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UPDATE ON TUBERCULOSIS CONTROL IN AFRICA

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The views expressed in the paper are those of the author.

Acronyms

ACSM	Advocacy, Communication and Social Mobilization
ADB	African Development Bank
ATM	HIV, TB and malaria
ART	Antiretroviral Therapy
AU	African Union
CBOs	Community Based Organizations
CSOs	Civil Society Organizations
DOTS	Directly Observed Therapy – Short Course
FBOs	Faith Based Organizations
G8	Group of Eight Industrialized Countries
GDF	Global Drug Facility
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIST	Global Joint Problem-Solving and Implementation Support Team
GLC	Green Light Committee
2GPSTB	Second Global Plan to Stop TB
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
MDGs	Millennium Development Goals
MDR-TB	Multi-drug resistant Tuberculosis
NGOs	Non-Governmental Organizations
NEPAD	New Partnership for African Development
PEPFAR	US President Emergency Fund for AIDS Relief
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategy Papers
RC	WHO/AFRO Regional Committee
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Program
UNECA	United Nations Economic Commission for Africa
VCT	Voluntary Counselling and Testing
WHA	World Health Assembly
WHO	World Health Organization

FOREWORD

The goal of the Abuja Declaration of 2001 was to arrest and reverse the accelerating rate of HIV/AIDS, tuberculosis (TB) and Other Related Infectious Diseases. The African Heads of State and Government recognized the challenge posed by these diseases and of developing feasible policies, strategies, structures and processes to ensure adequate prevention and control of these diseases. The Summit set up a framework for action articulating the commitments made by the leaders. The guiding objectives to convert the commitments into action included advocating for social and resource mobilization for sustainable programming of primary health care, developing policies and strategies to prevent and control TB and reduce its impact on socio-economic development. This report describes the burden of TB in Africa, progress made in fighting the disease, outlining the challenges and opportunities and the strategic way forward.

1. EXECUTIVE SUMMARY

1. Africa has a disproportionate burden of tuberculosis (TB). Home to 11% of the world's population, the continent reports more than a quarter of the global burden of TB. The TB epidemic is still rising and Africa is the epicentre of the global Human Immunodeficiency Virus (HIV) epidemic: it is estimated that 9% of all adults are living HIV and that approximately 35% of all TB patients are dually infected with HIV.

2. There are many regional and global commitments for strengthening the fight against TB dating back to the early 1990s. These include the World Health Assembly (WHA) global targets for TB control (1991), the declaration of TB as a global emergency (1993), the adoption of the Directly Observed Treatment Short course (DOTS) strategy (1994), the launch of the Stop TB Partnership Initiative (1998), the 2001 Abuja Declaration, and more recently, the Maputo Declaration on TB (2005) and the Second Global Plan to Stop TB (2006).

3. DOTS-based TB control programmes exist in virtually all countries. Funding has increased with the support of global initiatives, multilateral and bilateral organisations, civil society bodies and private foundations. National coordination of TB control is improving, and there is a greater visibility of political leaders on advocacy and awareness raising for TB. There is growing consensus about coordinating TB and HIV collaborative activities, and the increasing availability of antiretroviral therapy (ART) offers hope for dually infected TB patients. Despite these significant improvements, DOTS services are still not accessible to all segments of the population, due to a combination of weak and inefficient health systems, inadequate financial and human resources for health, lack of effective coordination, and other factors. As a result, case detection rates and treatment success rates are still low.

4. Challenges that need to be overcome for better control of TB include crosscutting issues such as how to ensure a public approach that is equitable and accessible to the vulnerable and disadvantaged in society. This will depend on efficient mobilisation and accountable distribution of financial and human resources, both significant challenges in themselves. Since HIV is fuelling the TB epidemic in Africa, two conditions are essential to achieve the global targets for TB control: firstly, scaling up and improving the quality of implementation of the DOTS strategy (mainly the responsibility of TB programmes), and secondly, countering the impact of HIV by fully implementing interventions to decrease HIV transmission and ensuring universal access to antiretroviral treatment (mainly the responsibility of HIV/AIDS programmes). Overcoming the formidable barrier posed by HIV across the continent in the face of continuing social and economic hardships remains a major challenge.

5. Opportunities abound for accelerating the expansion of DOTS and scaling up interventions to improve case detection and treatment success. TB control is now a key development priority on many health and development agendas, as shown by the scope and depth of global and regional resolutions and declarations for mobilization of political, technical and financial resources for improving health in Africa. Other opportunities are offered by the continuing strategic approaches to fighting TB using evidence-based solutions, such as the Second Global Plan to Stop TB and the forthcoming WHO African Region Strategic Plan for TB control.

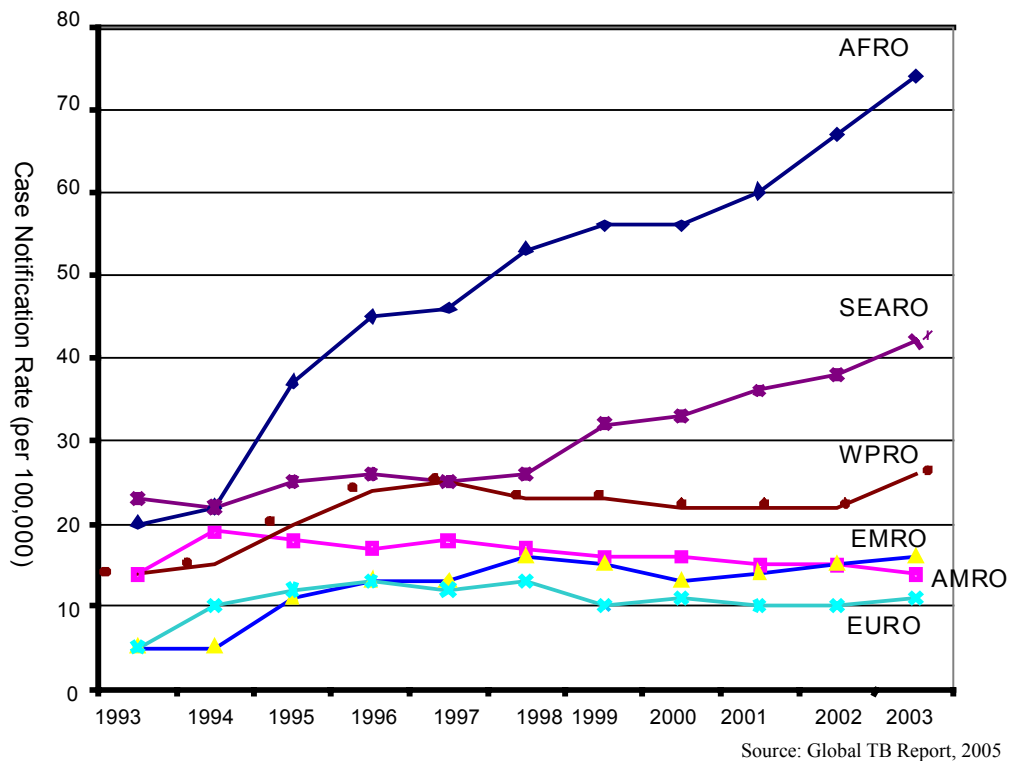
6. The vision of TB control efforts is to have an Africa free from TB. The strategic approach is to control TB (by quality DOTS expansion and enhancement to improve case detection and treatment outcomes) and to counter the impact of HIV on TB (by fully implementing interventions to decrease HIV transmission and ensuring universal access to antiretroviral treatment). This will be achieved by strengthening TB and HIV/AIDS programmes, improving collaborative TB/HIV interventions, strengthening health systems, developing partnerships and promoting research.

