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Implementing global TB control: solutions to DOTS expansion constraints

Report of the 2nd ad hoc Committee on the TB epidemic

The 2nd ad hoc Committee is convened by the DOTS Expansion Working Group (DEWG), one of six working groups established under the auspices of the Global Partnership to Stop TB.

A companion to the Global Plan to Stop TB
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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>DEWG</td>
<td>DOTS Expansion Working Group</td>
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<td>DOTS</td>
<td>The global strategy to control TB</td>
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<td>GDEP</td>
<td>Global DOTS Expansion Plan</td>
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<td>GDF</td>
<td>Global Drug Facility</td>
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<td>GFATM</td>
<td>Global Fund for AIDS, TB and Malaria</td>
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<td>GPSTB</td>
<td>Global Plan to Stop TB</td>
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<td>HBC</td>
<td>High burden country</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<td>IUATLD</td>
<td>International Union Against Tuberculosis and Lung Disease</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MDR-TB</td>
<td>Multidrug-resistant tuberculosis</td>
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<td>NICC</td>
<td>National Interagency Coordinating Committee</td>
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<td>NGO</td>
<td>Non-governmental organization</td>
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<td>NTP</td>
<td>National Tuberculosis Programme</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<td>PRSP</td>
<td>Poverty Reduction Strategy Process</td>
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<td>TBCTA</td>
<td>TB Coalition for Technical Assistance</td>
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<tr>
<td>WHA</td>
<td>World Health Assembly</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Preface

The Global Plan to Stop TB (GPSTB) describes the essential implementation (DOTS expansion) and research measures to control TB. This report of a second ad hoc Committee on the TB Epidemic is a companion to the GPSTB, analysing the constraints to DOTS expansion and proposing solutions. The DOTS Expansion Working Group (DEWG) has convened this ad hoc Committee with the following objectives:

(1) to review the status of the TB epidemic, and country and global efforts to control it, with special emphasis on assessing the follow-up of the recommendations of the first ad hoc Committee on the TB Epidemic (London, 1998);
(2) to analyse the identified constraints (specific to TB programmes and more broadly related to health systems) towards achieving the WHA 2005 targets and identify feasible solutions at the national and international levels;
(3) to define a strategic direction for the DOTS expansion movement to implement fully the Global DOTS Expansion Plan and achieve the WHA 2005 targets;
(4) to define an approach beyond these targets towards reaching the Millennium Development Goals (MDGs) in 2015.

There are six working groups established under the auspices of the Global Partnership to Stop TB: three implementation working groups (DOTS expansion, DOTS-Plus and TB/HIV) and three working groups on development of new tools (drugs, diagnostics and vaccines). The ad hoc Committee includes the chairs of the three implementation working groups and other selected members representing a variety of constituencies, including high TB burden countries, international development assistance agencies, technical experts and researchers. The work of the ad hoc Committee links with that of the MDGs Project “Task Force 5” (Infectious Diseases and Access to Essential Medicines) in defining an approach to reaching the MDGs in 2015, through the participation of the members of the Task Force 5 working group “Combating TB”. The DEWG advocates the importance of research relevant to global TB control, as set out in the GPSTB.

1. Introduction: the current status of the global TB epidemic and control efforts

1.1 Burden of TB morbidity and mortality

The unprecedented scale of the TB epidemic and the human rights approach to TB demand effective and urgent action.1 TB ranks third among infectious diseases as a cause of disease burden, expressed as Disability-Adjusted Life Years (DALYs).2 WHO has estimated the global burden of tuberculosis and reviewed global trends and interactions with HIV.3 Worldwide in 2000 there were an estimated 8.2 million new cases of

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tuberculosis, with an incidence rate of 136/1000,000. Ten percent of all new tuberculosis cases in adults aged between 15 and 49 years were attributable to HIV infection. Globally there were 1.82 million deaths from tuberculosis in 2000, of which 226,000 (12%) were attributable to HIV. The global incidence rate of TB is growing at approximately 0.4%/year, but this overall global trend hides much faster increases in sub-Saharan Africa and in countries of the former Soviet Union. Table 1 shows the breakdown of global estimates by WHO regions.

Table 1. Summary of tuberculosis estimates in 2000 by WHO regions

<table>
<thead>
<tr>
<th>Population (millions)</th>
<th>AFR</th>
<th>AMR</th>
<th>EMR</th>
<th>EUR</th>
<th>SEAR</th>
<th>WPR</th>
<th>Global</th>
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<tbody>
<tr>
<td>New cases of TB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of cases</td>
<td>1,857</td>
<td>382</td>
<td>587</td>
<td>468</td>
<td>2,986</td>
<td>1,960</td>
<td>8,240</td>
</tr>
<tr>
<td>(thousands)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Incidence rate</td>
<td>290</td>
<td>46</td>
<td>121</td>
<td>54</td>
<td>194</td>
<td>116</td>
<td>136</td>
</tr>
<tr>
<td>(per 100,000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Change in incidence</td>
<td>4.3</td>
<td>-4.1</td>
<td>-1.4</td>
<td>2.8</td>
<td>-1.3</td>
<td>0.0</td>
<td>0.5</td>
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<td>rate 1997-2000 (%)/year</td>
<td></td>
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<tr>
<td>HIV-related TB</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>HIV prevalence in new</td>
<td>38</td>
<td>5.9</td>
<td>1.8</td>
<td>2.8</td>
<td>3.2</td>
<td>1.3</td>
<td>11</td>
</tr>
<tr>
<td>adult cases (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of cases</td>
<td>421</td>
<td>12</td>
<td>5.2</td>
<td>8.2</td>
<td>53</td>
<td>13</td>
<td>511</td>
</tr>
<tr>
<td>attributable to HIV</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>(thousands)</td>
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<td></td>
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</tr>
<tr>
<td>Incidence rate</td>
<td>65.8</td>
<td>1.4</td>
<td>1.1</td>
<td>0.9</td>
<td>3.5</td>
<td>0.8</td>
<td>8.4</td>
</tr>
<tr>
<td>cases attributable to</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>HIV (per 100,000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult cases attributable to HIV (%)</td>
<td>31</td>
<td>5.1</td>
<td>1.5</td>
<td>2.6</td>
<td>2.7</td>
<td>1.1</td>
<td>9</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Deaths</th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths from TB (thousands)</td>
<td>482</td>
<td>55</td>
<td>135</td>
<td>72</td>
<td>727</td>
<td>353</td>
<td>1,823</td>
</tr>
<tr>
<td>Deaths from TB (per 100,000)</td>
<td>75</td>
<td>6.6</td>
<td>28</td>
<td>8.3</td>
<td>47</td>
<td>21</td>
<td>30</td>
</tr>
<tr>
<td>Deaths from TB in HIV-infected adults (thousands)</td>
<td>203</td>
<td>3.9</td>
<td>3.0</td>
<td>1.6</td>
<td>29</td>
<td>5.7</td>
<td>246</td>
</tr>
<tr>
<td>TB deaths attributable to HIV (%)</td>
<td>39</td>
<td>6.5</td>
<td>2.0</td>
<td>2.1</td>
<td>3.7</td>
<td>1.5</td>
<td>12</td>
</tr>
</tbody>
</table>

Multidrug-resistant tuberculosis (MDR-TB) is a serious threat, since it arises wherever there has been, or is currently, inadequate application of anti-TB chemotherapy. Surveys have identified a high prevalence of MDR-TB in specific regions of the world, e.g. Estonia, Latvia, the Oblasts of Ivanovo and Tomsk in Russia, and the provinces of Henan and Zhejiang in China. More representative geographical coverage of global anti-TB drug resistance surveillance, with further data from longitudinal studies, enables more accurate and comprehensive monitoring of global trends in the spread of MDR-TB.

