

Pre-publication working version

**STRATEGIC PLAN FOR TUBERCULOSIS
CONTROL FOR THE AFRICAN REGION:
2006 - 2010**

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA
HARARE, ZIMBABWE

TABLE OF CONTENTS

1.	INTRODUCTION	3
2.	SITUATION ANALYSIS	3
2.1.	Magnitude of the TB epidemic	3
2.2.	Response analysis	3
2.2.1.	Global level:	3
2.2.2.	Regional level:	3
3.	ISSUES & CHALLENGES	3
3.1.	The HIV/AIDS Epidemic	3
3.2.	Human Resource	3
3.3.	Weak Health System Infrastructure	3
3.4.	Funding	3
3.5.	Laboratory network	3
3.6.	Political Commitment	3
3.7.	MDR-TB	3
3.8.	DOTS coverage and quality	3
3.9.	Public and Community Awareness and Involvement	3
3.10.	TB and poverty	3
3.11.	Declaration of TB as an Emergency in Africa	3
4.	PRIORITY AREAS	3
5.	OPPORTUNITIES	3
6.	GUIDING GLOBAL AND REGIONAL ORIENTATIONS	3
6.1.	Global Orientations	3
6.1.1.	The WHA TB Control Targets	3
6.1.2.	The Millennium Development Goals	3
6.1.3.	From the First Global Plan To Stop TB through the Second to The Stop TB Strategy	3
6.2.	Regional Orientations	3
6.2.1.	Regional Committee for Africa Resolution on TB Control (1994).	3
6.2.2.	Abuja Heads of State Summit on AIDS, Malaria, Tuberculosis and other diseases (April, 2001).	3
6.2.3.	NEPAD Health Strategy (2004)	3
6.2.4.	The WHO Regional Committee for Africa Declaration of TB as an Emergency	3
6.2.5.	AU Gaborone Declaration	3
6.2.6.	The Regional Director's Orientations	3
6.2.7.	Strategic Orientations for WHO Action in the African Region 2005-2009.	3
7.	GOAL AND OBJECTIVES	3
7.1.	Vision	3
7.2.	Mission	3
7.3.	Goal	3
7.4.	Objectives	3
7.5.	Targets and Indicators	3
7.6.	Guiding principles	3
7.6.1.	Country specific targeting and ownership	3
7.6.2.	Prioritization.	3
7.6.3.	Phased implementation of evidence-based best practices.	3
7.6.4.	Partnership building	3
7.6.5.	Equitable access to effective interventions	3
8.	STRATEGIES AND INTERVENTIONS	3
8.1.	Accelerate and achieve universal access to enhanced and expanded quality DOTS services through programme development; increase coverage and diversification of providers to all TB patients.	3
8.1.1.	Improve DOTS quality and coverage in public health facilities.	3
8.1.2.	Implement collaborative TB/HIV activities	3
8.1.3.	Enhance engagement of NGOs and private sectors	3
8.1.4.	Strengthened Community involvement in TB and TB/HIV care	3
8.1.5.	Extend DOTS to special areas	3
8.1.6.	Improve quality of TB diagnostic services including quality assured laboratory services.	3
8.1.7.	Practical Approach to Lung (PAL)Health	3
8.1.8.	Ensure Access to high quality Anti-TB drugs	3
8.1.9.	Prevention and management of multi-drug resistant TB	3

8.2.	Strengthen health service to support DOTS expansion and quality	3
8.2.1.	Strengthen Human resource capacity	3
8.2.2.	Strengthened health delivery systems for monitoring and evaluation of programme implementation, outcomes and impact	3
8.2.3.	Implementation of operational research on effectiveness of DOTS expansion and TB/HIV collaborative strategies and the field testing of new diagnostic tools and drugs	3
8.3.	Partnership strengthening for TB control	3
8.3.1.	Mainstreaming TB in national development agenda and initiatives	3
8.3.2.	Establish Stop TB Partnerships in Africa to expand Regional and Country level partnerships for DOTS expansion	3
8.3.3.	Sustainable and increased financial resources for TB control	3
9.	EXPECTED PROGRAMMATIC PERFORMANCE TARGETS BY 2010	3
10.	ACTIVITIES, TIMELINES AND MILESTONES	3
11.	ANNEX 1	Error! Bookmark not defined.

