ADVOCACY STRATEGY FOR THE TRANSITION TO OUTPATIENT TREATMENT OF TUBERCULOSIS: REPUBLIC OF MOLDOVA 2016-2018

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INTRODUCTION

This document was developed within the project «Together in Tuberculosis Control», run by the Moldova National Association of Tuberculosis Patients "SMIT" (Society of Moldova against TB), with the support of the Center for Health Policies and Studies from the sources allocated by the Global Fund to Fight HIV / AIDS, Tuberculosis and Malaria, through the EECA regional program (TB-REP).

The outpatient treatment includes and refers to healthcare provided to a patient outside a hospital. In the context of tuberculosis, outpatient treatment is defined as continuous comprehensive care. Thus, effective outpatient models should include a patient-centered approach that supports activities to increase adherence in the context of individual patient needs, while considering social and economic vulnerabilities.

From the point of view of infection control, the isolation of patients does not reduce the transmission of infection, as the highest rate of infection occurs before the diagnosis and placement of the person with TB in the hospitals. The risk of infecting other people with TB decreases considerably after a maximum of 14 days (2-14 days) of effective treatment. In such a way, the massive patients' hospitalization contributes to the unnecessary waste of both financial and human resources and often has a negative impact on the psychosocial life of patients with TB and their families.

From a public health perspective, outpatient treatment is more effective and cost-effective. Hospitalizing fewer patients will help reduce nosocomial infection.

In the context of joint efforts, it would be beneficial to reinforce referring systems, redirect financial resources, effectively integrate tuberculosis treatment into primary care, and provide patient support by promoting education campaigns and the involvement of civil society.

The vision of this document emerges from the need to advocate for outpatient treatment by increasing policy engagement and the implementation of people – centred care models.

The purpose of the advocacy strategy is to promote the transition to the outpatient tuberculosis model by creating a patient friendly environment and adopting responsible behaviour towards patient's needs.

The general objectives are:

1. Increasing political commitment to tuberculosis;
2. Increasing awareness of decision-makers in relation to person-centered tuberculosis care models;
3. Strengthening capacities of NGOs to ensure the sustainability of TB programs.

ADVOCACY IN THE PROMOTION OF OUTPATIENT TREATMENT

Advocacy activity is a public action carried out by a non-governmental organization or a group of organizations on behalf of disadvantaged groups to influence the responsible public authority and to gain recognition of the problems created that ignore, neglect or violate the legitimate rights of these groups. It also accepts the legitimacy of these issues and the solutions proposed by those who speak on behalf of these groups.

The advocacy process embraces a complex range of activities that simultaneously target several goals:

- promoting equal opportunities, tolerance and social inclusion;
- redistribution of power in favour of those who do not own it;
- responsibility for decision-makers and public institutions;
- increasing the level of public participation in taking decision;
- strengthening the capacity of civil society to influence public decisions, etc.

The Advocacy Strategy for the transition to tuberculosis outpatient treatment in the Republic of Moldova is designed to lay the foundations for planning, coordination, implementation and monitoring interventions in line with the current context as part of the national strategy of tuberculosis control.

This document highlights the core target and includes priority objectives supported by specific activities. In this context, the strategy is designed to implement multidimensional activities at the central, regional and community levels, using different pathways and methods to increase knowledge about new trends in tuberculosis care for a wide range of target groups: from the general population, groups of risk and affected communities, representatives of central formal authorities and informal ones.

The competent institutions in the Republic of Moldova approved the National Tuberculosis Control Program (NTP) for the years 2016-2020. This medium-term policy document includes government priorities aimed at implementing innovative strategies to reduce the burden of tuberculosis in the Republic of Moldova.

Current global trends are based on people-centered care methods. The planning and implementation of communication interventions to change the vertical attitude towards tuberculosis are manifested both by the community and by the representatives of government sector.

Discussions with NTP representatives, active civil society organizations in TB, as well as with direct beneficiaries have highlighted the need to develop and initiate processes aimed at fortifying and mobilizing civil society and the government sector with all its competent institutions.

A number of measures have been identified and taken from effective practices to stimulate the transition to outpatient tuberculosis treatment by spreading key messages to create a favourable environment for outpatient treatment. The transition and the set of reforms to be implemented will have a direct impact on the quality of care and, in fact, on increasing treatment success rates, making the whole society aware of the need to carry out these major towers in the tuberculosis care. The WHO in fact recommends carrying out advocacy interventions and namely the development of an advocacy strategy for the transition to outpatient TB treatment with audio-visual impact and prints for target groups.

In the Republic of Moldova, modest progresses have been made in recent years in the field of tuberculosis control by implementing the National Tuberculosis Control Programs (1996-2015), which indicates the need for strategic reforming interventions throughout the tuberculosis system.

The resources for developing the advocacy strategy for the transition to outpatient treatment are allocated within the project «Together in the Tuberculosis Contro», run by the Moldova National Association of Tuberculosis Patients "SMIT" (Society of Moldova against TB), with the support of the Center for Health Policies and Studies from the sources allocated by to the Global Fund to Fight HIV / AIDS, Tuberculosis and Malaria, through the EECA regional program (TB-REP).

The financial resources for the actual implementation of the activities of the advocacy strategy for the transition to outpatient treatment can come directly from internal financiers (state budget of the Ministry of Health, NHIC) or external (grants, non-reimbursable loans, as well as technical assistance from the World Health Organization and / or the Global Fund to Fight HIV / AIDS, Tuberculosis and Malaria).

Note: The National Legislative Context concerned in the process of elaboration of NTCP.

The program was developed in accordance with the provisions of Law no. 411 of March 28, 1995 on health care, Law no. 10-XVI of February 3, 2009 on State Public Health Surveillance, Law No.153-XVI of July 4, 2008 on tuberculosis control and prophylaxis, Law no.166 of July 11, 2012 for the approval of the National Development Strategy «Moldova 2020», Law no. 122 of July 02, 2014 for the ratification of the Association Agreement between the Republic of Moldova on the one hand and the European Union and the European Atomic Energy Community and their member states on the other hand Government Decision no. 886 of August 6, 2007 on National Health Policy, Government Decision no. 1471 of December 24, 2007 regarding the approval of the Health System Development Strategy for the period 2008-2017, the Government Decision no.1171 of December 21, 2010 approving the National Program for Tuberculosis Control for the years 2011-2015, the Government Decision no. 1023 of October 20, 2013 on the approval of the National Public Health Strategy for the years 2014-2020, the «End TB» World Health Organization Strategy for 2015-2035 and other national and international documents in the field.