1.2 Economic burden of TB

As a fundamental human right, health deserves investment for its own sake. TB patients and their families pay the cost of TB in suffering, pain and grief. TB also causes psychological and social costs. TB patients may be rejected by family and friends or lose their jobs. In some societies, TB patients are seen as damaged for life or unmarriageable. Such discrimination can result in anxiety, depression, and reduction in the quality of life.

In addition to alleviation of these human costs, alleviation of the global economic burden of TB also represents a justification for investment in TB control from the health economics perspective. The economic costs of TB fall into two categories: a) indirect costs to society, the community and the patient’s family through lost production; and b) direct costs to the health services and to the patient and the patient’s family. The largest indirect cost of TB for a patient is income lost by being too sick to work. Studies suggest that on average three to four months of work time are lost, resulting in average lost potential earnings of 20% to 30% of annual household income. For the families of those who die from the disease, there is the further loss of about 15 years of income because of the premature death of the TB sufferer. Regarding direct costs, the substantial non-treatment costs borne by TB patients and their families are often greater than the costs of treatment borne by the health sector. The case study of India provides an example of the enormous potential economic benefits of investing in TB control.

Households have developed strategies for coping with the costs of illness and death that result in actual losses being less than the potential losses. However, some of these short-term strategies can have significant long-term costs. In particular, selling assets can reduce a household’s economic prospects. Reducing children’s food intake or removing them from school can seriously undermine their health, education, and future prospects.

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1.3 Summary of current status of TB control

1.3.1 Milestones in the global response to TB since 1990.

In 1991, a World Health Assembly (WHA) resolution proposed that all countries adopt two TB control targets for the year 2000: to detect at least 70% of all new infectious cases and to cure at least 85% of those detected. During the second half of the 1990s, it became apparent that the year 2000 targets would not be met on time. Thus, WHO convened the first ad hoc Committee on the TB Epidemic in London in 1998, which made a number of recommendations to strengthen the various elements of the DOTS strategy and accelerate impact.

Subsequent events owed a great deal to the recommendations of the 1998 London ad hoc committee, including the establishment of a global alliance named Stop TB Partnership, the creation of a Global Drug Facility providing quality anti-TB drugs to countries in need, a Ministerial Conference in Amsterdam in March 2000 to call for renewed political commitment, and a strategic focus on 22 highest-burden countries, responsible for 80% of the global TB incidence.

In 2000, the WHA decided to postpone the targets initially set for 2000 until 2005. In May 2001, a Global DOTS Expansion Plan (GDEP) was published. The GDEP is based on two pillars: the preparation of mid-term (at least 5 years) DOTS expansion plans in all countries and the establishment of national interagency co-ordination committees, or similar mechanisms, ensuring that all national partners contribute to the implementation of the national plan. In October 2001 the GPSTB was launched, specifying the costed activities in implementation and research needed to reach the WHO targets in 2005.

After the 2000 G8 summit in Okinawa, the leaders of the world’s richest countries announced an ambitious commitment to achieve substantial reductions in the global burden of HIV/AIDS, TB and malaria by 2010. Established after the 2001 G8 summit in

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Genoa, the Global Fund for AIDS, TB and Malaria (GFATM) aims to bridge the funding gap to control these diseases. The disbursement of funds in the first two rounds so far to countries which received approval for their TB control proposals represents a significant step in increasing resource flows for TB control in high TB incidence countries.

The global DEWG meeting in Montreal 2002 resulted in a clearer understanding of the constraints facing each of the HBCs and highlighted the urgent need to accelerate progress in overcoming these constraints and reaching the 2005 targets. The meeting also clarified the conditions under which the 2005 targets will or will not be met, and stressed the importance of innovative approaches to improving case detection under DOTS in those countries with satisfactory treatment outcomes. These innovative approaches will need to involve the full range of governmental and non-governmental care providers, beyond those currently engaged in TB control activities.

1.3.2 Number of countries implementing the DOTS strategy

The number of countries implementing the DOTS strategy by 2001 was 155 (out of 210). By the end of year 2001, 61% of the world’s population lived in countries in principle providing DOTS (although in practice achieving less than full population coverage).

1.3.3 Cases detected under programmes implementing the DOTS strategy

DOTS programmes notified 2.4 million new TB cases, of which 1.2 million were smear-positive. Over 10 million patients have been diagnosed and treated in DOTS programmes since 1995. However, the 1.2 million smear-positive cases notified by DOTS programmes in 2001 represent only 32% of the estimated incidence, and the rate of progress in case finding between 2000 and 2001 was not significantly faster than the average since 1995, a mean annual increment of 137,000 cases. Globally, DOTS programmes would have to treat an extra 360,000 smear-positive patients each year to reach 70% case detection by the end of 2005.

Two thirds (67%) of the additional smear-positive cases reported under DOTS in 2001 (as compared with 2000) were found in India alone. There were smaller but marked improvements in case detection in Myanmar, the Philippines and Thailand. Other HBCs made minor gains in case detection, though Pakistan and Brazil reported significant increases in the geographic coverage of DOTS.

As DOTS programmes have expanded geographically, the proportion of estimated cases found within DOTS areas has remained constant at 40-50%. Overall, DOTS programmes in the 22 HBCs are not increasing case detection towards the 70% target within designated DOTS areas.

1.3.4 Treatment success

Treatment success under DOTS for the 2000 cohort was 82% on average, and has moved closer to the 85% target as the patient population has grown in size. Figure 1 shows
treatment success in DOTS and non-DOTS areas, by WHO region, for the 2000 cohort. All indicators of treatment outcome were worse in non-DOTS areas.