1. INTRODUCTION

Since the early 1990s, WHO/AFRO in collaboration with bilateral and multilateral partners have been supporting member states to develop DOTS based tuberculosis (TB) control programmes as part of overall health care delivery systems. Countries have been 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. These were based on the “TB Control Medium Term Strategic Plan (20001-2005) for the African Region¹”.

Progress has been made since the first strategic plan. In the past 5 or so years, there has been growing international attention and commitment to global health and TB, such as through the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the Stop TB Partnership which have provided further impetus and increased financial capacity to member states to more actively respond to the communicable diseases scourge in the region. On the African continent, DOTS based TB control programmes have been expanded in nearly all countries.. Advocacy for TB control has continued. Regional economic groupings and national governments are strongly affirming African leadership in addressing major health priorities affecting their populations, including TB. Despite these growing regional and international commitments, achievements and significant progress realised so far, TB remains one of the most important communicable diseases in the region. Most of the challenges and shortfalls that were identified in the lapsing Regional Strategic Plan remain relevant beyond 2005. There is a particular imperative arising from the unattained global and regional targets for TB control, including the WHA and Millennium Development Goals (MDGs) that present contemporary social and epidemiological justifications for an intensified fight against tuberculosis in the short, medium and long term. A new strategy is therefore needed that would spur the region on to overcome the new challenges to meet targets.

The key objectives of the previous plan were to promote the incorporation of the DOTS Strategy into plans for health sector development and in the essential health package at district level of member countries, to promote a coordinated approach to the TB /HIV dual epidemic and to re-enforce advocacy for TB control. The present plan is developed to take the regional fight against TB forward bearing in mind progress made, remaining and new challenges, the present and expected context and gaps. In order to reduce the burden of suffering and death due to TB in the Region, and to guide control action towards the WHA², MDG³ and Abuja targets, urgent, intensified and sustained extraordinary actions need to be undertaken by all Member States. This plan is to be used by the WHO AFRO and partners to guide and support Governments and National TB Control Programmes to develop medium-to-long-term TB control plans to accelerate progress towards the global and regional targets for TB Control, especially the WHA, MDG, Abuja and other Resolutions relevant to TB control in the African Region.

¹ Strategic Plan for Tuberculosis Control in the African Region: 2001-2005. World Health Organization. Regional Office for Africa, Harare, Zimbabwe. 2000.

² To detect 70% of new incident cases and successfully cure 85% of them by 2005.

³ To halt and begin to reverse the prevalence of Malaria and other diseases by 2015.

2. SITUATION ANALYSIS

2.1. Magnitude of the TB epidemic

The TB epidemic in the region has reached emergency proportions despite significant efforts by Member States in collaboration with WHO and other technical and donor partners to implement internationally recommended control strategies. While the majority of countries are implementing the internationally recommended Directly Observed Therapy Short Course (DOTS) Strategy, the African Region contributes a disproportionately high proportion of the global TB burden. Of the 22 countries responsible for 80% of total global TB burden (the high burden countries –HBCs), 9 are in the African Region and of the 15 countries with the highest estimated TB incidence rates per capita, 12 are in Africa. In 2003, with only 11% of the world's population, TB notifications from the Region accounted for 27% of all notified cases in the world⁴. During the same year, the highest TB notification rate (719 total cases per 100,000 population) was recorded in the African Region (Swaziland). The African Region was the worst of three epidemiological regions where TB incidence was still rising, even though the rate of increase has fallen from 15% per year in 1991 to less than 5% in 2003 (Figure 1)