DESCRIPTION OF THE SITUATION

Tuberculosis is one of the priority issues of the health system, and its prevention and control are strategic objectives of national interest.

Challenges and constraints that influence the effective control of tuberculosis are closely linked to socio-economic conditions and insufficient budgeting of resources, which contributes to the continuous transmission of infection, to the slow growth of treatment success and to the spread of tuberculosis.

According to the World Health Organization (WHO), the Republic of Moldova is among the 18 countries in the European Region where tuberculosis control is a priority and also among the 27 countries of the world with a high burden of multidrug-resistant tuberculosis (TB RR / MDR). According to WHO data of 2014, the global incidence through tuberculosis in the Republic of Moldova exceeded about 3 times the average registered in the WHO European Region (110 compared to 40 cases per 100 thousand population). (See Annexes: Table 1, 2, 3).

In this context, the WHO estimated for the Republic of Moldova in 2014 an incidence of 154 cases per 100 thousand population, being notified 99.7 cases per 100 thousand population. Accordingly, 2907 new and previously treated cases were registered, which represents 38% fewer cases than in 2011 (4673 or 114.3 cases per 100 thousand population) and 50% fewer cases compared to 2005 when 5742 new and previously treated cases of tuberculosis (or 133.9 cases per 100 thousand population) were notified.

In spite of interventions in the early detection of tuberculosis, including the application of new and rapid methods for the diagnosis of tuberculosis, the share of notified cases of tuberculosis in TB RR / MDR forms reached only 62%, compared to the WHO target of 85%, which attests the need to intensify interventions in detection by strengthening health system capacities to ensure rapid and complete diagnosis.

The burden of resistant tuberculosis is the main challenge for the National Tuberculosis Control Program and an obstacle to effective disease control. According to the WHO *"Global Tuberculosis 2014"* report, the estimated TB RR / MDR burden in the country in 2014 was 24% (690 cases) among the new cases and 62% (830 cases) among the previously treated cases. Respectively, it is estimated that annually in the Republic of Moldova it is necessary to diagnose about 1500 cases of TB RR / MDR, de facto being notified about 1000 cases of TB RR / MDR.

The success rate among new cases with bacteriologically confirmed pulmonary tuberculosis for the patients who initiated the treatment in 2013 represented 76%, and among cases with TB RR / MDR who initiated the treatment in 2012 it was 60%. The rate of patients lost from treatment monitoring varies between 7% for susceptible tuberculosis and 20% for resistant tuberculosis.

A major impediment in ensuring patient recovery and implicitly in limiting the spread of tuberculosis is the extended-resistance form (8%) and respectively the lack of adequate treatment because of low access to new generations of medicines. The challenges that threaten recent successes of tuberculosis control are determined by the severe financial costs of providing anti-tuberculosis medicines.

Despite the fact that in the Republic of Moldova the treatment of tuberculosis for all patients is free of charge, the purchase of the complementary drugs, necessary, for the treatment of adverse effects caused by anti-tuberculosis drugs is left entirely on the shoulders of the patients. Other challenges are related to health care assurance, psychological support, and the diversity of socio-economic issues faced by patients and their families. This is explained by insufficient patient-centered interventions throughout the treatment period. The needs of the patient with tuberculosis are multidimensional and the medical and support services provided by the legislation are insufficient to meet these needs. The operational study, conducted in 2013, *On the efficacy of treatment among tuberculosis patients who received stimulants,* demonstrates that offering them during treatment improved the success rate by 10%.

Ensuring a high level of community awareness regarding tuberculosis and providing timely assistance, as well as providing continued community support to tuberculosis patients and people at risk, will help to strengthen efforts to eliminate the disease.

Perceptions and knowledge about tuberculosis influence behaviours, respectively the education and information activities in vulnerable groups are important.

Respecting the human and patient rights as set out in national and international laws, including in the *Patient's Charter for Tuberculosis Care* drafted by WHO and World Care Council (2006), implies the need to develop and implement a comprehensive advocacy, community information and mobilization strategy. Discrimination and stigmatization of people with tuberculosis remains a widespread phenomenon both in the medical environment and in the community, and interventions are needed to eradicate them. Partnerships with non-governmental organizations and the local public administration on addressing the social aspects of the disease are current priorities and are to be extended, ensuring civil society participation in decision-making processes.

The interaction between tuberculosis and other diseases presents another major problem in tuberculosis control, and the increase in the number of patients with comorbidities (HIV human immunodeficiency virus, diabetes, etc.) and behavioural disorders caused by alcohol and drug use creates difficulties in the diagnosis and initiating of anti-tuberculosis treatment because of the manifestation with few symptoms of the disease, poor

accessibility to health services, or reduced awareness of symptoms.

Tuberculosis is the most common and frequent disease in people living with HIV. The rate of TB / HIV co-infection among new cases of tuberculosis reached 7% in 2014 compared to 5% in 2011. There are regional differences in the rate of TB / HIV co-infection, reaching alarming rates in the Eastern region 25% and 18% in the Balti municipality. In this context, strengthened actions are needed to achieve effective TB / HIV co-infection control at the management level as well as at the level of patient-centered activities.

Within the penitentiary system, the tuberculosis notification rate decreased from 2902 to 100,000 population (2005 y.) to 754 (2011 y.) and 525 in 2014, but is still five times higher than the country average. In 2014, 92 cases of tuberculosis were recorded in detainees, including about 30% at the entrance to the penitentiary system. Equivalent standards of healthcare, regardless of where the patient is, and ensuring continuity and monitoring of anti-tuberculosis treatment, including release from detention, are permanent priorities of the program.

One of the significant challenges in tuberculosis control is the presence of the infection transmission phenomenon in the TB hospitals, which leads to the exposure of patients, visitors and medical staff to a higher risk of tuberculosis. According to the operational study carried out in 2012, «*Studying the nosocomial transmission of multidrug-resistant tuberculosis by genotypic analysis of DNA diversity (Deoxyribonucleic acid) of Mycobacterium tuberculosis strains*», *the presence of* the re-infection phenomenon (intra-hospital transmission) is found in 68% cases, the isolation of patients with tuberculosis in hospitals leads to an increase in cases of resistant forms of tuberculosis, which subsequently require much higher costs for treatment.