2. BURDEN OF TUBERCULOSIS IN AFRICA

2.1 Overview

7. The WHO African Region contains only 11% of the world's population, but contributed 27% of the global total of notified TB cases in 2003¹. More than 34 African countries have notification rates of at least 300 cases per 100,000 population, compared to less than 15 per 100,000 population in developed countries. Between 1993 and 2003, the notification rate of new smear positive TB rose from 20 to 75 cases per 100 000, as shown in Figure 1 below.

Figure 1: Trend of notification rates for new smear positive TB cases by WHO Region. 1993-2003



8. The incidence of TB in many parts of the world has stabilised with the exception of Africa, South-east Asia and the Western Pacific region. As shown above, the increase is fastest in Africa, which has the world's worst per capita burden of TB disease.

¹ Global tuberculosis control: surveillance, planning, financing. WHO report 2005. Geneva, World Health Organization (WHO/HTM/TB/2005.349)

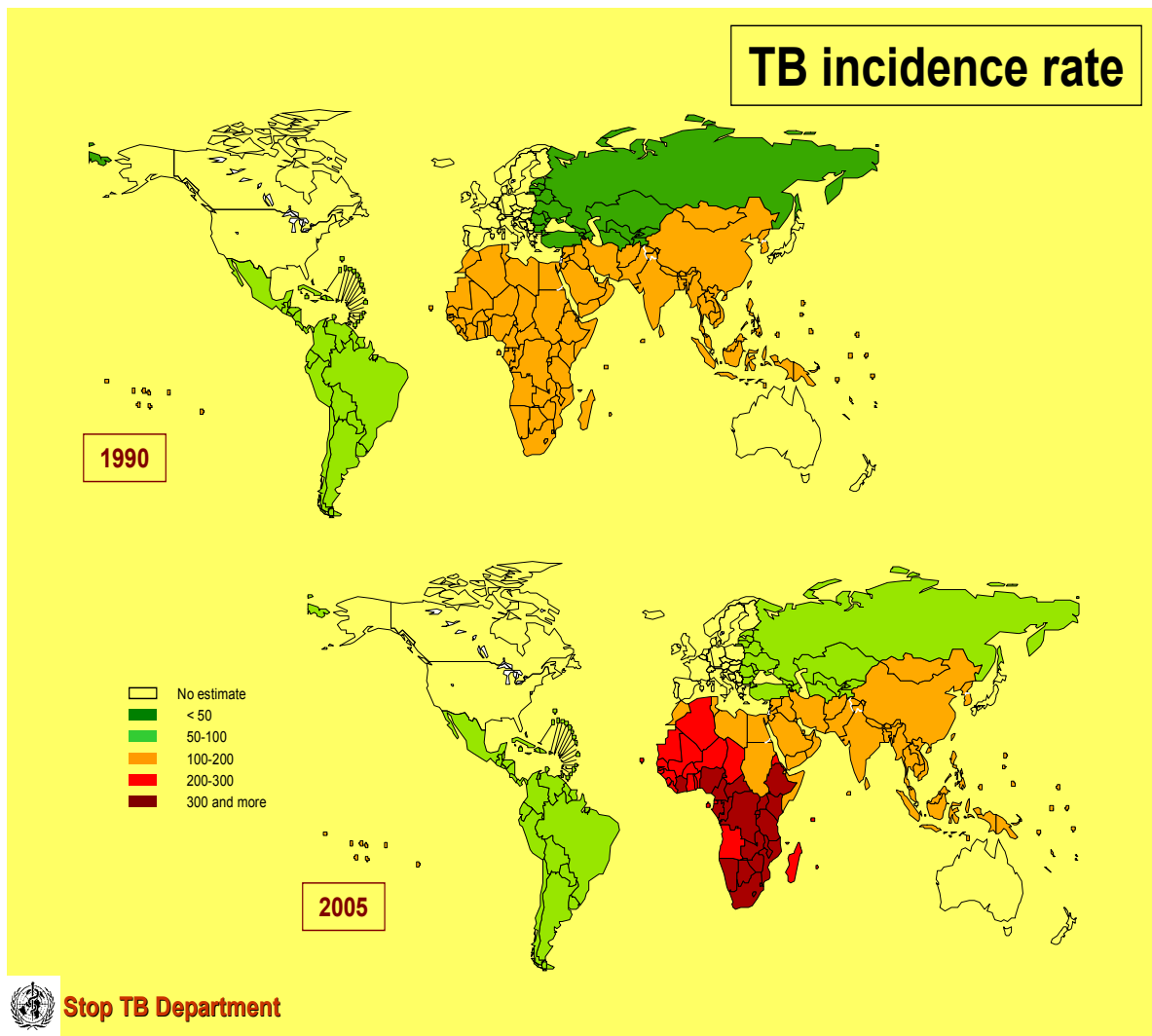
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2.2 Sub-regional differences in the burden of disease

9. There are sub-regional differences in the burden of TB in Africa. Southern and eastern Africa has the highest per capita burden. Seven southern African countries report between 400 – 700 cases per 100 000 population. In the Central African countries, six out of seven countries reported between 100 – 200 cases per 100 000 while North Africa has comparatively the lowest TB burden of less than 65 cases per 100 000 population. Most eastern African countries report less than 200 cases per 100 000 population with the exception of Kenya. More than 60% of western African countries register fewer than 100 cases per 100 000 population. Figure 2 below shows that most African countries are far worse off now than they were in 1990, with the vast majority reporting TB incidences above 100 cases per 100 000 population annually.