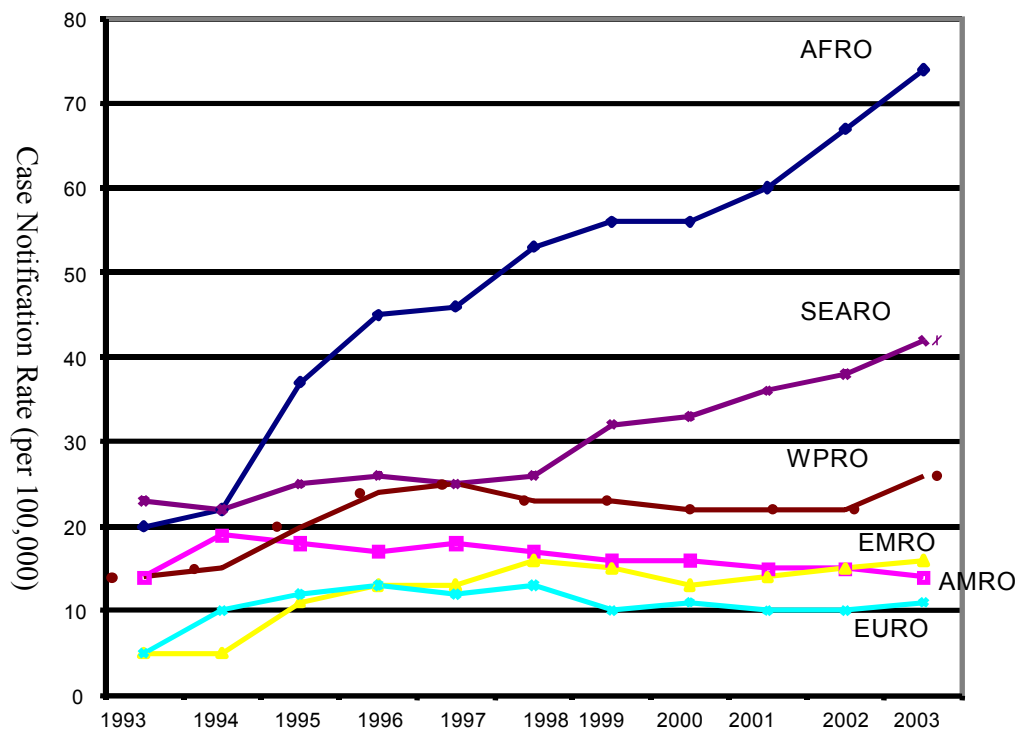


Figure 1: Trend of notification rates for new smear positive TB cases by WHO Region, 1993-2003

Further, the burden of TB is increasing: from 1990 (baseline year for MDG) to 2003 (the latest year's data) prevalence of all TB cases rose from 307 to 507/100,000, incidence rose from 146 to 345/100,000 and death rate rose from 41 to 78/100,000 population.

⁴ Global Tuberculosis Control: surveillance, planning, financing: WHO Report 2005. Geneva, World Health Organisation (WHO/HTM/TB/2005.349).

2.2. Response analysis

2.2.1. Global level:

Recognizing the worsening TB epidemic, especially in developing countries, the World Health Assembly (WHA) at its Forty-fourth sitting in 1991 (WHA44/1991/REC/1), adopted Resolution WHA44.8 setting “global target of cure of 85% sputum-positive patients under treatment and detection of 70% of cases by the year 2000, taking care to ensure that these programmes are integrated as far as possible into primary health care activities”. In 1993, TB was declared a Global emergency through Resolution WHA46.36. In 2000, when it became clear that most countries would not achieve the targets set in 1991, the target year was shifted to 2005 through Resolution WHA53/5.5⁵. In the same year, the Millennium Declaration was adopted, setting impact targets for AIDS, Malaria and other diseases, including TB. In response to resolution WHA51.13, the Stop Tuberculosis Initiative, now called the Stop TB Partnership, was established to lead a concerted effort to tackle the TB epidemic. The Stop TB Partnership formulated the Global Plan to Stop Tuberculosis⁶, which galvanised efforts to achieve the global targets. Since then TB case detection under DOTS has accelerated and the treatment outcome target has been met in some regions. The treatment success rate in the 2002 DOTS cohort was 82% on average, just below the 85% goal and by the end of 2005 the case detection rate is expected to reach 60% from 27% in 2000. In 2005, the WHA resolved for a sustainable financing for tuberculosis prevention and control including, among others, the commitment by member countries to ensure the availability of sufficient domestic resources and of sufficient external resources to achieve the internationally agreed development goal relevant to TB and contained in the MDGs, the setting up of national Stop TB Partnerships in each country, the setting up of collaboration between tuberculosis and HIV programmes and to integrate the prevention and control of tuberculosis in the mainstream of their health development plans⁷.

2.2.2. Regional level:

Countries in the African Region were the first to implement the DOTS strategy for TB control under programme conditions in the late seventies and early eighties in IUATLD supported programmes in Tanzania, Malawi, Benin, Senegal and Mozambique.