Tuberculosis treatment has a long duration, especially for drug-resistant forms (6 to 24 months), which may condition the reduction of patient compliance. In this respect, it is essential to grant multidirectional support to tuberculosis patients in outpatient treatment. The development of treatment regimens for resistant tuberculosis with the use of new anti-tuberculosis drugs, including for children, in order to reduce the time required for recovery, presents itself as a priority for scientific research and innovative approaches.

In order to ensure the effective control of tuberculosis, activities to strengthen the capacity of the health system through multidimensional involvement are required. According to the study conducted in 2013 «*The human potential in the health system involved in the provision of TB medical services*», family physicians and TB doctors have diametrically opposed views regarding the contribution of the centralization of the TB services and the unification of the hospitals, which affects the synergy of interventions increasing the efficiency of the TB control in the Republic of Moldova.

The organizational structure of the Program Coordination Unit is complex in accordance with its dimensions (management system of drugs, case and

supervision, courier system for transportation of sputum samples and drugs, drug storage and management system, electronic record system, national and international reporting system, and resource planning and management system) and imposes high administration costs. In this context, it is necessary to reorganize and strengthen the capacities of the TB control system through a series of modifications and adjustments that will support the objectives set out in this program and the directives of the international bodies (WHO Intermediate Evaluation Report, 2013).

The psychosocial services provided to tuberculosis patients and their families, as well as advocacy, information, education, communication and community mobilization activities, are mainly carried out by civil society organizations, largely funded from external sources.

Assessment and appreciation of the contribution made by civil society organizations to tuberculosis control and enhancing cooperation are essential to build a tuberculosis-free society.

In this respect, it is necessary to improve the existing cooperation mechanisms between all service providers: representatives of health and social systems, local public authorities, the education system and civil society organizations, to ensure the effectiveness of this cooperation.

It is important to note that the activities of the National Tuberculosis Control Program do not extend to the left bank of the Dniester (Transnistria), nor is there an official memorandum of cooperation with local authorities in the field of tuberculosis control. The provision of healthcare in the Transnistrian side continues to follow the Semashko model and is not in line with current healthcare trends in the treatment of tuberculosis. The local reports are validated by NTP, and in 2014 for the Transnistrian side on the left bank the global tuberculosis incidence was estimated at 121.7 per 100 thousand population compared to 80.8 per 100 thousand for the right bank.

At the same time, the NTP through the non-governmental organization AFI, from the Global Fund and NHIC sources provides support in the form of food packages or money equivalents based on the same criteria, to patients with TB on the left bank of the Dniester, which indicates an existent tacit cooperation between the two banks.

According to the World Bank's rating (2013), Moldova's continuous transition period places the country in the state category of an average level of development and, as a result, the country is to gradually take over the activities and totally move to state financing after 2017.

Withdrawing foreign donors will inevitably increase the risk for tuberculosis patients, their families, and the entire affected community, not to benefit from the services provided to the extent necessary. The national budget for tuberculosis control should provide segments of financing for psycho-social, medical and advocacy services delivered by civil society

organizations in a secure, sustainable and transparent manner. At the same time, the development of new standards and regulations for the provision of services by public associations will be a first step in ensuring the sustainability of good practice services.

In order to carry out the activities of the *National Tuberculosis Control Program for the years 2016-2020*, the estimated expenditure is 3,129 billion MDL, out of which 72% is provided for the strengthening of the health system capacities in order to ensure the effective control of tuberculosis, 17% to ensure universal access to treatment, 6% to ensure universal access to early diagnosis and 5% to other activities. At the level of the National Tuberculosis Control Program for the years 2016-2020, the budget deficit will increase by 2.5 times: from 45.9 million MDL in 2016 to 113 million MDL in 2020, and the total deficit for the right and left bank of the Dniester is expected to represent the amount of 424.4 million MDL or 13.6% of the total budget of the program.

The lack of an efficient and constructive political dialogue between representatives of the left and the right banks, with the withdrawal of financing from the Global Fund, will inevitably affect the population of Transnistria. The Transnistrian authorities are in a deep socio-economic crisis, and the treatment of tuberculosis with the whole package of interventions so far can certainly not be fully ensured. Thus tuberculosis control at the level of Transnistria after 2017 may take a different scale, with a negative impact on Moldova in its entirety.

Given the limited financial resources, the slow transition to the outpatient treatment model with the examination of good practices can be the solution that at the same time exposes issues that directly impact the patient and the quality of services provided in tuberculosis control. It can highlight exactly the right time to perform cost-effective health system reforms to gain the maximum return for society.

In conclusion, the transition period should be seen as an additional opportunity to increase political commitment and decision-maker visibility in relation to people-centered tuberculosis care models, to strengthen the capacities of civil society and affected populations in a treatment-friendly environment and to ensure the sustainability of TB programs and interventions.

CURRENT TRENDS IN TUBERCULOSIS CARE

The treatment of tuberculosis in the Republic of Moldova is a standardized one, following the DOT strategy in the treatment of susceptible tuberculosis and the DOT plus strategy in the treatment of resistant tuberculosis.

In the context of the severity of the tuberculosis epidemic, the PAS Centre in cooperation with the WHO, launched on January 1, 2016 a regional TB-REP project (TB Regional Project on Strengthening Health Systems for Effective TB and TB-DR Control) in order to reduce the TB burden and stop the spread of TB-MDR in the 11 countries in the region through political engagement and implementation of people-centered care models.

According to the latest official data of World Health Organization, (Global Tuberculosis Report 2015), 15 of the 25 countries with a high burden of drug-resistant tuberculosis are in the European region and the Republic of Moldova is among them. According to the report:

- mortality was reduced by 47% compared to 1990
- 43.000,000 lives saved (2000-2014)
- 1.500,000 died because of TB

The average number of visits to the physician a patient makes in the Republic of Moldova during the treatment in the case of classical tuberculosis (new case BKK +/new case BKK-/extra pulmonary) is 116 and for TB-MDR - 336. The estimated rate of hospitalization (%) in case of new case BKK +/TB-MDR - 95-96 days, new case BKK-/extra pulmonary -50. In terms of average length of hospitalization (days) new case BKK + - 56, new case BKK-/extra pulmonary - 40, TB-MDR -140 days. (See Table 4)

The Republic of Moldova has an Association Agreement with the European Union and this process implies an intense harmonization of policies and legislation in the field of public health, including tuberculosis control.