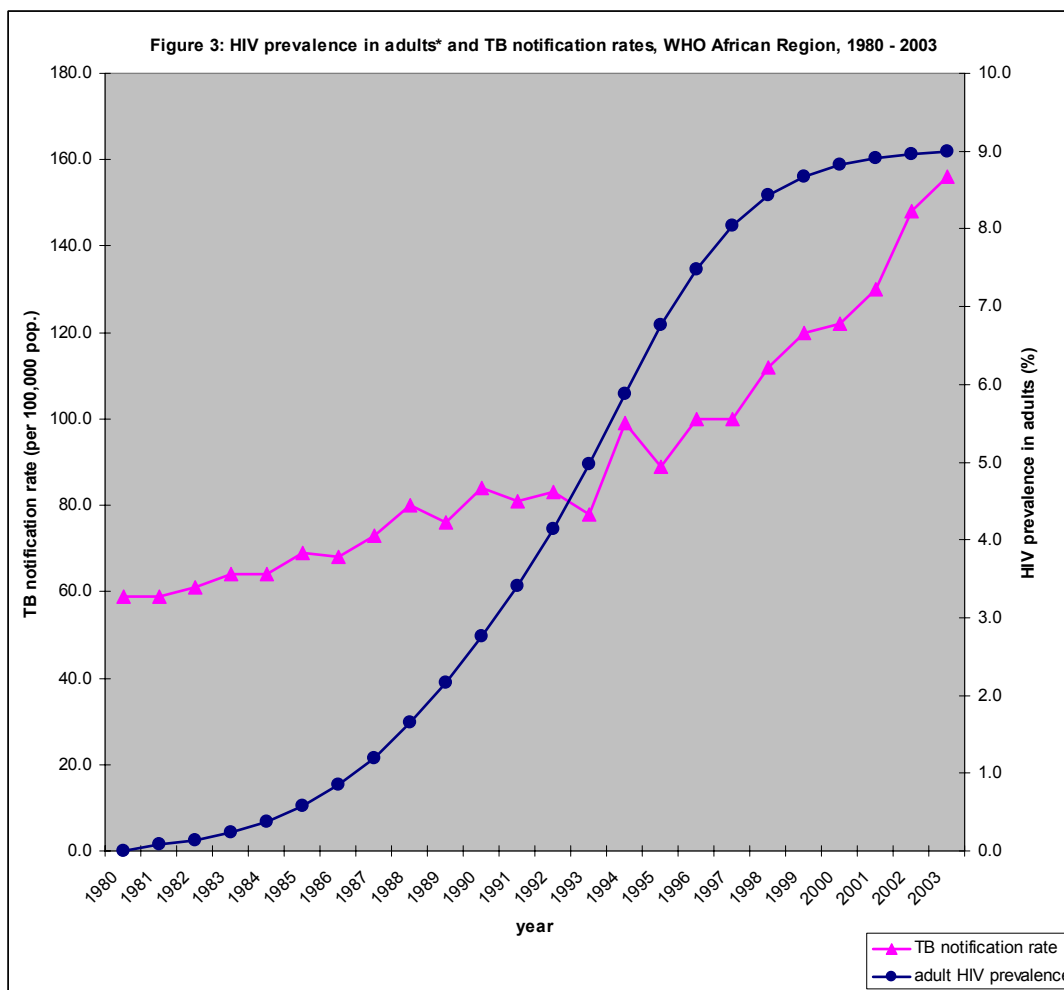
Figure 2: Global trend of TB incidence, 1990 – 2005



2.3 TB and HIV

10. There are many factors responsible for the spiralling TB epidemic, such as poor health infrastructure, organisation, management, poverty, weak health systems and poor management of human resources. The HIV/AIDS epidemic is one of the most important risk factors for TB incidence and death in Africa. In 2003, the average prevalence of HIV among adults (15 – 49 years) in sub-Saharan Africa was 9%. HIV has complicated the clinical management of TB, overloaded public health services and increased the stigma associated with this ancient disease. TB is now more difficult to diagnose, and dually infected patients have a higher mortality because they often have a much more severe illness than HIV-negative TB patients due to immunosuppression. Though TB itself remains curable even in the presence of HIV, the risk of recurrence of disease is higher than in HIV-negative TB patients. TB/HIV patients are also more likely to develop adverse reactions to treatment, increasing their chances of interrupting treatment and consequently, that of developing multidrug-resistant disease.

11. Figure 3 below shows how the steep increase in TB notifications across the continent occurred about five to six years after the increase in the HIV epidemic.



Source: WHO THD Surveillance Workshop, 2005 (unpublished)

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12. Approximately 35% of all TB patients in sub-Saharan Africa are dually infected with HIV, compared to the global average of 8%. TB is the commonest cause of morbidity and mortality among People Living with HIV. HIV causes TB to occur more frequently, particularly in younger economically productive members of society, and especially among girls and young women (15-24 years)². The additional load placed upon health systems by HIV is overstressing health care workers and facilities alike. One of the results is the increased likelihood of missing potential TB patients among the multitudes of very sick patients seen at public health facilities.

13. Figure 4 below illustrates the devastating effect of HIV upon the TB epidemic in southern Africa. The proportion of adult TB patients who are co-infected with HIV is at least 50% in eight of the 12 countries depicted here.

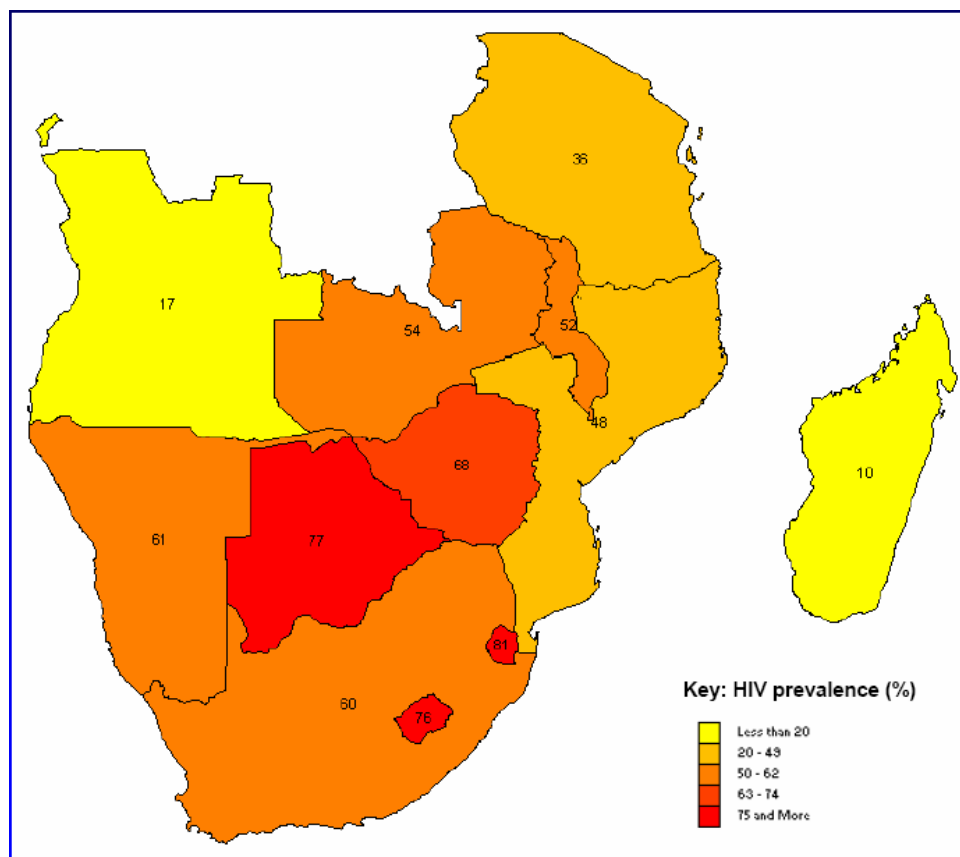
² Global tuberculosis control: surveillance, planning, financing. WHO report 2005. Geneva, World Health Organization (WHO/HTM/TB/2005.349).