In pursuance of the global TB control resolutions cited above, the Regional Committee for Africa adopted a Resolution⁸ calling upon Member States to develop and implement strengthened DOTS based TB Control Programmes. The WHO AFRO has been supporting member states to develop DOTS based TB control programmes as part of overall health care delivery systems. Countries have been 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. These were based on the Regional TB Control Medium Term Strategic Plan for the period 20001-2005. To date, virtually all 46 Member States in the Region are implementing the Strategy. Thirty of these have attained countrywide coverage with DOTS services (2003 data), especially in the public health sector. As DOTS based programmes have been expanded, both case detection and treatment success rates have been increasing too. DOTS coverage increased from 43% in 1995 to 85% in 2003 (Figure 2)^{9,10}. Figure 3 shows trends in population coverage in comparison with other WHO regions. Figure 4 on the other hand shows DOTS coverage by country in the African Region based on 2004 data.

⁵ To detect 70% of sputum smear positive TB cases and successfully cure 85% of them by 2005

⁶ The Global Plan to Stop Tuberculosis. Phase 1: 2001-2005. 2002 World Health Organization.

⁷ Fifty-eighth WORLD HEALTH ASSEMBLY WHA58.14 Agenda item 13.4, 25 May 2005. Sustainable financing for tuberculosis prevention and control.

⁸ Resolution AFR/RC48/R6 of 1994

⁹ WHO/AFRO Regional TB Surveillance Report 2001. WHO Office for the African Region, Harare, Zimbabwe 2002.

¹⁰ Tuberculosis Epidemiological Surveillance Report 2003. WHO Office for the African Region, Harare, Zimbabwe 2004

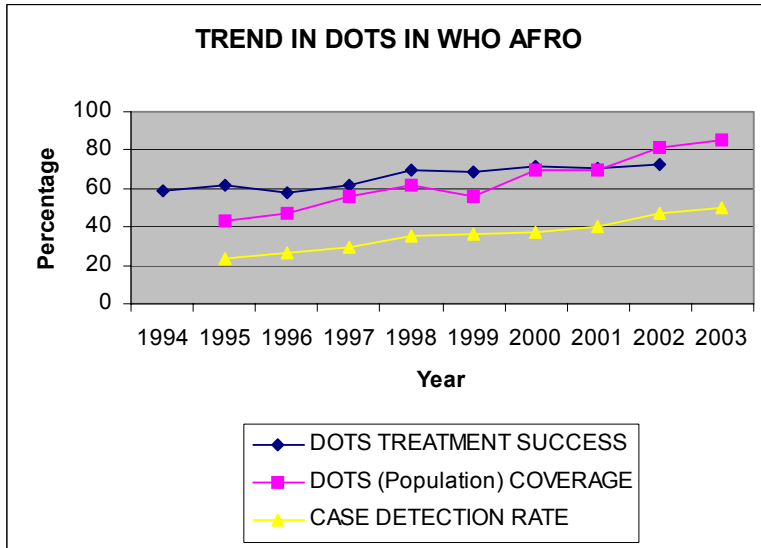


Figure 2 Trends in DOTS detection, treatment success rate and population coverage in the WHO African Region. 1994 to 2003