The context of health systems and financing the health sector from the percentage of public health expenditures varies greatly from one country to another in the region. It is clear that the current financing models are focused on hospitalization and that financing is not directly correlated with general TB performance. For a vertical return to tuberculosis control, some countries have introduced systems of payment per diagnosed case that allow better funding for outpatient treatment models. At the same time, payments based on performance were introduced in other countries to stimulate better clinical outcomes.

Thus, the trend of transition from inpatient-based vertical models to people-centered models is an innovative one for post-Soviet countries, and calls for a greater role to be given to primary health care in early detection and treatment, increase of monitoring and individual social support, and

promoting community-based care models.

The regional objective, recommended by the WHO, is to lower the hospitalization rate by 2018 from 67.4% to 30% of sensitive tuberculosis and from 86% to 50% of resistant tuberculosis. (See Table 5)

Also, the duration of the inpatient treatment is to be reduced in the short term of sensitive tuberculosis from 60 to 30 days and from 180 to 90 days with resistant tuberculosis. (See Table 6)

In February 2013, the Regional Office for Europe of the World Health Organization (WHO), at the request of the Ministry of Health of the Republic of Moldova, carried out the full evaluation of the NTP. After completing the NTP evaluation, it was found that the challenges identified during the assessment were as follows:

- Long-term and unjustified hospitalization;
- Social support and treatment support for patients with TB and TB-MDR was fragmented and without continuous insurance;
- The absence of a defined formal structure and a mechanism for central level financing of NTP resulting in vague terms of reference, responsibilities and commitments from the Institute of Phthisiopneumology, unclear links with other governmental organizations, and insufficient supervision and monitoring of extra-hospital management;
- Lack of clear coordination between NTP and non-governmental organizations at the community level and the absence of a legal framework for their involvement. Insufficient knowledge of NGOs and civil society in the field of TB;
- Poor motivation of primary health care in TB and TB-MDR management cases;
- Insufficient human resources in the TB services;
- Inadequate understanding of people needs by health service providers and a low level of patients' education.

In this context, following the assessment of the NTP in 2013, a number of international experts' reports have been developed that outlined some possible scenarios for improving outpatient treatment of TB patients, including:

WHO Joint tuberculosis control programme review to the Republic of Moldova, 6–9 September 2009. Consolidated report, Copenhagen: WHO, 2012; Thybo S. GLC Monitoring Mission to the Republic of Moldova. 2010; Thybo S. GLC Monitoring Mission to the Republic of Moldova. October 2011:¸ Salakaia A, Mirtskhulava V. The Global Drug Facility mission report, the Republic of Moldova. Monitoring mission fifth year direct procurement, 3-7 October, 2011; Schreuder B. KNCV-WHO/Europe collaboration on HSS and M/XDR-TB. HSS and M/XDR TB mission report to Moldova. Final version. The Hague 2011, Berger D. Community Involvement in Tuberculosis Care and Prevention: Republic of Moldova – Situational Analysis on the Model

and Implementation of Round 9 of the Global Fund. TB/HIV and Community Engagement (THC) Unit of the Stop TB Department of WHO. 2011, Cercone J. Technical assistance to the Ministry of Health and the National TB Programme in investment planning and improvement of TB service delivery system in the Republic of Moldova. Consultancy report. Chisinau, 2012.

The advocacy strategy for moving to outpatient treatment is, in fact, a need to adjust treatment in tuberculosis to current expenditure optimization conditions and, most importantly, a need to place patient wishes and needs at the heart of these changes.

The provision of outpatient treatment is closely related to the criteria for hospitalization, the current funding mechanisms for health services, and the health reform that is under way. In general, interventions aimed at improving the adherence to treatment for TB and TB-M / XDR patients should be focused on the healthcare system and on each individual patient.

Thus, international standards for TB support and patient's charter present the responsibilities of both parties – patients and service providers.

According to the *Outpatient care plan for tuberculosis patients to improve compliance and reduce the rate of abandonment of treatment in the Republic of Moldova, 2013-2015*, it is evident that at the moment, country practice is to hospitalize infectious TB patients and a large part of non-infectious patients in contradiction with the fact that the evidence supports the need to reduce hospitalization because of the increased risk of nosocomial infections and also because of the high cost compared to outpatient treatment management. Optimizing hospital beds for patients with TB will create resources to strengthen outpatient treatment.

The Ministry of Health initiated the general optimization of hospital beds and reviewed the TB treatment guide (December 2012) providing treatment of TB in four hospitals: „*Chiril Draganiuc*" Institute of Phthisiopneumology, Chisinau TB Municipal Hospital, Balti TB Department, and the TB-MDR Hospital in Vorniceni.

At the same time, the general optimization of hospital beds should be done in accordance with patient-centered care models, so that in the case of hospitalization, the patient should be given the opportunity to be hospitalized in an institution close to his or her place of living.

However, above all, at the initiation of treatment, the patient should be presented with both treatment alternatives: for both inpatient and outpatient treatment. Experience shows that many patients with TB did not have the opportunity to pronounce for themselves the preferred alternative for initiating anti-tuberculosis treatment.

In the context of beds' optimization, according to MH Order no. 1568 of 27.12.2013 and no. 466 of June 11, 2015 the number of beds with the TB profile in 2014 constituted 925 beds and in June 2015 it was reduced to 785 beds, which denotes the tendency of bed reduction at the national level. (See Table 7, 8, 9, 10)

It is necessary to develop and implement a strategy of reforming the entire care system of TB and to reduce the number of hospital beds for TB patients. In this way, the savings from the reduction of the number of beds in hospitals could be used by the National Health Insurance Company (NHIC) to strengthen the management of outpatient treatment of tuberculosis.

However, it is important to ensure a real redirection of the sources obtained from the reduction in the number of beds in the outpatient treatment. The financing mechanism through the NHIC does not provide for non-contracted (non-spent) money by hospitals to be directed to outpatient treatment of patients. Hence, the urgency of developing or adjusting a new payment mechanism.

The independence of most institutions determines the need to develop a detailed plan in cooperation with the NHIC, most providers (hospitals), and the NTP, so that all stakeholders are aligned with this change. Otherwise, even if the hospitalization policy for TB patients will be changed, the savings will not go to the TB service.

The National Guidelines for TB Treatment approved in December 2012 admits the following hospitalization criteria:

- Serious clinical condition;
- Positive sputum (at the same time, the guidelines stipulate that if the required sanitary and epidemiological conditions are respected and DOT can be assured, even sputum positive patients can be treated in inpatient conditions);
- Factors that influence home care, such as the presence of pregnant women or children, etc.;
- Directly observed treatment cannot be assured;
- Severe side effects or co-morbidity;
- Patients with TB-DR to bacterial sputum conversion and assessment of tolerance to second-line drugs.