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Figure 4: Prevalence of HIV in adult (15 – 49 years) TB patients in Southern Africa, 2004



Source: Global TB Report, 2006 (unpublished)

14. Not only does Africa have the world's worst burden of TB, but also the worst death rate among TB patients, a fact partly due to the impact of HIV. Of the 41 countries with the highest prevalence of HIV-infected TB patients, 29 of these countries are in Africa. It is estimated that almost a quarter of a million people die every year with dual TB/HIV disease, and that more than 80% of these people die in Africa.

15. Controlling TB in isolation from HIV therefore will not achieve any meaningful success. With one third of the world's population infected with TB (though the vast majority will not develop disease), the intersection of the HIV and TB epidemics has complicated the control of both diseases.

3. PROGRESS MADE IN TB CONTROL

3.1 Political commitments to TB Control

16. African Heads of State and Government demonstrated their commitment in the Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (ORID) of April 2001³, which recognized the challenges of developing feasible policies, strategies, structures and processes to ensure adequate prevention and control of HIV/AIDS, TB and ORID. By 2001, TB had been declared as a global emergency by WHO and the DOTS strategy (government commitment, diagnosis through microscopy, standardized and supervised treatment, uninterrupted drug supply, and regular monitoring) adopted as the main framework to combat TB globally^{4,5}. The Amsterdam Declaration of 2000 endorsed the Stop TB Initiative, the first Global Plan to Stop TB was launched in 2001 and the expanded DOTS framework, the basis for all TB control activities⁶, in 2002.

17. The Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases of July 2003⁷ reaffirmed the Abuja Declaration, as did the AU/NEPAD Health Strategy of 2003⁸ and the African Union (AU) Assembly Decision 55(IV) on the Interim Report on HIV/AIDS, TB, Malaria and Polio of January 2005. The New Partnership for African Development (NEPAD) Health Strategy seeks to reduce the burden of disease through six priority areas, including the scaling up of disease control. For TB control, the NEPAD Health Strategy advocates increased access to quality DOTS services, such as community based DOTS, collaborative TB/HIV/AIDS activities and public-private partnerships, and the development of regional strategies to mobilise human and financial resources for TB control activities.

18. In May 2005, the African Union and the Stop TB Partnership endorsed a "Blueprint" to accelerate TB control activities and achieve the Millennium Development Goals (MDG) TB targets in Africa. The Global Plan to Stop TB (2006-2015) provides the ten-year framework for TB control, and within that context, the "Blueprint" sets out the priority activities for Africa in the near term. The "Blueprint" describes activities and financial needs for 2006-2007 as part of efforts to reach the MDGs, and has key recommendations for all key stakeholders.

19. DOTS, the WHO-recommended TB control strategy, remains essential for controlling TB, but global statistics suggest that the strategy alone will not be sufficient to achieve the 2015 TB-related MDG and the Stop TB Partnership targets, especially in Africa⁹. In August 2005, recognising this fact and in response to an ongoing epidemic that has more than quadrupled since 1990 and is killing more than half a million people every year, African Ministers of Health declared TB an emergency in the region in the Maputo Declaration¹⁰. The Maputo Declaration makes recommendations to Member States and technical and financing partners to

³ The Outcome of the African Summit on HIV/AIDS, Tuberculosis and other related infectious diseases. Abuja Nigeria, April 2001.

⁴ World Health Organization. Framework for effective tuberculosis control. WHO/TB/94.179. Geneva: WHO, 1994.

⁵ Regional Committee for Africa Resolution AFR/RC44/R6. September 1994.

⁶ World Health Organization. An expanded DOTS framework for effective tuberculosis control. WHO/CDS/TB/2002.297. Geneva: WHO, 2002.

⁷ AU Maputo Declaration

⁸ NEPAD Health Strategy: Executive Summary

⁹ Stop TB Partnership and WHO. Global Plan to Stop TB 2006-2015 (WHO/HTM/STB/2006.35). Geneva: World Health Organization, 2006.

¹⁰ The fifty-fifth session of the WHO Regional Committee for Africa held at Maputo, Mozambique, August 2005, Resolution AFR/RC55/R5: Tuberculosis control: The situation in the African Region.

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develop and implement with immediate effect emergency strategies and plans to control the worsening TB epidemic. These plans include the commitment of more human and financial resources to strengthen DOTS programmes and to scale up activities in order to improve case detection and treatment success. The range of interventions includes strengthening TB/HIV collaborative interventions, expanding national partnership for TB control, implementing strategies to reduce patient default and transfer-out rates, and hastening research on new effective shorter duration treatment regimens and appropriate diagnostic tools for TB.

20. AU member countries further committed themselves to the achievement of Universal Access to Treatment and Care by 2015 at a Summit held in Gaborone, Botswana in October 2005¹¹. The Gaborone Declaration seeks to develop an integrated health care delivery system based on client-based essential health package delivery, to scale up access of HIV, TB and malaria treatment and to strengthen health systems, promoting the allocation of at least 15% of the national budget to health as resolved in the Abuja 2001 Declaration.