Figure 1. Treatment success in (a) DOTS and (b) non-DOTS areas, by WHO region, 2000 cohort

The documented treatment success under DOTS varied from 73% in Africa to 92% in the Western Pacific Region. Fatal outcomes were most common in Africa, where a higher fraction of cases are HIV-positive, and Europe, where a higher fraction of cases occur among the elderly. Treatment interruption (default) was most frequent in the African (10%), Eastern Mediterranean (7%) and South-East Asian (7%) Regions. Transfer without follow-up was also especially high in Africa (7%). Treatment failure was conspicuously high in the European region (7%), mainly because of high failure rates in former Soviet countries (9%), most likely due to high MDR-TB prevalence. Comparing
treatment results for seven consecutive cohorts (1994-2000) shows that the overall success rates have remained approximately stable at 77-82% under DOTS.

1.3.5 Countries achieving the WHO targets

Sixteen countries had reached targets for case detection and cure by the end of 2001, but Viet Nam was the only HBC among them (following the departure of Peru from the list of HBCs in 2001). Twenty of the 22 HBCs are known to have adequate plans for DOTS expansion; implementation of many of these plans began in 2001 or 2002, and will be scaled up only in 2003.

1.3.6 Financing


1.3.7 Conclusions

Globally, treatment success under DOTS had reached 82% (for the cohort of patients registered in 2000) yet case detection under DOTS was only 32% (in 2001). If the current rate of DOTS expansion in maintained, the WHA 70% detection target will not be reached by 2005, but only by 2013. If that target is to be reached, DOTS programmes must improve case finding within designated DOTS areas (including public and private health providers) and must expand to new areas. To reach the 85% target for treatment success, cure rates must be improved under DOTS in some countries, especially those in sub-Saharan Africa.

Although both funding for TB programmes and planning for DOTS expansion improved during 2002, deficiencies in funding staff and health infrastructure are likely to hinder progress towards both of the global targets. At present, judging from their formal budgets, NTPs are significantly underestimating the cost of rectifying these deficiencies.

1.4 Need for a clear strategic direction by the Stop TB Partnership and WHO to allow full implementation of global TB control as part of the Global Plan to Stop TB.

Five years after the 1st ad hoc Committee’s report, it is time to take stock of global progress in TB control. The positive side of the balance sheet shows: a) the above sequence of key milestones in international commitment and planning; b) increased funding flows for TB control (e.g. through the GFATM); c) a series of implementation steps internationally (e.g. flow of anti-TB drugs through the GDF) and in many countries (e.g. expanded implementation of the DOTS strategy and improved case detection); and d) a decrease in the estimated TB incidence rate from 1997-2000 (%/year) in the American (- 4.1%), Eastern Mediterranean (- 1.4%) and South-East Asian (- 1.3%) Regions.

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16 Maher D, Kochi A. Combating tuberculosis. RT International 1997; 80-81 and 110.
However, the negative side of the balance sheet shows: a) insufficient international commitment to, and planning for, actions beyond the current scope of the main stakeholders in TB control; b) a funding gap for TB control, largely representing the funding necessary to strengthen the general health service infrastructure and to provide high-quality technical support to countries; c) inadequate achievement of progress towards the 2005 targets globally for case detection and in particular regions for treatment success (72% in Africa and 77% in Europe); and d) an increase in the estimated TB incidence rate from 1997-2000 (%/year) in the African (4.3%) and European (2.8%) Regions, with no change in the Western Pacific Region.

There is thus a need for a clear strategic direction by the Stop TB Partnership and WHO to enable full and accelerated implementation of global TB control as part of the GPSTB. The purpose of convening the 2nd ad hoc Committee is to identify the strategic direction over the next 5 years for the Stop TB Partnership and, through its working groups, to implement global TB control as part of the GPSTB, achieve the WHA 2005 targets and make progress towards achieving the MDGs 2015 targets. WHO has a special role both as the lead UN agency for health and as the coordinating secretariat of the three implementation working groups. This report sets out the 2nd ad hoc Committee’s recommendations to the wide range of stakeholders concerned with implementing global TB control.

2. The 1st (London) ad hoc Committee’s recommendations: assessment of global progress since 1998.

This section reviews the global progress in meeting the recommendations as set out in the 1st ad hoc Committee’s report in 1998, with an assessment of the achievements and still unresolved problems and constraints, in order to focus attention on the urgent needs for implementing global TB control.

2.1 Political will and commitment

In general, building political commitment and will among the politicians and other key decision-makers at each particular level (globally, nationally and within countries) requires both direct persuasion and popular pressure. In response to direct persuasion by UN agencies and others, senior political leaders have expressed their political commitment to TB control at a number of international conferences. Convened in response to the London ad hoc Committee recommendation, the international Ministerial Conference in Amsterdam in 2000 called for renewed political commitment to global TB control, through the “Amsterdam declaration to Stop TB”. Ministerial representatives from 20 HBCs representing 80% of the global TB burden made a commitment to ensuring “that sufficient human and financial resources are available on a sustainable basis and expanded to meet the challenges of stopping TB”.

African Heads of State at the summit in Abuja in 2000 affirmed their political will and commitment to contribute increased resources to control HIV/AIDS, TB, malaria and other diseases. In practice, few countries have demonstrated progress in increasing
resources to control TB in keeping with the stated commitment. In persuading political leaders to voice their commitment to control of TB and other public health priorities, there is a risk that political leaders may voice their commitment, in order to show willingness, without backing up their words with actions. At the national level, popular pressure to build political commitment and will to control TB depends on advocacy and lobbying activities of TB interest groups. In comparison with the countries where HIV/AIDS is a priority problem, few high TB burden countries have well organised TB interest or activist groups, even where HIV-related TB is a priority problem. How to mobilise efforts from outside to promote the formation and activities of TB interest or activist groups, while avoiding the danger of undermining local ownership and direction of these groups, remains an unsolved challenge.

2.2 Financing

2.2.1 Estimates

Within the GDEP it was estimated that at least 1.2 billion US$ are needed yearly to achieve the 2005 targets. Sixty-nine percent of the need was estimated to be covered (including pledges) by the governments of the endemic countries, while the financial gap was around 300 million US$ annually. The Global Plan to Stop TB confirmed, using slightly different methods, that a total 6 billion US$ would be needed during the next 5 years to achieve the targets.

2.2.2 Funding flows and gaps for HBCs

A total of US$ 245 million in new funding for DOTS expansion in HBCs was committed during 2002, to cover the five-year planning period 2001-2005. This reduces the total funding gap identified by NTPs for 2001-2005 to only US$ 200 million. For 2003 the funding gap identified by NTPs is US$52 million. However, the funding gaps identified by NTPs may be underestimates of the real gap for two main reasons: a) failure to consider investment in general health staff and infrastructure; b) under-budgeting for innovative approaches to case finding and case holding. At the end of 2002 WHO estimated a possible funding gap (not yet identified by NTPs) of about 170 US$ million per year, excluding innovative approaches (for which more work is necessary to define the funding needs and gaps).

2.2.3 Global Fund against AIDS, TB and Malaria (GFATM)

Since its inception in 2001, the GFATM has made significant funding contributions to TB control. The full extent to which the GFATM will meet the necessary additional resources identified in the GPSTB depends on its capacity to mobilise additional resources.