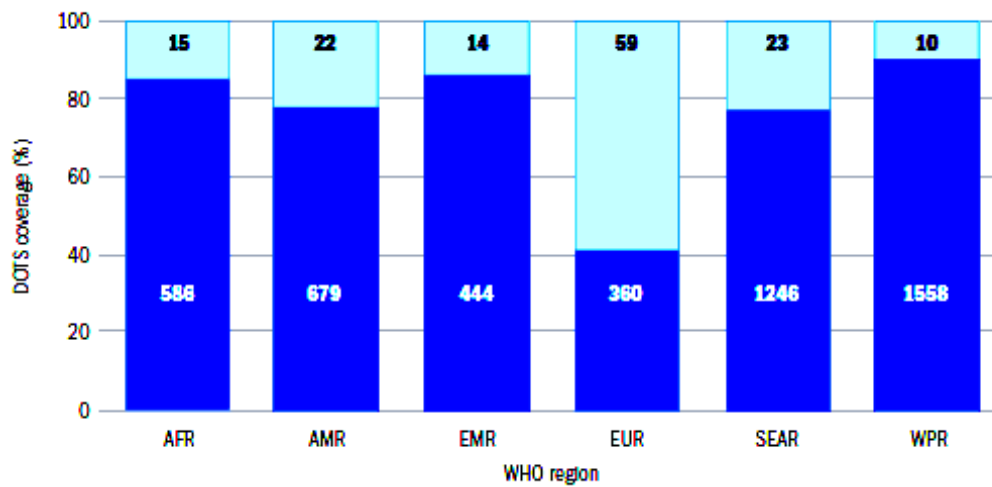


Figure 3 Comparison of population access to DOTS services in the African and other WHO Regions¹¹. The shaded portion of each bar shows the DOTS coverage as a percentage of the population. The numbers in each bar show the population (in millions) with (dark portion) or outside (light portion) DOTS areas.

¹¹ *Global Tuberculosis Control: surveillance, planning, financing*: WHO Report 2005. Geneva, World Health Organization (WHO/HTM/TB/2005.349).

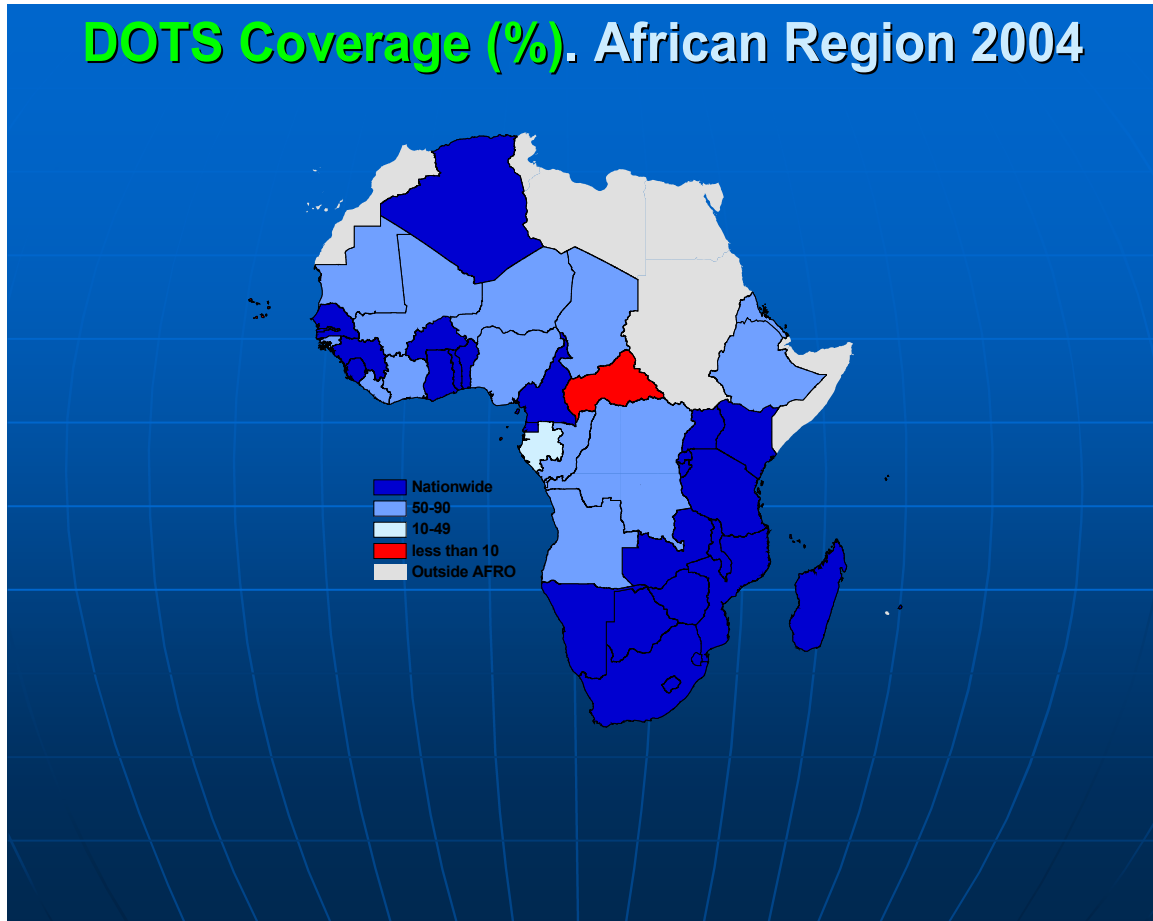


Figure 4: DOTS coverage by country in the African Region, 2004.