3.2 Status of TB Control in Africa

21. The internationally recommended strategy for effective TB control is the Directly-Observed Treatment, Short course (DOTS). The five components of this strategy are:

- a. **Sustained political commitment** to increase human and financial resources and make TB control a nation-wide activity integral to the national health system;
- b. **Access to quality-assured TB sputum microscopy** for case detection among persons presenting with, or found through screening to have, symptoms of TB (most importantly prolonged cough). Special attention is necessary for case detection among HIV-infected people and other high-risk groups, e.g. people in institutions.
- c. **Standardized short-course chemotherapy to all cases of TB under proper case-management conditions including direct observation of treatment** – proper case management conditions imply technically sound and socially supportive treatment services;
- d. **Uninterrupted supply of quality-assured drugs** with reliable drug procurement and distribution systems and,
- e. **Recording and reporting system enabling outcome assessment** of every patient and assessment of the overall programme performance.

22. In most countries, the quality and population coverage of DOTS are still low. The scaling up of DOTS expansion initiatives is still in the initial phase in most countries, TB laboratory service networks are poorly developed and insufficiently resourced to provide essential TB services, and there are crippling shortages of appropriately trained staff at most levels of the health system.

23. TB is a disease of the poor but TB control activities do not have high visibility in Poverty Reduction Strategy Papers (PRSPs), Medium Term Expenditure Frameworks (MTEF), Poverty Reduction Support Credits (PRSCs) and other broad planning mechanisms such as Sector-Wide Approaches (SWAPs) which hold the potential for placing financing for TB control in a sustainable and flexible long-term developmental framework.

24. Many countries have allocated specific budget lines for TB control activities in their ministries

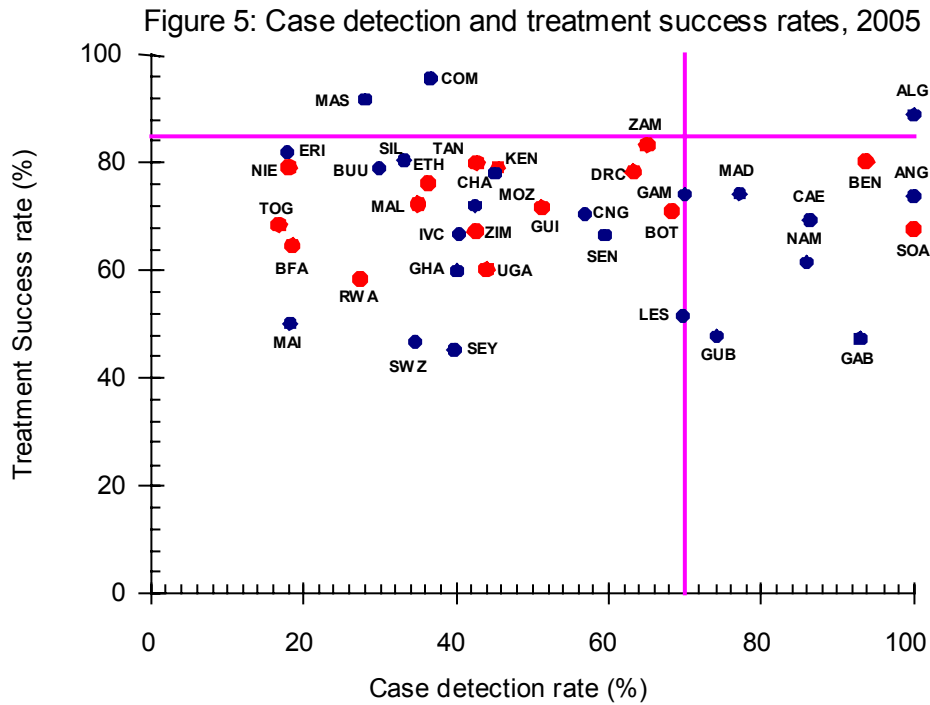
¹¹ 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH2), Gaborone, Botswana 10 – 14 October 2005.

of health budgets though unfavourable trends of domestic funding of TB control still exist in many countries. The advent of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the increased support from multilateral and bilateral financing partners and private foundations, have led to the release of significant additional funding to TB control. Many TB programmes were traditionally under-funded. Indeed, in many countries, the greater challenge now is the effective absorption of these additional funds, which are often markedly more than the programmes were used to dealing with. In line with the widespread shortages of human resources for health in Africa, many TB control programmes are seriously understaffed, and experience high staff turnover due to migration to the private sector or abroad, with HIV also taking its toll.

25. National coordination of TB control efforts is improving. About two-thirds of the 53 African countries have national technical coordinating bodies and 47 are implementing TB control according to written national guidelines. Heads of State and Government are increasingly involved in national commemoration of the World TB days for advocacy and social mobilization. The growing consensus to coordination of TB and HIV prevention, treatment, care and support has led to the development of national TB/HIV coordinating bodies but these are still very few. The increasing availability of antiretroviral therapy offers hope to TB patients, for whom a diagnosis of TB is often the first evidence of underlying HIV infection.

26. Members of the Stop TB Partnership, an initiative of multilateral and bilateral organisations, private corporations and civil society organisations, increased their support to national TB control efforts. Coordination of the support from the increasing number of international partners has proved challenging to many countries, and the increasing demands for technical and financial reports is straining the capacity of TB control programmes to function efficiently. Formal national Stop TB Partnerships for advocacy and resource mobilisation are only beginning to form in most countries. Four sub-regional TB control initiatives were established to coordinate cross-border TB control activities and to share experiences. All are hosted by sub-regional economic bodies; however most of them are not functioning actively.

27. Most of the international strategies for effective TB control were piloted in Africa. Recent interventions such as community-based TB care and public-private partnerships are now spreading within countries and in the region. There is greater involvement of civil society organizations, communities and the private sector but most are currently in the initial phase. More than 20 countries are currently implementing community-based TB care services, with only Malawi and Uganda having extended it to all districts. Figure 5 below shows the progress made in countries in the WHO African region by 2003 towards the global targets for TB control of 70% case detection of the estimated smear-positive cases and 85% successful treatment of these.