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In 2002, the GFATM announced in the first round of grants the approval of 16 applications for funding for TB control, for a total of US$ 176 million over 2 years, including applications from the following HBCs: China, Ethiopia, India, Indonesia, South Africa (for HIV/AIDS and TB), Thailand and Vietnam. In 2003, the GFATM announced in the second round of grants the approval of 27 applications for funding for TB control, for a total of US$ 122 million over 2 years, including applications from the following HBCs: Afghanistan (for TB, HIV/AIDS, and malaria), Cambodia, DR Congo, India, Kenya, Myanmar, Mozambique, Nigeria, Pakistan, the Phillipines, and Uganda. Except in the case of the Philippines (where more funding is required) acceptance of the above proposals will close or significantly reduce the estimated funding gap for TB control in 2003 in these HBCs. GFATM grants to some countries for joint TB and HIV programme activities should help to overcome the common problem of separate funding of TB and of HIV programmes as a barrier to their collaboration.

2.3 Human resources

Human resources for health (HRH) refers to both the numbers of staff and the quality of their performance. Increasing the numbers, capacity and competence of health workers must be seen in the perspective of the larger health system, rather than of specific TB control. The 1st ad hoc Committee identified neglect of HRH as one of the main constraints to global DOTS expansion. Many of the issues raised still remain to be adequately addressed. In 2003, lack of adequate human resources ranked first among the five key constraints to reaching the global targets for TB control in the 22 HBCs.

International training courses are an essential component of technical assistance to countries, together with the development of generic training materials and tools for the effective management of human resources at country level. Implementation of training programmes for TB control activities requires considerable further attention to: a) the quality of training; b) the need for better management of training programmes; c) the need for ongoing follow-up of training and re-training; d) factors influencing behavioural change of health workers; and e) the community and environmental factors facilitating or obstructing change.

Although there is growing recognition of the importance of training and human resource development as an integral part of NTP activities, there has been little progress in finding ways to counter the loss of health care staff involved in organising and delivering TB care in many developing countries. The main staff losses are due to migration, recruitment for other jobs, and in sub-Saharan Africa, illness and death due to HIV/AIDS. In conclusion, developing HRH in developing countries is a top priority for health systems in general and TB control in particular.

2.4 Health system organization and management capacity

Common themes in health system organization (health reforms) include integration, decentralisation and increasing privatization (including cost-recovery strategies). There has been progress in understanding the implications of health reforms for TB control, and
ways in which NTP managers can best position their programmes to overcome challenges and maximise opportunities. Ministries of Health need to ensure that the framework for TB control is moulded into a DOTS implementation plan which reflects the priorities and strategies of the overall health system, and builds on the strengths of the Primary Health Care (PHC) network for delivery of TB control. Health reforms vary considerably from country to country depending on variables such as the political aim of the government, the influence of donors and other partners, and the current stage of the process. Thus it is not surprising that NTPs in different countries have met with varying degrees of success in ensuring that the operational realities of changing health systems incorporate all the components of the DOTS strategy.

Although many NTP personnel and others involved in TB control at different levels exercise considerable managerial responsibilities, few have acquired managerial expertise through “hands-on” experience. There is substantial scope for improving the more formal development of managerial capability among these personnel and thereby helping to ensure high-quality managerial performance.

2.5 Anti-TB drugs

The 1st ad hoc Committee stressed the importance of ensuring access to high quality anti-TB drugs for DOTS implementation. At the Amsterdam Conference on TB and Sustainable Development in March 2000, the HBCs called for a new initiative to increase access to high quality anti-TB drugs. In response, the Global Partnership to Stop TB launched the Global TB Drug Facility (GDF) in 2001. The GDF is hosted by WHO, and managed by the secretariat of the Global Partnership to Stop TB. It aims to provide anti-TB drugs to treat up to 11.6 million patients, in assisting countries reach the WHA global TB control targets by 2005.

The primary mechanism of support from the GDF is in the form of 'grants in kind' of first-line TB drugs. The quantity provided is calculated on the basis of the number of additional patients to be treated in accordance with a national DOTS expansion plan to reach the global targets by 2005. In addition to grants in kind, the GDF direct procurement mechanism supports countries which have adequate funds for drugs, but lack efficient mechanisms for procurement and quality assurance. Such a system can also be used by donors which provide funds or grants in kind to countries for TB control, and to Non Governmental Organizations (NGOs) that lack their own procurement mechanisms.

The GDF has already made significant progress in fulfilling its mission. In the first year of operation, the main activities were to: a) set up systems and processes for applications, review, procurement and monitoring; and b) process the drug orders of the initial countries approved for support. In the second year of operations these systems and processes were finalised and the GDF moved from an interim operation to a full procurement mechanism. The main activities continued in 2002 and additional activities

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were to: a) set up systems for countries to buy drugs through a direct procurement mechanism; b) set up systems to ensure that countries and agencies (including GDF) can identify quality assured TB products; c) monitor countries that had received drugs.

By March 2003, the GDF had received applications from 60 countries of which 39 have been approved for support. It has placed 33 orders for TB drugs. The number of countries which have received deliveries of TB drugs has now risen to 19 whilst the total number of patients approved for treatment stands at 1.85 million. Two countries have purchased low cost TB drugs through the Direct Procurement mechanism. Other countries are currently negotiating to purchase drugs through the GDF Direct Procurement mechanism. The GDF has established a robust and standardised mechanism for pre-qualification of manufacturers of TB drugs with the assistance of the WHO Department for Essential Drugs and Medicines (WHO/EDM). A stockpile of GDF products has been established, to improve the ability of the GDF to respond rapidly to countries needing drugs.

2.6 Information

The report of the 1st ad hoc committee emphasized the importance of country adoption of the WHO/IUATLD information system, and WHO global monitoring of the TB situation using, in particular, two indicators, case detection and treatment success. The report also made reference to introducing appropriate legislation, and WHO support to countries in developing the monitoring systems.

There has been considerable progress in adoption of the WHO/IUATLD monitoring system, as more and more countries have come under the DOTS classification. There has also been considerable progress in global monitoring, with the creation and further refinement of country-specific estimates of TB incidence, and the on-going collection and analysis of data from all countries resulting in, among other things, an annual report on epidemiology, planning, and financing. Routine monitoring has enabled measurement of progress toward the global indicators.

On the other hand, coordination and comprehensiveness of national monitoring systems is still often lacking, with some sectors (e.g., government institutions, private practice) being incorporated slowly. Also, country missions and regional discussions suggest that the WHO/IUATLD monitoring system has been implemented with varying levels of understanding, that the classical system of quarterly reporting in aggregate is insufficient for some countries' needs, and that management and transfer of TB data in developing countries (with increasingly wide access to computers) is not always very efficient. Finally, despite progress at the global level in using available data to make the best estimates possible, a number of HBCs have no recent prevalence surveys (of infection or disease), and thus rely on routine monitoring data only in interpreting their progress.

