rGLC Mission Report- Updating Sri Lanka NPTCCD PMDT Guidelines

Consultant Name: Dr Muhammad Asif
Time period

- 1st of July 2021 to 10th of August 2021
- Total duration of the – 20 working days.

End date –However, due to lengthy work repeated review process, holidays and COVID 19 wave, *the actual submission* of *final draft took place on 16th September 2021*.

Background:

In line with WHO target of ending TB in 2035, Sri Lanka has pledge to End TB in 2025 by emphasizing active case finding, management and enhancing preventive measures. Early intervention and prevention of Drug resistance TB is vital in this endeavor as it poses a threat to hinder the progress towards the targets set by the End TB.

The National Program for Tuberculosis Control and Chest Diseases (NPTCCD), as the main focal point at national level responsible for controlling TB burden in the country, has provided technical guidance and implementation support for many identified strategies to achieve the End TB goal. Developing national guidelines is one such key activities at NPTCCD.

To contribute to End TB strategy by National Program for Tuberculosis Control and Chest Diseases (NPTCCD)by revising the national PMDT guidelines based on international recommendations and updates from WHO guidelines and GLC missions on management of PMDT

Objectives:

- To assess the recommendations on management of drug resistance TB by WHO and GLC mission and other health agencies.

- To revise the new PMDT guidelines by the International consultants according to WHO recent recommendations and international best practices

Methodology of Guideline Development Process

NPTCCD established the guideline development group comprising of following specialists and relevant medical officers. The GDG worked together having multiple consultative meetings, consensus development, e-mail communication.

- WHO Independent Consultant (International consultant, rGLC member SEARO)
- Consultant Respiratory Physician (National Consultant)
- Consultant Microbiologists NTRL

- National PMDT Co-coordinator
- Senior Registrar/Consultant Community Physician NPTCCD
- Medical Officer High risk group NPTCCD

The work plan for guideline was developed (attached herewith as annex) and shared with consultative group and NPTCCD Director. The above group had meetings and sharing of chapters by chapters as assigned, review, feedback and finalization. The diagnostic and treatment algorithms were developed and finalized.

Work Performed and Delivered:

Work Performed	**Delivered**	**Comment**
Assessment of new guidelines/recommendations/updates by WHO & GLC mission on management of drug resistance TB	A list of relevant updates/ new recommendations on management of drug resistant TB with the references	Chapter by chapter revision approach and distribution of chapters among guideline development group
Revising the current PMDT national guidelines (2014) with the incorporation of the new recommendations.	Revised and updated final printable PMDT guidelines submitted to NPTTCD Director	The major regimen design and diagnostic and treatment update were discussed with Respiratory physician d and DTCOs TB for consensus development as a process as per work plan.

Recommendations:

1. NPTCCD should carefully plan to shift from Hospital based care to ambulatory care with stronger community-based care for MDRTB network
2. Chest Xray and Gene Xpert MTB Rif based model of diagnosis among presumptive TB clients of for early and enhanced detection of TB and RR TB. Pilot testing may 1st apply and the its scale up
3. A modified oral shorter regimen under operational research or as approved by national MDRTB committee and NPTCCD to gain more confidence on OSSTR and should be priority regimen among eligible patients.
4. Capacity building for DR TB management through provision of trainings to all MDR TB physicians on revised guidelines and then cascade trainings

5. Capacity for DST to Group A and B drugs and use of Xpert XDR TB platform for early detection of FQ resistance

Annex:

Work Plan for DR TB Guideline Update 2021-Sri Lanka NPTCCD

1.Outline and Distribution of Chapters for DR TB Guidelines update

S#	Chapter	Responsible Person	Comments
1	Background Information	PMDT Coordinator/DR Asif/ NPTCCD	
2	TB CONTROL ACTIVITIES IN SRI LANKA	NPTCCD	
3	FRAMEWORK FOR EFFECTIVE CONTROL OF MDR-TB	Local consultant/ PMDT Coordinator /NPTCCD	
4	DEFINITIONS AND CLASSIFICATIONS	Dr Asif	
5	STRATEGIES FOR CASE FINDING AND DIAGNOSIS OF DR TB	NTRL Consultant Microbiologist/ Dr Asif /National consultant	
6	TREATMENT OF MDR-TB	Dr Asif / National Consultant/PMDT Coordinator	
7	TREATMENT OF MONO AND POLY DRUG RESISTANT TB	Dr Asif/ National Consultant/PMDT Coordinator	
8	TREATMENT OF DRUG RESISTANT TB UNDER SPECIAL SITUATIONS	Dr Asif/ National Consultant/PMDT Coordinator	
9	DR TB AND HIV INFECTION	Dr Asif/ National Consultant/PMDT Coordinator	
10	MONITORING AND SUPERVISION	PMDT Coordinator, NPTCCD, Consultant Microbiologist	Perhaps we should place chap 11at 10 ?
11	ADVERSE DRUG REACTIONS (ADRS) AND MANAGEMENT	Dr Asif/ National Consultant/PMDT Coordinator	This should be ow aDSM Implementation and practices
12	TREATMENT ADHERENCE	PMDT Coordinator/consultant community physician NPTCCD	
13	INFECTION CONTROL IN CONTEXT OF DR-TB	PMDT Coordinator/consultant community	