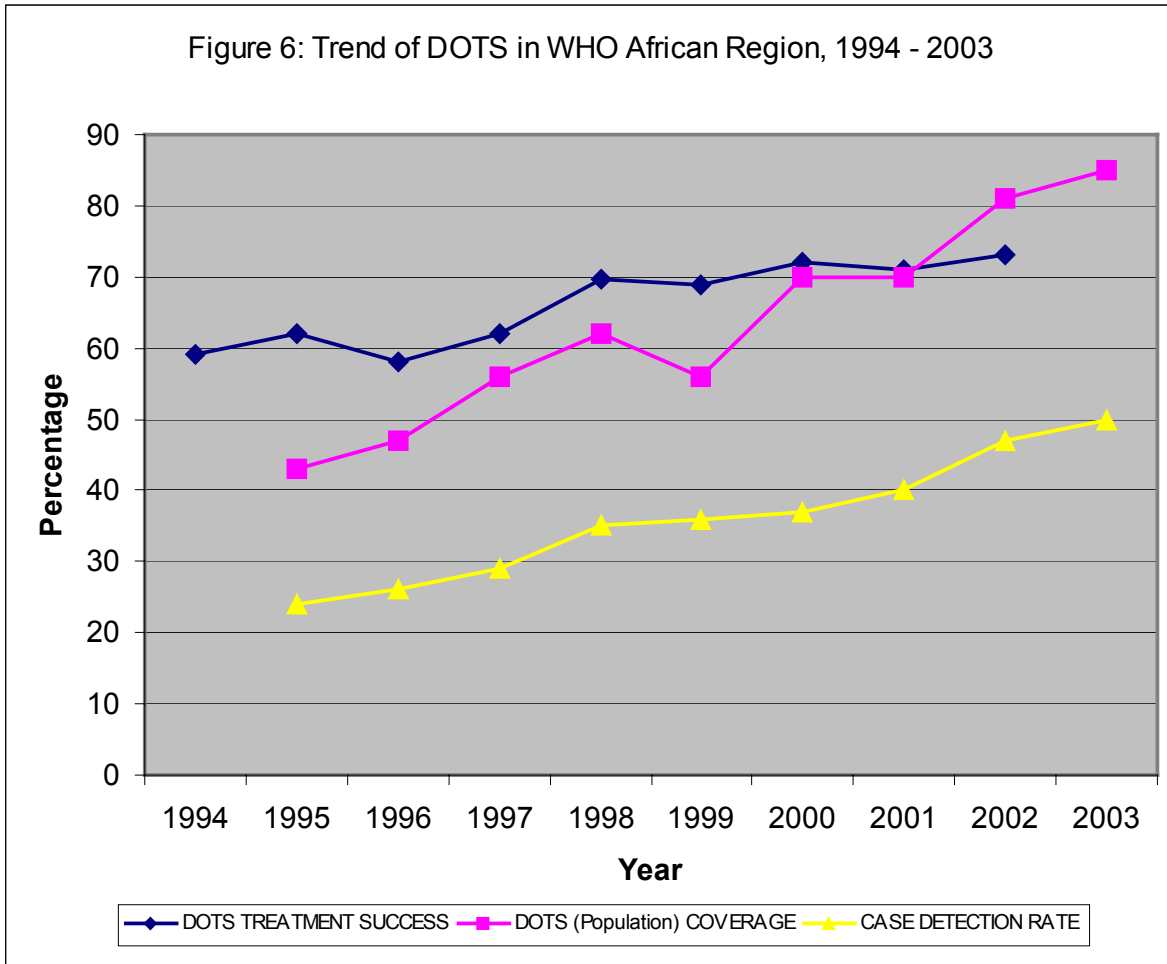


(Courtesy of Brian Williams, WHO, Geneva)

29. Only three countries achieved treatment success rates over 85%, ten achieved the case detection target and just one attained both targets. Many countries are still far from reaching the targets. Among three WHO regions that have increasing TB incidences, the African region has the lowest case detection and treatment success rates. Attainment of these targets is essential for there to be a significant impact on the morbidity and mortality placed on the continent by TB.

30. Member states developed DOTS-based TB control programmes as part of overall health care delivery systems. With the expansion of DOTS-based programmes, especially in the public sector, DOTS coverage increased from 43% in 1995 to 85% in 2003, which compares favourably with those of other WHO regions of the world. Case detection increased to a still low 47% in 2003 while treatment success has stalled at approximately 70% for the past five years.

31. Figure 6 below shows the slow progress towards the targets in the WHO African region from 1994 to 2003.



29. Many collaborative TB/HIV activities are at the initiation stage in most countries. Antiretroviral therapy (ART) can reduce the high mortality of TB/HIV co-infection but 86 out of 1000 TB patients were tested for HIV, 4 out of 1000 co-infected patients were assessed for ART and 2 out of 1000 TB/HIV co-infected were started on ART¹². Unless urgent steps are taken to improve TB control efforts, Africa is not expected to attain the global targets by 2015. The Maputo Declaration of 2005 clearly recognises this in calling for “urgent and extraordinary” action to expand DOTS and collaborative TB/HIV interventions.

30. In conclusion, there has been significant progress in implementing the DOTS strategy on the African continent. DOTS-based TB control programmes now exist virtually in all countries with operational TB surveillance systems in all but four countries. However, the impact on the TB burden has not been significant and approximately 2.4 million TB cases and 500,000 TB-related deaths still occur every year.

31. It is ironic that African countries were the first to implement the DOTS strategy for TB control under programme conditions, as far back as the late seventies and early eighties, yet the continent still has some ground to cover in the fight against TB. There are many factors militating against progress, as will be discussed in the following section.

¹² as 12 above

4. CHALLENGES AND OPPORTUNITIES

4.1 Challenges

32. Africa is lagging behind in the fight against TB, and will not reach global targets for reducing and reversing its impact if current levels of control efforts are not significantly improved. Long before drugs were available for treating TB, the incidence of TB began falling in developed countries, primarily of improving socio-economic conditions. This puts into perspective the role that TB control programme can play in controlling TB. Early detection of infectious TB patients and curing them is the surest way to breaking the chain of transmission. There is abundant evidence that it is possible to increase case detection and treatment success, even in resource-poor settings. The challenge is how to implement proven strategies in an effective and sustainable manner.

33. Coordination of national and international efforts in TB control is critical, as is improved linkages between TB and HIV control programmes in providing prevention, treatment, care and support to dually infected patients. This depends on crosscutting issues such as governance, organization of health systems, human resource development and management. Because these qualities are needed at the highest level, political commitment is one of the pillars of the DOTS strategy.