2.7 Research

The 1st ad hoc Committee stressed the importance of research to contribute to implementing TB control. Achieving the goals of the GPSTB requires not only scaling up
of implementation of the current interventions of proven effectiveness, but also research to determine how to implement these interventions and monitor their impact, and to develop improved and new interventions, including specific tuberculosis control tools (e.g. a more effective vaccine,\textsuperscript{19} better diagnostic tests\textsuperscript{20} and preventive\textsuperscript{21} and therapeutic\textsuperscript{22} approaches). The DEWG advocates for research for global TB control as set out in the GPSTB. Milestones in supporting and promoting TB research since the report of the 1\textsuperscript{st} ad hoc Committee include the establishment of the TB research working groups under the auspices of the Global Partnership to Stop TB (i.e. the Global Alliance for new TB drugs, the TB Diagnostics Initiative and the TB Vaccines Initiative) and the increased funding flows for TB research, e.g. from the Bill and Melinda Gates Foundation.


3.1 Implementation working groups of the Stop TB Partnership

National plans to expand implementation of the DOTS strategy and achieve the 2005 WHA targets require NTPs to address three key issues: i) improving coverage and quality of DOTS expansion (including community involvement, engagement of private-for-profit practitioners, training of international and national experts, strengthening laboratory networks); ii) countering the impact of HIV on TB; and iii) controlling the spread of drug-resistant TB. The Stop TB Partnership helps countries to address these three key issues through the following three respective implementation Working Groups: DOTS Expansion Working Group, TB/HIV Working Group, and DOTS-Plus Working Group. Activities of the three implementation working groups under the Stop TB Partnership feed into DOTS expansion.

3.2 DOTS Expansion

The DOTS Expansion Working Group (DEWG) was established in 2000 and consists of the NTP managers of the 22 HBCs and the main technical and financial agencies concerned with TB control. The DEWG has developed the Global DOTS Expansion Plan (GDEP), comprising two pillars: 1) national 5 year DOTS expansion plans; 2) national inter-agency coordinating committees (NICCs). The DEWG set up two sub-groups in 2002, one on strengthening laboratories and one on public-private mix. Members of the DEWG are promoting the identification and training of international and national experts, e.g. through links with the Task Force Training, established under the auspices of the TB Coalition for Technical Assistance (TBCTA).

\textsuperscript{19} Young DB. Current tuberculosis vaccine development. \textit{Clin Infect Dis} 2000; June 3 Suppl 3: S254-6
3.2.1 International coordination

At international level, the DEWG has enhanced coordination of DOTS expansion, through the identification of partners working in the HBCs and the organization of annual meetings. The annual DEWG meeting is the key forum for reviewing progress in TB control in the HBCs and identifying constraints and solutions.

3.2.2 National 5 year DOTS expansion plans

By the end of 2002, 20 HBCs have developed medium-term DOTS expansion plans, with many countries having started implementation. Each country’s DOTS expansion plan should involve, in addition to all government health care providers as the initial priority, the full range of non-governmental health care providers, especially community groups, NGOs and private-for-profit practitioners.

3.2.3 NICCs

At the national level, the DEWG assists countries in establishing NICCs with the aim of promoting the coordination of an often large number of stakeholders. Upto 2002, 18 HBCs have established functional NICCs.

3.3 TB/HIV

The establishment of the Global TB/HIV working group in 2001 under the auspices of the Stop TB Partnership provided a mechanism for coordinating the global response to HIV-related TB as part of overall global DOTS expansion activities. The main achievements of the working group so far have been the endorsement of a global strategic framework to decrease the burden of TB/HIV23 and of the guidelines for implementation of collaborative TB and HIV programme activities.24 There has been limited success so far in forging a strong sense of common purpose among the partners and in advocating for a bigger and more effective response to TB/HIV. The extent to which the working group can add value in promoting collaboration between HIV/AIDS and TB programmes at national level (policies, technical assistance to countries, operational research) is not yet clear.

The attention on the global need to improve case detection runs the risk of diverting attention from the need to improve TB treatment outcomes in sub-Saharan Africa, where in many NTPs the rates of adverse outcomes (default, transfer out, and unknown outcome) are unsatisfactory. In addition, the high case fatality in NTPs in those countries in sub-Saharan Africa with the highest HIV seroprevalence remains an unsolved problem.

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3.4 DOTS-Plus

WHO and the IUATLD have conducted anti-TB drug resistance surveys since 1994 through a network of sub-regional laboratories and investigators. These surveys have unveiled foci of high MDR-TB prevalence in various settings worldwide. In response to the seriousness of MDR-TB as a public health problem in several countries, the DOTS-Plus Working Group was established in 1999 to promote improved management of MDR-TB in resource-limited countries. DOTS-Plus aims to assess the feasibility and cost-effectiveness of the use of second-line anti-TB drugs within the DOTS strategy. DOTS-Plus is built upon the five principles of DOTS. In 2000 the Working Group successfully negotiated with the pharmaceutical industry concessional prices of second-line drugs that otherwise were unaffordable in poor settings. As a result, the prices of the most expensive regimens have dropped by 95%.

Through the Working Group Green Light Committee, by 2003 pilot projects were underway in Costa Rica, Estonia, Latvia, Malawi, Mexico, Peru, the Philippines, and the Russian Federation. Data gathered in these settings are contributing to the forging of policy guidelines on the management of MDR-TB in resource-limited countries, e.g., *Management of Chronic and Multidrug-Resistant Cases. In: Treatment of Tuberculosis: Guidelines for National Programmes (3rd Edition) 2003. WHO: Geneva.* The provision of a sound response to MDR-TB is contributing to accelerate the achievement of the global targets by identifying and curing MDR-TB cases, which in some countries constitute a substantial part of the overall pool of tuberculosis cases. Currently the Working Group is fostering the insertion of MDR-TB management plans within DOTS expansion/strengthening plans in those settings where TB programmes have the capacity to respond to a documented and urgent need to address MDR-TB.

4. DOTS expansion and achievement of WHA 2005 targets by the 22 high-burden countries (HBC) countries: assessment of specific constraints and possible solutions.