In this plan, a number of alternatives to hospitalization are proposed, as follows: involvement of PHC providers, greater involvement of NGOs, strengthening of TB district centers, increase of social support and treatment support. These motivation and mobilization mechanisms may reduce the abandonment rate in the coming years, but require continuous use and reasonable planning in accordance with the current health reform.

At the same time, the *Human Potential in the health system involved in the provision of phthisio pneumological medical assistance (Chisinau 2012)* denotes the fact that the management of tuberculosis patients is one of the main determinants in TB care.

The TB doctors were interviewed on treatment options for patients with destructive and bacillary tuberculosis. Thus, 48.2% of physicians consider that the mentioned patients can be treated only in inpatient conditions and 51.8%

of physicians consider that these patients can be treated by the combined method – inpatient + outpatient.

In the opinion of TB doctors, outpatient treatment for patients with destructive and bacillary forms is not optional. However, contrary to the above, physicians operate with double standards if the patient with destructive or bacillary tuberculosis is in a relationship with the physician. As a result, outpatient treatment is also available for such patient-relatives.

Thus, 45.8% of physicians consider that a relative or a friend of the mentioned forms of tuberculosis can be treated only in inpatient conditions, 47% doctors consider that they can be treated by the combined method of inpatient + outpatient, and 7.2% doctors believe that a relative or friend with destructive and bacillary forms can be treated in outpatient.

The compliance to treatment of tuberculosis is influenced by various socio-economic factors, but it is also necessary to mention the psychological impact of long-term hospitalization on the psychosocial life of patients with TB.

The report, based on the *Impact of long-term hospitalization on the psychosocial life of the tuberculosis patient*, shows that outpatient treatment has a broad spectrum of medical, psychosocial and financial benefits in relation to inpatient treatment because it:

- Reduces the risk of acquiring nosocomial infections in the profile of stationary patients (studies in the field demonstrate that the control of the stationary infection cannot be assured at the required quality level);
- Reduces the negative impact of long-term hospitalization on the psychosocial life of patients and their families;
- Isolation of stationary patients does not reduce the transmission of tuberculosis infection, and the risk of infecting with TB is considerably reduced in no more than 14 days of effective treatment, as mentioned in the beginning of the paperwork.
- Reduces retirement from family and social life;
- Reduces discontinuation of long-term professional activities;
- Reduces unnecessary waste of financial and human resources in hospitals;
- Reduces discrimination;
- Outpatient treatment is psychologically more comfortable and favorable for patients and offers the possibility of treatment in a familiar environment that doesn't damage the usual way of life.

In conclusion, a way to overcome the psychosocial problems faced by the patient is to reduce the period of hospitalization for those who require it and to observe the qualified treatment in outpatient conditions, thus preserving the person's psycho-emotional integrity and role in his social space.

Thus, in TB, the success of the treatment depends on the interaction of several factors among which we emphasize: the interest and concern of the patient towards his or her health; the attitude and responsibility towards the therapeutic scheme established in direct correlation with the level of professionalism of medical representatives; and, of course, the involvement of society without which the efficiency of anti-tuberculosis treatment cannot be guaranteed.

TARGET GROUPS. PARTNERS

The ***target groups*** of activities in this strategy are divided into two categories:

1) Direct beneficiaries, as follows:

- ***Decision makers / Deciders:*** at the national level but especially at the local level, service providers, family doctors, local authorities, sanitation workers, education, labor, and social assistance sections have an essential role to play in adopting local measures on retraining and hiring the labor force as well as providing social assistance to underprivileged populations. These authorities can develop coordinated IEC activities aimed at groups with needs, including the necessary human and material resources for the implementation of actions. Frequently, however, the authorities are either unaware of the magnitude of the TB issue, do not recognize its importance, or have a discriminatory attitude towards people affected by TB.
- ***Patients with TB*****:** the provision of correct and complete treatment so that the patient heals clinically and para-clinically.

2) Indirect beneficiaries, as follows:

- ***General population:*** It is absolutely necessary to include the general population in information, education programs, because their level of knowledge is relatively low in TB areas.
- ***Mass-media:*** The correct reflection of TB phenomena in the media is strategically important.

Partners and implementers

The advocacy process for the promotion of outpatient treatment must be achieved through real partnerships and by cooperation at the national, regional and local levels between:

NTP
Public health
Primary Health Care
Social and Community Assistance
Patients
Central and Local Public Authorities
Non-governmental organizations
Religious groups
Press
Business environment

Ideally, there is a working group at the national level to coordinate activities with the NTP. The technical secretariat of this group can be provided by representatives of civil society, with intra- and extra-medical collaboration.

The approval at the national level of a legislative framework that would allow NGOs to access public funds that would facilitate multi-disciplinary activities appropriate to the needs of local communities.

Financial resources

For the adequate deployment of activities, financial resources are an essential element. In order to implement the Advocacy Plan for ambulatory treatment, it is necessary to coordinate and correlate financing with real needs. You can also access sources from:

– Technical and financial support from the World Health Organization;

– External financing, e.g. from European funds and other non-reimbursable loans from the Global Fund to Fight against HIV/AIDS, TB and Malaria etc.

MONITORING AND ASSESSMENT

The components described below are essential for measuring the achievement of the proposed goals and objectives, and the effectiveness of the activities carried out.

Monitoring is a permanent process that will be applied to estimate the extent to which the actions and activities of the strategy are actually taking place, and to identify deficiencies to correct them. Monitoring provides information on the performance level of the activities in line with the proposed ones, thus allowing for a comparison of the actual result with the estimated / expected outcome. Monitoring focuses, in particular, on the process and the actual activities, rather than on results or impacts. Monitoring is a constant activity within the Action Plan.

Assessment is the systematic review of the effects and impact of activities in order to estimate the extent to which the objectives of the strategy are met. Assessment is carried out using the most common quantitative research techniques, but there are also cases where qualitative assessment techniques can be used (e.g. yes / no in the approval of a political document). Assessment takes place periodically, the most common approach at the beginning - intermediate stages / at the middle – end stages.