34. TB has long been a disease of the poor. It also causes poverty and leads to stigmatization and social isolation, hindering early diagnosis and treatment of disease. TB places an uneven burden on society, affecting the poor and very poor. The challenge is to governments therefore to adopt deliberate pro-poor approaches to the reform of public health systems. This often hinges on effective resource mobilization but more crucially on efficient and accountable resource distribution, including human resources for health. For TB control to be effective, there are several specific challenges that should be overcome. These are summarised as follows:

- i. The primary challenge facing Africa is how to rapidly improve case detection and treatment success rates in order to meet global targets of TB control;
- ii. The raging AIDS epidemic poses a formidable threat to efforts to contain the TB epidemic, and the twin diseases are also causing health care worker losses, making the challenge formidable;
- iii. How to accurately measure TB incidence in order to assess progress towards the MDGs and Abuja targets at country level is another major challenge;
- iv. The quality of DOTS services in most countries is still poor and the services are not accessible to all. The challenge is to scale up DOTS expansion using new initiatives such as community based DOTS, involvement of private sector and DOTS in special situations, interventions which are still in the developmental phase in most countries;
- v. Mobilising communities and other stakeholders to scale up access to DOTS services is a challenge that is made even more urgent by the chronic shortages of human resources for health in virtually all countries in Africa;

- vi. Weak, malfunctioning and under-funded health delivery systems and infrastructure prevent effective TB control. Adapting and improving such services to the benefit of all people especially vulnerable populations and the poor is a major challenge in low-resource settings;
- vii. The mobilization of domestic resources is insufficient and represents a severe constraint on further progress in TB control, among other public health activities;
- viii. Additional external support from financing and technical partners presents additional challenges to programmes, which now deal with a wide range of accounting and reporting requirements, often with overstretched staff and without national coordination;
- ix. Strengthening laboratory networks to ensure quality management and monitoring of drug susceptibility is challenging. Most countries have no reference laboratory or national quality assurance programme, and access to laboratories is still poor due to inadequate facilities and pervasive health personnel shortages;
- x. Community awareness and involvement in TB control present significant challenges in most countries, and there is lack of appreciation by most politicians and communities of the importance of TB control in the achievement of the MDGs and development. There is low knowledge of TB, its treatment and control and poor involvement of communities in TB detection and treatment;
- xi. There is a critical need to develop new vaccines, diagnostic techniques and drugs to ensure effective prevention, quick and accurate diagnosis and rapid cure of TB.

4.3 Opportunities

35. The African Union and sub-regional economic groupings have adopted proactive approaches to development that emphasise issues of governance and social conditions for improving health. There is a greater global focus on Africa and an increased flow of resources. Health issues are now mainstreamed into the design of Poverty Reduction Strategic Plans (PRSPs) and included in initiatives such as the extended Highly Indebted Poor Countries (HIPC) initiative and debt cancellation. The MDGs, World Health Assembly, Regional Committees and African Union resolutions and the NEPAD Health Strategy offer further opportunities by stimulating increased technical and financial support to strengthening TB control efforts in Africa. The establishment of the GFATM and increased funding and coordination by AU Member States, bilateral and multilateral organizations, NGOs and the private sector has enhanced national responses and promises to build on existing capacity in expanding DOTS. The main opportunities that present themselves for accelerating the expansion of DOTS and scaling up interventions to improve case detection and treatment success are:

- i. The control of TB is now a key development priority on the health and development agendas of African political leaders and global partners;
- ii. The AU, the United Nations Economic Commission for Africa, sub-regional economic bodies, and NEPAD provide opportunities for addressing the broader determinants of health;
- iii. International global and regional resolutions and declarations provide favourable opportunities for mobilization of political, technical and financial resources for improving health in Africa;

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- iv. The development and strengthening of global and regional partnerships to address specific health problems, such as TB and HIV, present opportunities for improved TB control;
- v. Increased health financing and calls for efficient and equitable resource allocation mechanisms, the greater recognition for pro-poor approaches to resource management, and the increasing role of global partnerships to fight diseases of poverty such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), are positive developments. The GFATM in particular has transformed the field in TB prevention and care, and many countries now have significant financial resources for the first time in many years;
- vi. Growing international consensus about addressing health as important for socioeconomic development and poverty reduction;
- vii. Continuing strategic approaches to fighting TB using evidence-based solutions such as the WHO Regional Office for Africa's development of a vision of using proven interventions to guide future interventions for the attainment by all peoples in the African Region of the highest possible level of health;
- viii. Further opportunities are presented by specific responses to the TB epidemic such as the Maputo Declaration of August 2005, the "blueprint" developed by the global Stop TB Partnership calling for US \$1.1 billion in new funding for TB control in Africa during 2006-2007, the Gaborone Declaration of October 2005, the Second Global Plan to Stop TB, and the forthcoming WHO African Region Strategic Plan for TB control for 2006 - 2015

5. WAY FORWARD

35. There is national and international consensus on the strategic direction required for an effective response to TB. What is required is even greater commitment to the actual implementation of proven interventions to meet global control targets. Countries must ensure predictable and sustained financing, with support from donors. The World Health Assembly Resolution on "Sustainable financing for tuberculosis prevention and control" (WHA58.14) expressed the commitment of member states "to ensure the availability of sufficient domestic resources and of sufficient external resources to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration.

36. National ownership of policy development and implementation is an absolute must for a coordinated response to TB and TB/HIV. Health sector reforms must ensure the removal of bottlenecks at sub-national levels and the bolstering of the capacity at operational levels of the health system. This will require strengthening human resource capacity, procurement and supply systems and national health information management systems. The role of research in improving TB control programme performance should be strengthened. DOTS is still necessary for effective TB control but will not be enough in the presence of high HIV prevalence.

5.1 The Maputo Declaration, August 2005

37. In August 2005, African Health Ministers declared TB an emergency in Africa in recognition of the gravity of the epidemic and the slow progress made in combating the disease. The Resolution recognised that

Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria (ATM), Abuja, May 2 – 4, 2006

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unless urgent and extraordinary are taken, the MDG and Abuja Declaration targets for effective TB control would not be achieved. The Resolution urges Member States to rapidly improve case detection and treatment outcomes by:

a) Programmatic actions:

- Accelerating DOTS coverage at district and national level
- Reducing patient default and transfer out rates
- Accelerating scale up of TB/HIV interventions

b) Health system strengthening actions

- Expanding national partnerships for TB control
- Improving human resources for TB control
- Mobilising additional resources for TB control

5.2 Strategic Plan for TB Control in Africa, 2006 – 2015

38. Since the early 1990s, WHO/AFRO, in collaboration with bilateral and multilateral partners, has been supporting member states to develop DOTS-based TB control programmes as part of overall health care delivery systems. The first WHO/AFRO strategic plan for TB control in Africa spanned the years 2001 to 2005¹³. Countries were supported to develop strategies for case detection and treatment, frameworks for national plan development and implementation, mechanisms for increasing access to high quality drugs and commodities, strategies for human resource development, systems for assessing progress and development of partnerships to mobilize internal and external resources necessary for scaling up interventions.

39. The second strategic plan for TB control in Africa, covering the years 2006 – 2015, envisages a region where TB ceases to be a major public health problem through the application of high quality, accessible and affordable TB control services. The mission is to promote and facilitate the identification, adoption and implementation of highly efficient and effective TB prevention, care and support strategies and services in all member states. The overall goal of this TB Control Strategy is to accelerate the reduction of TB related morbidity and mortality towards the achievement of the TB related Millennium Development Goal targets by 2015.