The NTP managers of the HBCs identified and presented at the DEWG meeting in Montreal in 2002 the main constraints and proposed solutions to overcome those constraints. The table shows for each HBC the key indicators of TB control (i.e. DOTS coverage and success rate under DOTS), national HIV prevalence, and main constraints and possible solutions.
## Main identified constraints in the 22 High-Burden Countries (HBC)

<table>
<thead>
<tr>
<th>22 High TB Burden Countries</th>
<th>Cumulative incidence 2001 (%)</th>
<th>Dots Coverage 2001 (%)</th>
<th>Case det. rate under DOTS 2001 (%)</th>
<th>Success rate under DOTS 2000 (%)</th>
<th>HIV/AIDS prevalence 15-49 y (%)</th>
<th>Main identified constraints*</th>
<th>Main possible actions*</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>21.5</td>
<td>45</td>
<td>n.a.</td>
<td>84</td>
<td>0.8</td>
<td>1) Insufficient financial support at State level, uncertainty of future ext. funding 2) Private sector handling large TB case loads but not following DOTS strategy</td>
<td>1) Advocate at State level for higher commitment on TB control 2) Involve NGOs, private practitioners and large hospitals in DOTS strategy</td>
</tr>
<tr>
<td>China</td>
<td>38.7</td>
<td>68</td>
<td>20</td>
<td>95</td>
<td>0.1</td>
<td>1) Insufficient cooperation between TB institutions and general hospitals 2) Insufficient political and financial support at local level in some Provinces for expanding or maintaining DOTS 3) Lack of TB staff and TB programme managers</td>
<td>1) Pilot different scenarios for the involvement of general hospitals in DOTS implementation 2) Establish multisectoral leading groups and hold NICC meetings to improve political and financial support at Provincial level 3) Advocate national and local Government to post additional staff on TB control, train staff</td>
</tr>
<tr>
<td>Indonesia</td>
<td>45.6</td>
<td>98</td>
<td>21</td>
<td>87</td>
<td>0.1</td>
<td>1) Decentralization with insufficient commitment at local level and limited staff capacity at central and provincial level 2) Poor drug management and quality control 3) Weak reporting and supervision 4) Limited involvement of public hospitals and private sector</td>
<td>1) Strengthen central and provincial TB teams; train staff on management and supervision 2) Establish drug quality control system and train staff on drug distribution 3) Strengthen quarterly reporting and supervision 4) Engage public hospitals and private sector in DOTS strategy</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Country</th>
<th>PDD (%)</th>
<th>PDD (%)</th>
<th>PDD (%)</th>
<th>PDD (%)</th>
<th>DOT (%)</th>
</tr>
</thead>
</table>
| Bangladesh     | 49.5    | 95      | 28      | 83      | <0.1    | 1) Interruption of main DOTS activities while in the process of health sector reform  
2) Lack of skilled staff, poor infrastructure |
| Nigeria        | 52.9    | 55      | 20      | 79      | 5.8     | 1) Insufficient budget for TB control; poor condition of health care infrastructure at PHC level  
2) Lack of supervision; low staff motivation  
3) Limited involvement of hospitals  
4) High level of TB/HIV with limited collaboration between programmes |
| South Africa   | 56.1    | 77      | 85      | 66      | 20.1    | 1) No national policy for diagnosis and treatment  
2) Inadequate recording and lack of monitoring  
3) High level of TB/HIV with limited collaboration between programmes |
| Pakistan       | 59.1    | 24      | 10      | 74      | 0.1     | 1) Lack of human resources at local level  
2) Large involvement of private sector with no guidance |
| Philippines    | 61.9    | 95      | 57      | 88      | <0.1    | 1) Underdeveloped partnership with private sector to deliver DOTS  
2) Lack of monitoring and supervision |
| Russian Fed.   | 64.3    | 15      | 31      | 68      | 0.9     | 1) Lack of coordination and resistance to DOTS policy implementation  
2) Lack of financial and human resources  
3) High level of MDR-TB in certain areas |
| Ethiopia       | 66.6    | 70      | 42      | 80      | 6.4     | 1) Lack of HR (quantity and quality); high staff turn over  
2) Weak access to PHC and TB services  
3) High level of TB/HIV with limited collaboration between programmes |
| Kenya          | 68.8    | 100     | 47      | 80      | 15.0    | 1) Lack of trained staff at local level  
2) High level of TB/HIV with limited collaboration between programmes |
|                |         |         |         |         |         | 1) Advocate at national and regional level  
2) Train staff, involve NGOs and PP |
|                |         |         |         |         |         | 1) Obtain commitment of Federal and State level for increased financial support and mobilization of external support  
2) Strengthen supervision  
3) Engage hospitals in DOTS strategy  
4) Develop TB/HIV collaborative strategy |
|                |         |         |         |         |         | 1) Advocate at Federal level  
2) Resource allocation, donor meeting, train staff  
3) DOTS plus and guidelines |
|                |         |         |         |         |         | 1) Increase number of health staff and limit turn over; train staff  
2) Involve community in pilot areas  
3) Implement TB/HIV collaborative strategy |
|                |         |         |         |         |         | 1) Improve recruitment and retention of staff, training  
2) Develop TB/HIV collaborative strategy |
<table>
<thead>
<tr>
<th>Country</th>
<th>TB Score</th>
<th>HIV Score</th>
<th>TB Incidence</th>
<th>TB Fatality</th>
<th>Trend</th>
<th>Problems</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>DR Congo</td>
<td>70.8</td>
<td>70</td>
<td>61</td>
<td>78</td>
<td>4.9</td>
<td>1) Lack of TB units in large cities</td>
<td>1) Request resources to establish additional centres in large cities</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>2) Poor access to TB services</td>
<td>2) Community involvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3) Lack of TB staff at provincial level</td>
<td>3) Advocate for and train new TB staff</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>72.5</td>
<td>99.8</td>
<td>84</td>
<td>92</td>
<td>0.3</td>
<td>1) Limited health services in remote areas</td>
<td>1) Outpatient TB services in PHC units</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>2) Large TB activity in private sector with little guidance and no reporting</td>
<td>2) Regulate and involve private sector</td>
</tr>
<tr>
<td>UR Tanzania</td>
<td>74</td>
<td>100</td>
<td>47</td>
<td>78</td>
<td>7.8</td>
<td>1) Insufficient number of diagnostic services</td>
<td>1) Increase number of diagnostic centres</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>2) Lack of trained health and lab staff</td>
<td>2) Increase number of staff, train staff</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3) High level of TB/HIV with limited collaboration between programmes</td>
<td>3) Develop TB/HIV collaborative strategy</td>
</tr>
<tr>
<td>Brazil</td>
<td>75.3</td>
<td>32</td>
<td>78</td>
<td>84</td>
<td>0.7</td>
<td>1) Lack of political commitment at state level</td>
<td>1) Advocate with new government to obtain full commitment and implement DOTS at all levels</td>
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<td></td>
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<td></td>
<td></td>
<td>2) Poor reporting and monitoring</td>
<td>2) Train staff on reporting and monitoring</td>
</tr>
<tr>
<td>Thailand</td>
<td>76.3</td>
<td></td>
<td></td>
<td></td>
<td>1.8</td>
<td>1) TB division has no control over budget</td>
<td>1) Advocate for TB at provincial level</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2) Potential breakdown of monitoring and reporting system</td>
<td>2) Provinces to develop TB targets; central office to ensure accuracy of reporting</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>77.3</td>
<td>100</td>
<td>47</td>
<td>69</td>
<td>33.7</td>
<td>1) Lack of TB health staff and TB managers</td>
<td>1) Advocate to increase number of staff, train staff</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2) Insufficient funding</td>
<td>2) Financial resource mobilisation</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3) High level of TB/HIV with limited collaboration between programmes</td>
<td>3) Develop TB/HIV collaborative strategy</td>
</tr>
<tr>
<td>Cambodia</td>
<td>78.3</td>
<td>100</td>
<td>41</td>
<td>91</td>
<td>2.7</td>
<td>1) Poor access to TB services in rural areas</td>
<td>1) Introduce community care</td>
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<td></td>
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<td>2) Low adherence to DOTS in the private sector and hospitals</td>
<td>2) Develop pilot PPM projects</td>
</tr>
<tr>
<td>Country</td>
<td>1) Detection (new sputum smear positive cases, %)</td>
<td>2) Adult HIV/AIDS rate (15-49), end of 2001</td>
<td></td>
<td></td>
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</tbody>
</table>
| Uganda       | 79.3                                             | 1) Poor access to TB services
2) Insufficient laboratory capacity, no QA system
3) Staff limited due to quotas set by government
4) High level of TB/HIV with limited collaboration between programmes |
|              | 100 52 63 5.0 | 1) Increase community based care for TB control
2) Train lab staff, equip lab, identify lab focal points
3) Second staff from other institutions and partners
4) Develop TB/HIV collaborative strategy |
| Myanmar      | 80.2                                             | 1) Insufficient financial resources
2) Lack of HR (quality and quantity)
3) Weak infrastructure for implementation |
|              | 78 60 82  n.a. | 1) Resource mobilisation
2) Advocate to increase number of health staff, train staff
3) Build infrastructure with donors and partners |
| Afghanistan  | 81                                               | 1) Poor health infrastructure
2) Lack of HR, weak NTP capacity
3) High stigma and low community involvement |
|              | n.a.                                             | 1) Reconstruction of health system
2) Train new staff, strengthen NTP
3) IEC strategy, develop community-based care |
| Mozambique   | 81.6                                             | 1) No published DOTS expansion plan
2) Lack of trained staff
3) Weak laboratory capacity
4) High level of TB/HIV with limited collaboration between programmes |
|              | 100 68 75 13.0 | 1) Develop a DOTS expansion plan
2) Increase number of staff with additional funding and based on plan
3) Establish adequate laboratory services
4) Develop TB/HIV collaborative strategy |

