Advocacy, Communication and Social Mobilization (ACSM) is to build partnership among all stakeholders for:

- i. Improving the knowledge of TB control policies, services and activities,
- ii. Building up two way communication between TB care providers and people with TB,

- iii. Mobilizing societies and communities in the campaign to fight TB.

Community participation in TB Care:

The NTP strategy in community participation is to involve the civil society in fighting the TB problem. In addition a complete network between the NTP and all NGOs nationwide will be established. *(we need to expand this further)*

This network will be responsible for:

- Assessing the knowledge, attitude and perception of the population regarding TB;
- Assessing the social needs and rehabilitation requirements for TB patients;
- Involving community leaders to collaborate for case detection and health education;
- Involvement in the World TB day and smoking cessation day,
- Forming community volunteers, groups for taking care of TB patients and implementing DOTS strategy.

4.2 Patients' Charter for Tuberculosis Care:

Developed by patients from around the world, the patients' charter outlines the rights and responsibilities of people with TB and complements the ISTC for health care providers. It is based on the principles of various international and national charters and conventions on health and human rights. Its purpose is to empower people with TB and communities and to make the patient-provider relationship mutually beneficial. The charter sets out the ways in which patients, communities, health care providers and governments can work as partners and enhance the effectiveness of health services in general and TB care in particular. It provides a useful tool for achievement of greater involvement of people in TB care.

NTP social workers will distribute the translated version of patients' charter among patients. Possibility of working with ex-TB patients will be investigated.

5. Enabling and promoting operational research

NTP in collaboration with WHO, and other national and international partners will conduct evidence-based operational, community based researches which will be a tool for policy makers to take right decisions.

These researches will tackle major areas of TB control regarding provision of services, effectiveness and value for money, patient/provider satisfaction, interventional procedures which could improve outcomes, sociological studies, impact of new approaches and evaluating the existing procedures.

A national committee composed of NTP staff and university professors will prepare and update an action plan annually to conduct researches.

6. Strengthening health system response to TB

Health system strengthening is defined as “improving capacity in some critical components of health systems, in order to achieve more equitable and sustained improvement across health services and outcomes”

Under this component NTP will strengthen early referral of suspect TB cases from Primary health care services and expand on Practical Approaches to Lung health (PAL).

I. PAL expansion is planned in 2011 onwards.

Human Resource Development (Human Resources for Health)

With the support of the GFATM project, adequate number of staff is provided to implement the DOTS, however there is a need to improve capacity of the staff. WHO is currently providing training to the health centre staffs in Mogadisho and Hargeysa. NTP will develop a detailed training need assessment.

In 2010-2011 training curriculum will be revised including all components of stop TB strategy catering different categories of staff including physicians, supervisors, nurses and community health workers. In order to reach territories, cascade training courses will be organized funded by GFATM grant.

At central levels, NTP team will receive international training course to improve their skills and management capacity. The following training courses will be organized according to the current strategic plan:

- 1) Refresher training course on DOTS for physicians and nurses
 - 2) Training course for supervisors
 - 3) Training of laboratory technicians on direct sputum microscopy
 - 4) Training of laboratory technicians on culture and DST
 - 5) Training of physicians on MDR-TB management
 - 6) Training of NTP staff on programme management
- International management training for central staff (2/y) :
 - Health financing for one central staff member each year
 - Leadership and project management for one central staff member each year
 - National training for four central staff on management each year
 - IUATLD annual conference for three staff members each year
 - Two workshops to update guidelines
 - Three orientation workshops each year to strengthen coordination with other sectors

II. Milestones

The key indicators reflecting the major progresses towards the goals in the calendar are as follows:

Planned Milestones

Component	Year					Remarks
	2010	2011	2012	2013	2014	
PAL expansion						
DOT for all TB patients						
National Reference Laboratory with Culture and DST						
GLC application approved						
MDR-TB Scale up started						
3Is piloted						
Full implementation of collaborative TB/HIV activities						
National TB-IC action plan finalised						
Patients' charter distributed						
PAL expansion						

III. Monitoring & Evaluation

Consider MESST, M&E activities by GFATM and CCM-Italy as well as making progress in more ownership by the nationals. Each five year an external review of the programme. What is the vision of partners on M&E. How to improve M&E while improving the capacity of NTP to conduct supervision at regional levels.

IV. Timeline

N	Activity	Implementer	Year															Remarks
			2010			2011			2012			2013			2014			
1.1	Distribution of the approved Strategic plan	Ministries of Health																