The main task of monitoring and assessment should always be to provide the management team with a constant flow of information focused on decisions. The indicators must have the following characteristics:

- Indicators should correctly reflect the objectives of expanding tuberculosis outpatient treatment with strict observance of DOT (Directly Observed Treatment).
- Indicators should be verifiable, reliable, relevant, rational, specific, appropriate and cost-effective.
- In the choice of indicators, regardless of level (data, objectives, result, impact), it is important to limit their number to a set of major indicators. A multitude of indicators create difficulties in interpretation as well as inability to focus on essential issues.
- There are two important criteria in the choice of indicators: a) the degree of measurement and b) the cost of obtaining and processing the data.
- There is a need to reach a balance between indicators close to the level of activities (which are so specific and large in number) and the furthest (fewer and more general).
- Indicators are applied to TB programs conducted at the governmental and non-governmental level.

M & A must rely as much as possible on the existing statistics system so that there is no overload of reporting for the staff involved. Thus, all indicators

that relate to the NTP network, as in other programs, will be collected and analyzed as far as possible to measure the effects of a strategy. First of all, it is necessary to analyze all these indicators to check their relevance for advocacy activities.

Monitoring & Assessment Tools

Knowledge-Attitudes-Practices Studies (KAP) – This type of quantitative study allows exploring the level of knowledge and probing the attitudes of the concerned target group – knowledge and attitudes being important determinants of behaviors – including questions that also identify the real behavior of people surveyed. Similarly, by repeating the same study at certain time intervals, one can observe the dynamic evolution of certain phenomena. The interventions made during that time can be evaluated by observing the changes induced at the level of knowledge, attitudes, and behaviors of the population.

Surveys – In addition to measuring actual behavioral impacts, a good monitoring system will be able to detect the extent to which target segments have been taken into account through mobilization and social communication activities, and how their behavior has changed.

Analysis of press monitoring – Detection and analysis of the quantity and content of the press (all observations on a particular topic, e.g. free sputum testing, which appears in a different form than commercials on television, radio or written press).

Monitoring policy changes – Monitoring policy changes depends on the type of change and the social level that has the power to make the change.

Qualitative studies – Qualitative studies, usually conducted in the form of in-depth interviews or focus groups, allow in-depth exploration of the attitudes and motivations of a particular population group about a particular behavior. This type of study allows identifying logical behavioral schemes for the target population groups, and highlighting the barriers identified in adopting the desired behavior. On the basis of the results obtained, effective ways of intervention (communication channels, transmitted messages, etc.) that can induce a certain change in the concerned target group can be identified.

ACTION PLAN 2016 -2018

The purpose of the advocacy strategy is to promote the transition to the outpatient treatment model for tuberculosis by adopting friendly and responsible behaviors towards patients and creating a favorable environment for outpatient treatment.

The general ***objectives*** are:

1. Increasing political commitment to tuberculosis;
2. Increasing awareness of decision-makers in relation to person-centered tuberculosis care models;
3. Strengthening the capacities of NGOs to ensure the sustainability of TB programs.

Key messages

The National Association of Tuberculosis Patients held a round table to familiarize representatives of civil society organizations with new objectives in tuberculosis control at the European level that promotes outpatient treatment in TB and to discuss key implementation tools at the national level. The practical exercise of the round table has generated a series of key messages for the advocacy campaign that can be used successfully in the strategy implementation process.

Nr.	The content of the message (country specific)	Target
1	Invest in health! Patients with TB are your voters.	LPA
2	You are responsible for the health of your community.	LPA / PHC / Community
3	We want a comunity free of TB.	Community
4	The best care and support for the TB patient is provided by the family.	Community
5	Mayor, family doctor, community social worker are the godparents/godfathers/cousins of a TB patient. Do not send your godfather to the hospital, because his wife remains without supervision.	Community
6	Invest today in TB people and have a budget for roads next year.	LPA
7	Non-discrimination of people with TB.	Community
8	People with TB need family support.	Community
9	The success of TB treatment depends on family and community.	Community
10	The informed community keeps tuberculosis away.	Community
11	Community, do not forget: TB can be prevented.	Community
12	An informed family avoids TB.	Community
13	Treat TB at home. At home even the walls help.	PHC / Community

14	Home treatment avoids additional contamination.	PHC
15	Outpatient treatment is more cost-effective.	PHC
16	TB treatment at home is less traumatic.	LPA / PHC / Community
17	Deliver people-centered care.	PHC
18	Ensure DOT.	PHC
19	Promote psychosocial support.	LPA / PHC / Community
20	Respect confidentiality.	LPA / PHC

TB REP PROJECT: SMIT ADVOCACY STRATEGY March 2017 to December 2018

Overall Goal	**Promote transition to ambulatory treatment by strengthening a TB patient-friendly medium.**					
Specific Objective 1: SMIT ensures visibility of people centred care with at administrative level representatives						
Expected results	Activities	Outputs	Timeframe	Risks	Targets/key decision makers	Partners
SMIT ensures the active involvement of community representatives in TB patient care models	SMIT works with PHC, PLA, Social Services etc to organise round tables, meetings etc. SMIT use the «voice of people» to inform their advocacy and strategies towards people centred care.	Decision makers are presented with people's perspective on people-centred care and people's opinion on certain practices	2017-2018	Little funding to take actions	Administrative units representatives, local decision makers	PAS, NTP
Specific Objective 2: Increase political commitment on TB						
Expected results	Activities	Outputs	Timeframe	Risks	Targets/key decision makers	Partners
Moldova High level decision makers put TB higher up on the political agenda	SMIT works with parliamentarians to advocate for reducing hospitalisation and organise round tables or meetings.	Political commitment from decision makers on transition	2017-2018	Commitment may remain on paper	Moldova Government	PAS, WHO, NTP
	SMIT publishes a Patient perspective on TB services, hospitalisation impact on patient life, TB KAP on PLA, with specific recommendations to Moldova decision makers	The «voice of people» is used to inform on people centred care.	2017-2018	Patient's voice is not heard	Moldova Government	PAS, WHO, civil society

	SMIT advocates for changing finance mechanisms in TB care	Working Group constitued	2018	Low political commi-tment	Moldova Government	Civil Society, PAS, NTP
	SMIT advocates for transition to patient models of care by participating in country Roadmap development and bringing inputs from community.	Roundmap drafted	2017	Moldova Society is infor-med	Moldova Government	Civil Society, PAS, NTP
Specific Objective 3: Building CSO durability						
Expected results	Activities	Outputs	Timeframe	Risks	Targets/key decision makers	Part-ners
CSO capacity is built by advocating for a paying mecanism of CSO services	Advocacy for CSO accreditation	Working Grrop constitued	2018	Low priority for govern-ment	Moldova Government	PAS, WHO, civil society
	Advocacy for standardization of CSO psychosocial and suport services	Psychosocial and suport services standartised	2017-2018	Low priority for govern-ment	Moldova Government	PAS, WHO, civil society
	Advocacy for defining a paying mecanisms of CSO services	Paying mechanism drafted	2018	Low priority for govern-ment	Moldova Government	PAS, WHO, civil society