*Not reviewed by countries
1) Detection (new sputum smear positive cases, %)
2) Adult HIV/AIDS rate (15-49), end of 2001
5 Key issues for DOTS expansion and achievement of the 2005 WHA targets: assessment of approaches beyond the current scope of the Stop TB Partnership.

5.1 Health sector issues beyond the current scope of the Stop TB Partnership.

The Stop TB Partnership mainly promotes DOTS expansion and achievement of the 2005 WHA targets through the activities of the three implementation Working Groups (DOTS Expansion, TB/HIV, and DOTS-Plus). However, for successful DOTS expansion and achievement of the 2005 WHA targets, and beyond these targets achievement of the 2015 MDGs, countries need to face broad health sector issues. These issues are generally beyond the current scope of the Stop TB Partnership: inadequate health infrastructure, human resources for health, PHC services, social mobilization for health, private sector and corporate sectors' contributions, poverty alleviation strategies and equity initiatives.

5.2 Health infrastructure

The existing health infrastructure in many countries is at present simply inadequate to enable health providers to deliver the essential package of care, including the DOTS strategy, with full population coverage. Current approaches to estimating financial needs for TB control have focused on the financial needs of NTPs. However, scaling up implementation of the DOTS strategy to achieve full population coverage requires additional investments in the general health infrastructure (which do not appear in current NTP-specific budgets). Thus closing the funding gap for NTP needs will not suffice to reach the global targets in countries with inadequate general health infrastructure.

The Commission on Macroeconomics and Health has estimated globally the funding needs for the general health infrastructure and the funding needs for general health infrastructure improvements necessary to provide the essential package of care with full population access.27 The estimated total annual financial need to deliver the essential package of care globally is $57 billion ($26 billion for disease-specific activities and $31 billion for general health infrastructure improvements). Achieving global targets for health, including TB targets, requires investment in the general health infrastructure as well as in the disease-specific activities which constitute the essential package of health care. Those concerned with TB control must join forces with those concerned with delivering the other elements of the essential package of care to demand the necessary investments in general health infrastructure improvements.

5.3 Human resources for health

5.4 Primary care services

5.5 Social mobilization for health

5.6 Private sector and corporate sectors' contributions

N.B. The outcomes of a series of consultations in 2003 will inform sections 5.3 – 5.6 of the *ad hoc* committee’s report.

5.7 Poverty alleviation strategies and equity initiatives.

The drive to achieve the overall MDGs and in particular the TB targets represents an aspiration to serve the poor. Because TB is a disease of poverty, the DOTS strategy is generally thought of as “pro-poor”. However, there is increasing evidence that there are significant socioeconomic differences in apparently homogeneously poor populations. Therefore it is necessary to know whether implementation of the DOTS strategy serves the poor. The use of programme-incidence (or coverage-inequality analysis), a technique to examine socioeconomic disparities in health conditions and service delivery, can determine the distribution of NTP coverage and outputs across socioeconomic groups within the populations the NTPs serve. Global DOTS expansion must include equity initiatives in order to ensure that among the poor, the less well-off benefit as much as the better-off from efforts to extend access to the DOTS strategy and deliver successful NTP outcomes.

6. Recommendations for achieving the WHA 2005 targets, and beyond these targets for reaching the MDGs in 2015

N.B. The *ad hoc* Committee will develop these recommendations in the light of the consultations planned in 2003 on the key broad health system issues relevant to implementing global TB control. Identifying milestones for these recommendations will enable future evaluation of progress in their implementation.

6.1 Recommendations based on analysis of constraints and proposed solutions

The *ad hoc* Committee has analysed the constraints to achieving the WHA 2005 targets, and beyond these targets for reaching the MDGs in 2015, and proposed possible solutions. The Committee makes the following recommendations for immediate action on the part of stakeholders:

6.2 Stop TB Partnership

The Stop TB Partnership Coordinating Board to revise its membership to include high-level political representatives, both from high TB burden and from OECD countries.

The Stop TB Partnership Coordinating Board to seek alliances with key agencies and bodies in sectors other than the health sector, in order to widen the range of partners and include those with potential to influence policies in key institutions affecting global economics, e.g. World Bank, International Monetary Fund, World Trade Organization (WTO). Those governments that have blocked agreement at the WTO to lift restrictions

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on exports of cheap generic drugs should come under pressure from the Stop TB Partnership Coordinating Board to sign up to the agreement.