40. The primary objective of the Strategic Plan for TB Control in Africa is to reach and sustain the WHA control targets for 2005 extended to 2010: 70% case detection rate for new smear positive TB cases and 85% treatment success rate for those started on treatment in all member countries by end 2010. The indicators are the DOTS coverage, the prevalence and death rates associated with TB, and the proportion of TB cases detected and cured under DOTS. The strategic approaches to achieve these targets are:

- i. Acceleration and achievement of universal access to enhanced and expanded quality DOTS services for all TB patients;
- ii. Health system strengthening to support expansion and extension of quality DOTS services

¹³ Strategic Plan for Tuberculosis Control in the African Region: 2001-2005. World Health Organization. Regional Office for Africa, Harare, Zimbabwe. 2000.

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- iii. Combating the TB/HIV dual epidemic;
- iv. Partnership strengthening for TB control, especially public-private partnerships and increased involvement of communities and civil society

41. The implementation of the strategy will depend on country-specific frameworks for TB control, with support from relevant national and international partners. Each country should embark on phased implementation of evidence-based best practices to ensure cost-effective utilisation of available resources. Strong partnerships are essential at all levels in all sectors of the health system. A pro-poor and equity based approach to the delivery of TB control services should be adopted, and barriers to early diagnosis and effective treatment addressed in a sustainable manner. This will require innovative approaches to reach vulnerable groups and hard-to-reach populations such as slum-dwellers, nomadic populations, refugees and displaced persons.

5.3 Second Global Plan to Stop TB (2GPSTB)

42. The strategy for TB control in Africa is in consonance with and guided by regional and global strategic orientations, including the recently launched Second Global Plan to Stop TB (2GPSTB). The development of 2GPSTB arose from recognition of the need for a new strategy building on and extending beyond the DOTS strategy in order to achieve targets for TB control. The vision of 2GPSTB is a world free of TB, with the goal of dramatically reducing the burden of TB by 2015 in line with the MDGs and the Stop TB Partnership targets.

43. The Plan has four objectives:

- To achieve universal access to high-quality diagnosis and patient-centred treatment
- To reduce the human suffering and socioeconomic burden associated with TB
- To protect poor and vulnerable populations from TB, TB/HIV and multidrug-resistant TB
- To support the development of new tools and enable their timely and effective use

44. The components of the strategy include high-quality DOTS expansion and enhancement, radically scaled-up TB/HIV activities in line with the UNAIDS/G8 goal of universal access by 2010, addressing multidrug-resistant TB, research and development into new drugs, diagnostics and vaccines, with health system strengthening, development of partnerships with care providers, patients and communities (Annex 1).

Anne I:

The Maputo Declaration on TB

REGIONAL COMMITTEE FOR AFRICA

AFR/RC55/R5

25 August 2005

Fifty-fifth session

ORIGINAL: ENGLISH

Maputo, Mozambique 22-26 August 2005

TUBERCULOSIS CONTROL: THE SITUATION IN THE AFRICAN REGION
(Document AFR/RC55/INF.DOC/3)

The Regional Committee,

Deeply concerned about the gravity of the tuberculosis epidemic in the African Region,

Recalling Resolution AFR/RC44/R6 of September 1994 by the Regional Committee on implementation of short course TB therapy for control programmes in the Region.

Noting the national and international commitments to fight AIDS, tuberculosis and malaria; and the increasing financial resources made available, among others, by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Stop TB Partnership and bilateral partners;

Convinced that unless urgent extraordinary actions are undertaken to address the current trend of the epidemic, the situation will only get worse and the Abuja and Millennium Development Goal targets will not be achieved;

1. **DECLARES** tuberculosis an emergency in the African Region;
2. **URGES** Member States:
 - (a) to develop and implement with immediate effect emergency strategies and plans to control the worsening tuberculosis epidemic;
 - (b) to rapidly improve tuberculosis case detection and treatment success-rates;
 - (c) to accelerate directly-observed treatment short-course(DOTS) coverage at district and national levels;
 - (d) to accelerate implementation of interventions to combat the TB/HIV epidemic, including increased access to ARVs by doubly-infected patients;
 - (e) to expand national partnership for tuberculosis control, especially public-private partnerships;
 - (f) to improve the quantity and quality of staff involved in tuberculosis control;
 - (g) to implement strategies to reduce patient default and transfer-out rates to 10% or less.

3. **REQUESTS** the Regional Director:

- (a) to provide intensified technical support to Member States for scaling up control interventions in order to rapidly reduce tuberculosis incidence and death;
- (b) to hasten research on new effective shorter duration treatment regimens and appropriate diagnostic tools for tuberculosis;
- (c) to mobilize additional resources for tuberculosis control in the Region;
- (d) to report to the Regional Committee every two years on progress with tuberculosis control in the Region.

Eighth meeting, 25 August 2005

Annex 2: The Stop TB Strategy at a Glance

Vision: A TB-free world

Goal: To dramatically reduce the global burden of TB by 2015 in line with the MDGs and the Stop TB Partnership targets

Objectives:

- Achieve universal access to high-quality diagnosis and patient-centred treatment
- Reduce the human suffering and socioeconomic burden associated with TB
- Protect poor and vulnerable populations from TB, TB/HIV and multidrug-resistant TB
- Support development of new tools and enable their timely and effective use

Targets: MDG 6, Target 8: Halt and begin to reverse the incidence of TB by 2015

Targets endorsed by Stop TB Partnership:

By 2005: detect at least 70% of sputum smear-positive TB cases and cure at least 85% of these cases

By 2015: reduce prevalence of and deaths due to TB by 50% relative to 1990

By 2050: eliminate TB as a public health problem (1 case per million population)

Components:

1. Pursue high-quality DOTS expansion and enhancement

- a. Political commitment with increased and sustained financing
- b. Case detection through quality-assured bacteriology
- c. Standardized treatment, with supervision and patient support
- d. An Effective drug supply and management system
- e. Monitoring and evaluation system, and impact measurement

2. Address TB/HIV, MDR-TB and other challenges

- Implement TB/HIV collaborative activities
- Prevent and control multidrug-resistant TB
- Address prisoners, refugees, other high-risk groups and special situations

3. Contribute to health system strengthening

- Actively participate in efforts to improve system-wide policy, human resources, financing, management, service delivery and information systems
- Sharing innovations that strengthen systems, including the Practical Approach to Lung Health
- Adapt innovations from other fields

4. Engage all care providers

- Public-Public and Public-Private Mix (PPM) approaches
- International Standards for TB Care

5. Empower people with TB and communities

- Advocacy, communication and social mobilization
- Community participation in TB care
- Patients' Charter for Tuberculosis Care

6. Enable and promote research

- Programme-based operational research
- Research to develop new diagnostics, drugs and vaccines