ANNEXES

TABLE 1

Global incidence, 18 countries, 2014

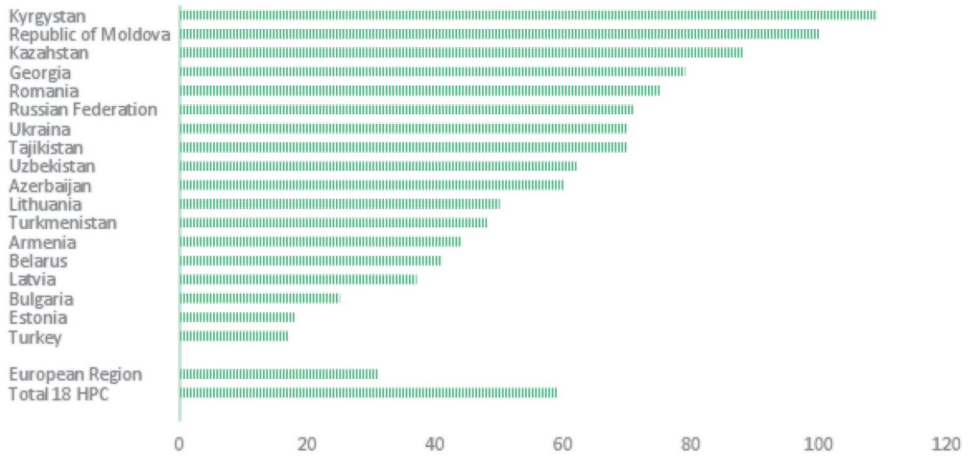


TABLE 2

Global incidence through TB in RM, 1990-2014 (100 thousand)

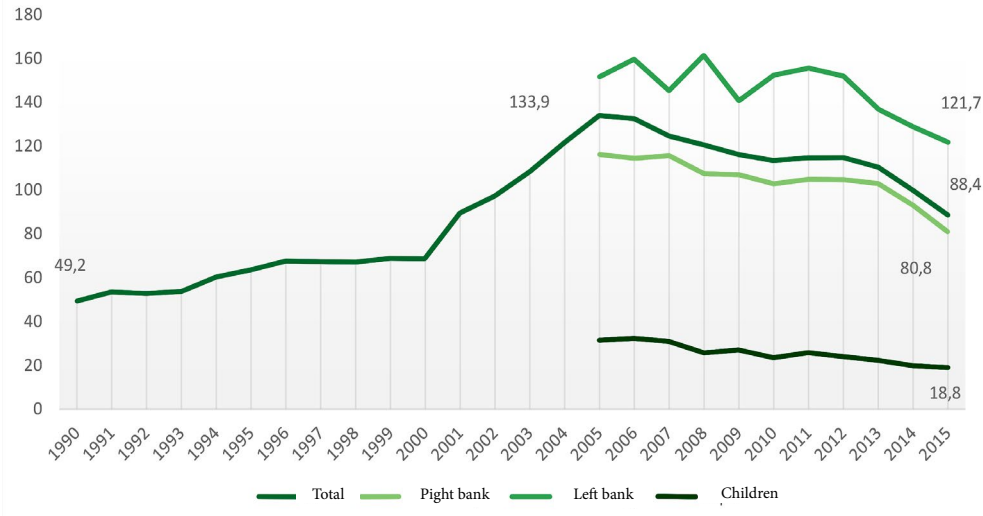
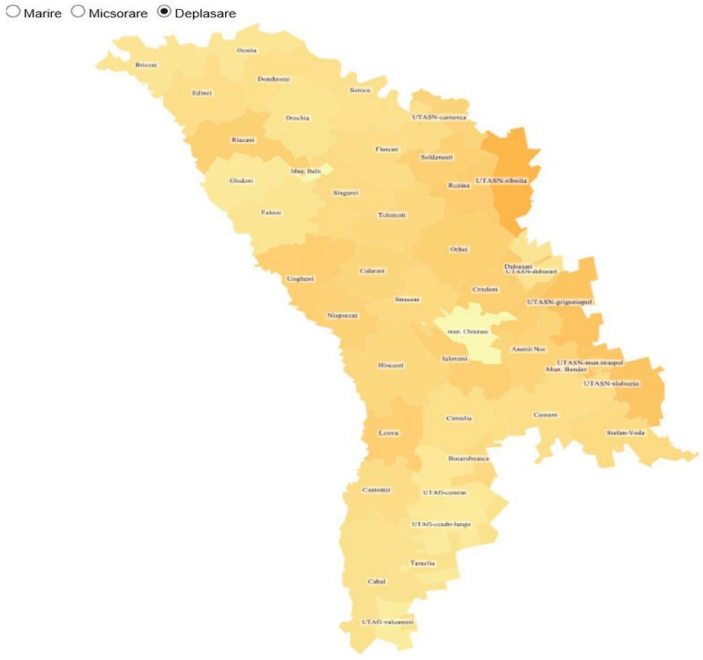


TABLE 3

Incidence of new case, 2015 (100 thousand)



Mun.Chisinau	71.87
Mun. Balti	102.66
Dubasari /Cocieri	119.17
Basarabeasca	87.25
Briceni	55.64
Vulcanesti	34.30
Glodeni	44.82
Donduseni	68.97
Drochia	58.92
Edinet	71.28
Cahul	64.97
Calarasi	94.55
Cantemir	77.22
Causeni	72.47
Comrat	46.98
Hincesti	90.10
Criuleni	109.94
Ialoveni	111.11
Singerei	82.20
Leova	112.94
Nisporeni	106.09
Anenii Noi	100.70
Ocnita	53.12
Orhei	108.56
Rezina	117.35
Riscani	107.96
Soroca	66.93
Straseni	86.83
Stefan Voda	80.43
Taraclia	63.87
Telenesti	87.69
Ungheni	113.31
Falesti	56.61
Floresti	74.64
Ceadir-Lunga	39.78
Soldanesti	108.79
Cimislia	69.33
Directia 4	-
Calea ferata	-
Ministerul justitiei	565.71
Bender	108.50
Tiraspol	99.66
Dnestrovsk	96.00
Grigoriopol	140.80
Dubasari (SN)	54.30
Camenca	96.28
Penitenciare, Transnistria	511.11
Ribnita	177.78
Slobozia	135.77