The Stop TB Partnership Coordinating Board to explore ways of promoting and accelerating the implementation of the GPSTB by harnessing the contribution to TB control activities of the whole range of health care providers, including all Ministry of Health facilities, NGOs, employers, private practitioners, religious organizations and community groups.

The Stop TB Partnership Coordinating Board to explore ways of increasing the number of trained health staff in key posts for TB control, especially in those countries losing staff to economic migration and deaths from HIV/AIDS.

6.3 Task Force 5 of the Millennium Development Goals Project

As part of Task Force 5 of the MDGs Project, the working group “Combating tuberculosis” to incorporate the recommendations of the ad hoc Committee as an integral part of the work of the MDGs Project.

6.4 Partners in development assistance

OECD countries to increase the proportion of their development assistance funding on health in proportion to an increase in their overall contribution as a percentage of GDP towards the 0.7% internationally agreed target.

The Global Fund for AIDS, TB and Malaria to contribute significant funds (e.g. a fixed minimum proportion of grants) to support strengthening of general (especially primary) health services, as part of funding provision for proposals to improve TB control.

Bilateral overseas development assistance agencies to increase the amount of funding available for TB control, in order to strengthen current approaches to improving case detection rates and treatment success rates, and support innovative approaches. This should include specific funding through a special fund to support the activities of TB technical assistance agencies and the coordination of technical assistance by the secretariat of the DEWG.

Bilateral overseas development assistance agencies to increase the amount of funding available for training increased numbers of health care staff, including a dramatic expansion in training of the paramedical staff who in many countries provide the largest part of provision of TB control activities, e.g. laboratory technicians, nurses and clinical officers.

6.5 Global financial institutions

The World Bank and the International Monetary Fund to revise regulations capping social sector spending in the least developed countries. This should help ensure the
additionality of funding provided through the Global Fund and to increase the likelihood of countries being able to increase salary payments for health staff and other government employees, and thus promote their retention.

6.6 World Trade Organization

The World Trade Organization to agree on trade regulations which enable access to affordable drugs to treat priority public health diseases in the least developed countries.

6.7 WHO

WHO should reflect its stated commitment to control of TB as one of the priority public health problems of poverty in a significantly increased core budgetary contribution to the Stop TB Department.

WHO should reflect its commitment to supporting the Global Stop TB Partnership by establishing several regular budget posts to the Stop TB Partnership secretariat.

WHO should reflect its commitment to TB control by expanding its network of international and national staff in the HBCs and other selected countries.

WHO should invest greater efforts in improving the accuracy of estimates of progress towards achieving targets, including strengthening this capacity in the Regional Offices.

6.8 Technical agencies

Technical agencies should adopt quality control schemes in order to ensure that they deliver high-quality technical assistance.

Technical agencies should expand the scope and intensity of their technical assistance by training and mobilising a dramatically expanded number of national counterparts, especially in priority countries.

Technical agencies should mobilise significantly increased levels of technical support to those countries which are making particularly slow progress towards achieving the targets.

6.9 High TB incidence countries

Ministries of Finance to devote a greater proportion of funding to the Ministry of Health for expenditure on costed plans for achieving targets for priority public health programmes, including TB. These extra resources should include funding of incentive schemes in order to retain key national staff.
Ministries of Finance to work with Ministries of Health to ensure that the benefits of the Poverty Reduction Strategy Process extend to increased resource flows for the control of TB as a priority disease of poverty.

Ministries of Health to provide increased human and financial resources to strengthen National TB Programmes so that they can play their full role in stewardship of TB control activities:

in coordinating the activities of the full range of health providers within the health care system, and thereby ensuring improved case detection, and recording and reporting of treatment outcomes for all TB patients irrespective of whichever health provider is responsible for their care;

in ensuring quality control of NTP operations in order to maximise case-finding and the achievement of favourable treatment outcomes;

in ensuring that the distribution of NTP coverage and outputs is equitable across all socioeconomic groups.

Ministries of Health to rationalise planning and budgeting for priority public health problems where there is significant overlap, e.g. by preparing joint costed plans and budgets for the overlapping epidemics of TB and HIV.

6.10 Research

The ad hoc Committee will consult with the research working groups under the auspices of the Global Partnership to Stop TB in formulating recommendations on research relevant to implementing global TB control.
Annex 1  Members of the 2nd ad hoc committee on the TB epidemic

E Back, United Kingdom Department for International Development
N Billo, International Union Against Tuberculosis and Lung Disease, Paris, France
A Bloom, United States Agency for International Development
J Broekmans, Royal Netherlands Tuberculosis Association
M Dayrit, Secretary for Health, Phillipines
G Elzinga, National Institute of Public Health and Environmental Protection, Netherlands (Chair, TB/HIV Working Group)
S England, Stop TB Partnership Secretariat, Switzerland
J Kim, Partners in Health, Boston, USA (Chair, DOTS-plus Working Group and Millennium Development Goals Project Task Force V)
A Kutwa, National Tuberculosis and Leprosy Programme, Kenya
D Maher, Stop TB Department, World Health Organization, Switzerland
P Naryanan, Tuberculosis Research Centre, Chennai, India
F Omaswa, Ministry of Health, Uganda
M Raviglione, Stop TB Department, World Health Organization (Chair, DOTS Expansion Working Group), Switzerland
K Shah, National Tuberculosis Programme, Pakistan
E Ticona, National Tuberculosis Programme, Peru
D Weil, World Bank, Washington DC, USA
Annex 2   The 2nd *ad hoc* committee’s report: consultative process and timetable

(1) In March/April 2003, the DEWG secretariat in the WHO Stop TB Department will prepare an outline and then a first draft with input from all the *ad hoc* committee members.

(2) The DEWG secretariat will present the initial outline to the members of the TB subgroup of Task Force V of the MDGs Project and to the Stop TB Partnership Coordinating Board at their respective meetings in Brasilia in early April 2003, before circulating a draft report to the Core Group of the DEWG and other selected individuals.

(3) In Spring and Summer 2003, the secretariat will convene a series of four consultations involving selected groups of public health experts for input in areas beyond the current more specific TB scope of the Stop TB Partnership (including primary care, human resources, social mobilisation, expanding the Partnership and health system reform).

(4) In June 2003 WHO’s Strategic and Technical Advisory Group on TB (STAG TB) will review the next draft.

(5) In September 2003, the *ad hoc* committee will meet to finalise its report, taking into consideration the outcomes of the series of four preceding consultations.

(6) In October 2003, the secretariat will circulate the final draft to all high-burden countries and present the report at the 4th DEWG meeting in the Hague, for final endorsement by countries and all partners.

(7) In late October 2003, the secretariat will distribute and publicise the report at the Stop TB Partners’ Forum for broad political endorsement. The report will be one of the products of MDG Task Force V.

(8) In 2004, the report may form the basis for revisiting the Global Plan to Stop TB as part of the MDG Task Force V initiative.