		physician/MO High Risk group /Consultant Micr*obiologist*	
14	TRAINING ON MDR-TB MANAGEMENT	PMDT Coordinator/National Consultant /Dr Asif	
15	Supply chain MANAGEMENT	PMDT Coordinator ,NPTCCD, chief Pharmacist	
16	ROLE OF NGOS AND CSOS	Coordinator/consultant community physician NPTCCD	
17	RECORDING AND REPORTING	PMDT Coordinator NPTCCD	

2: Questions to discuss and decision to be made by 2nd of July 2021

Diagnosis:

As the case finding for TB and DR Tb has been historically low and new Targets in NSP has been set to accurate case finding so following need to discussed and agreed upon by Program in he light of new NSP; All the following depends upon resources available and planning.

1. Changing/revising G.Xpert testing Criteria for Sri Lanka?

2. Use of Chest-ray and GX among all presumptive TB cases as upfront Test?

3.Use of FL LPA among TB patients for diagnosing Hr TB where RR TB has been excluded? (we can discuss on high risk Tb patient testing for FL LPA if resources are constraint.

Treatment:

1. **Shifting from Hospitalized care to ambulatory care treatment model for DRTB patients**- It is understood that number pf RR/MDR TB patients are low in numbers and program has more confidence in treating as in patent until CL negative. However, every practice has its harms and benefits. In the light of WHO recommendations and repeated rGLC and other missions' recommendations this is the time when Program should plan to shift to ambulatory care of treatment (except those who require admission for certain reasons). Program should emphasize on stronger community-based care for DR TB patients (CBC) which is useful for program and patients. One point to note that despite of hospitalization the CL conversion is 3-5 months which is longer comparatively as most patients are converting at average 2 months.
2. **Use of OSTR as priority regimen in Sri Lanka among eligible patients**- It is understood that program has more confidence on longer regimen because of local experience. But this is not in line with global evidence and best practices. There might be other factors that lead to low TSR or relapse among STR and need to be carefully evaluated. Patients be assessed and offered shorter or longer regimens as per eligibility criteria and choices available. It might be even good that program may plan mOSTR(modified OSTR) under operational research to learn and understand

and developing local experience and confidence building. Currently globally there is huge move and research being conducted to shorten treatment durations and thus Sri Lanka PMDT should also take the opportunity at this point to discuss and decide as this is in the larger benefit of patients and program in the longer run as being equally effective, less toxic and significantly cost benefits.

3. **BPaL Regimen under OR**- Is program thinking and planning for BPaL regimen under OR? As perhaps the pre -XDR(FQ Res) patients might be low in number but still this is useful because of evidence showing high TSR wit 6-9 months of regimen.

The reason for highlighting these questions (diagnosis and Treatment) are as we are revising DR TB guidelines and these should be reflected in new guidelines if decision by program is made.

3.Timeline for DR TB Guideline Development

Activity	Timelines	Responsible Person	Comments
Meeting to discuss final decisions on Questions listed in this document	1st July 2021	Activity Coordinator	
All responsible consultative group members to start relevant chapters write up as assigned	1st July 2021	All consultative group members	
Presentation and discussion on proposed Diagnostic Algorithm, DR TB Treatment regimens and Treatment algorithm for Sri Lanka	5th July 2021	Dr Asif/ National consultant/ National Consultant Microbiologist	All three consultants work closely to develop consensus between 1st and 5th July Review and Discussions /inputs and to make changes
All chapters write up shared by assigned officers	By or before 13th July 2021		Desk review by other members and inputs
Compiling all reviewed chapters	By 20th July		Further Review and any changes
Submission of 1st Draft to NPTCCD and DTCOs TB	22nd July 2021	Dr Asif and Activity Coordinator	
National PMDT central Committee meeting to review guidelines	?	?	
Incorporation of any Suggested Changes	?	All consultants and Activity Coordinator	
Final DR TB guidelines update document submission	10th August 2021	Dr Asif and Activity Coordinator	