TABLE 4

Country	The average number of visits to the doctor during the treatment performed by the patient			Estimated rate of hospitalization (%)			Average hospitalization time (days)		
	New case BKK+	New case BKK-/ extrapul-monary	TB-MDR	New case BKK+	New case BKK-/ extrapul-monary	TB-MDR	New case BKK+	New case BKK-/ extrapul-monary	TB-MDR
Armenia	112	104	312	94	78	75	60	50	90
Azerbaijan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Belarus	180	180	540	100	80	100	60	30	180
Georgia	N/A	N/A	N/A	70	30	90	25	10	60
Kazakhstan	80	70	220	95	84	35	80	60	120
Kyrgyzstan	104	104	560	60	34	100	84	84	146
Moldova	116	116	336	95	50	96	56	40	140
Tajikistan	168	168	604	50	30	30	56	70	180
Turkmenistan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ukraine	100	120	480	100	30	100	90	50	180
Uzbekistan	168	168	612	70	60	40	56	56	90

TABLE 5

Regional objective: decrease in hospitalization rate (%)

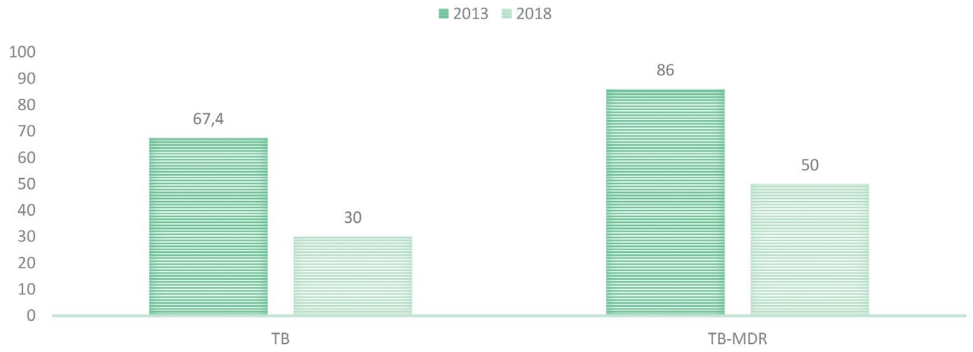


TABLE 6

Regional objective: Duration of treatment (days)

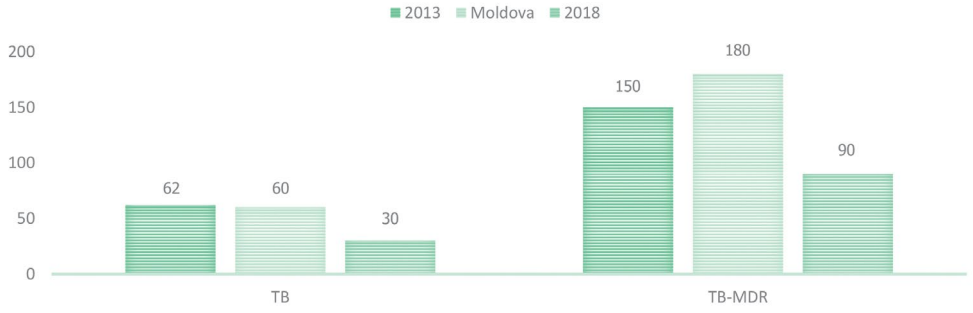


TABLE 7

Order MS no. 1568 of 27.12.2013:
Distribution of the number of beds in TB in 2014

Nr.		The IMSP Institute of Phthisiopneumology «Chiril Draganiuc»	IMSP SCM FP, Chisinau	IMSP SCM DFP, Balti
	No. of beds sensitive TB	250	260	100
	No. of beds resistant TB	160	40	40
	No. of beds children TB	-	75	-
Total (925 beds)		410	375	140

TABLE 8

Nr.		IMSP IFP „Chiril Draganiuc"	IMSP SCM FP, Chisinau	IMSP SCM DFP, Balti
	No. of beds	410	375/75	140
	Average length of bed use	338	286/227	331,2
	Rotation bed	4,0	3,6/4,3	3,8
	Average hospitalization time	80,0	76,7/68/4	88,2
	Lethality	3,8	6,6	11,1
	Using beds' fund	92,6	78,4	90,7

TABLE 9

Order MS no. 466 of 11.06.2015: Distribution of the number of beds in TB in the years 2015 and 2016

Nr.		IMSP IFP „Chiril Draganiuc"	IMSP SCM FP, Chisinau	IMSP SCM DFP, Balti
	No. of beds sensitive TB	200	205	100
	No. of beds resistant TB	350 (240 non-functional / Vorniceni II block)	-	-
	No. of beds children TB	-	60	-
Total (925 beds)		550	375	100

TABLE 10

Nr.		IMSP IFP „Chiril Draganiuc"	IMSP SCM FP, Chisinau	IMSP SCM DFP, Balti
	No. of beds	360	345/60 265/60 (06/2015)	140/100 (06/2015)
	Average length of bed use	328,8	241/278,9	288,1
	Rotation bed	4,6	2,9/4,1	3,8
	Average hospitalization time	70,6	73,7/66,4	84,5
	Lethality	5,8	3,6/0,8	11,0
	Using beds' fund	96,7	70,1	84,7

LIST OF ABBREVIATION

AIDS	– Human acquired immune deficiency syndrome
BKK	– Bacillus Koch
DNA	– Deoxyribonucleic Acid
DOT	– Directly Observed Treatment
EECA	– Eastern Europe and Central Asia
HIV	– Human Immunodeficiency Virus
IEC	– Information-Education-Communication
LPA	– Local Public Administration
NHIC	– National Health Insurance Company
NGO	– Non-governmental Organization
NTP	– National Tuberculosis Control Program
PHC	– Primary Health Care
TB	– Tuberculosis
TB-DR	– Drug-resistant Tuberculosis
TB-MDR	– Multi-Drug-Resistant Tuberculosis
TB-REP	– TB Regional EECA Project
TB-RR	– Rifampicin Resistant Tuberculosis
TB-XDR	– Extensively Drug-Resistant Tuberculosis
WHO	– World Health Organization
MH	– Ministry of Health
RM	– Republic of Moldova

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