Case detection rate (CDR) has also improved from 24% in 1995 to 50% in 2003. Also, treatment success for new smear-positive cases under DOTS increased from 62% in 1995 to around 73% in 2002 and 2003 cohorts.

However, latest data (2006 WHO Global TB Control Report) indicates that the TB epidemic in the WHO African Region is still huge and worsening. The average case detection rate of 50% and treatment success rate of 72% and those in nearly all the countries in the African Region are still below the WHA targets as seen in Figure 5. Region's treatment success rate is the worst among WHO Regions. This relatively poor treatment success rate is mainly due to a combined effect of a high default rate (10%), transferred out without follow up rate (5%) and lost to follow up (5%) rate.

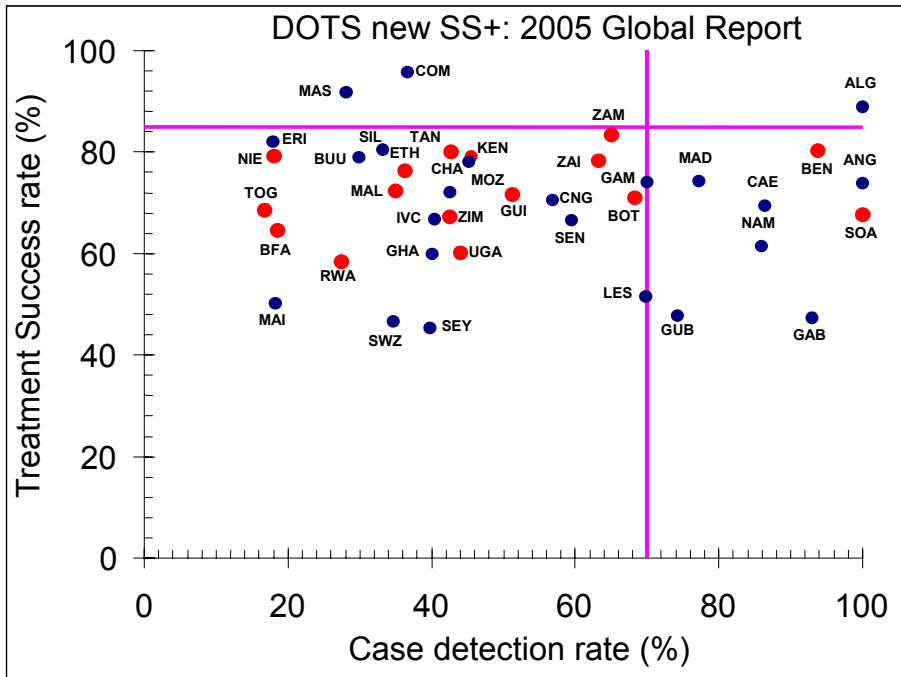


Figure 5 DOTS Status in WHO AFRO countries in 2003: 2 countries reported treatment success rates over 85%, 10 reported case detection rates 70% or more and only one has reached both targets. (Courtesy of Brian Williams, WHO, Geneva. November 2005)

3. ISSUES & CHALLENGES

3.1. The HIV/AIDS Epidemic

The HIV/AIDS epidemic has become the most important risk factor for TB incidence and death. On average, 35% of new TB patients in the Region are co-infected with HIV compared to 8% globally. TB related death rates in countries with high HIV prevalence have risen up to 20% during the past 10 years¹². Also, HIV infection is causing TB to occur more and more in younger economically productive members of society, especially girls and young women (15-24 years). At the same time, many collaborative TB/HIV activities are still in their infancy even in countries where policies have been developed.

High mortality due to TB/HIV co-infection is another HIV related challenge that can be reduced with antiretroviral therapy (ART), yet only 86 out of every 1000 TB patients were tested for HIV, 4 out of every 1000 co-infected patients were assessed for ART and 2 out of every 1000 TB/HIV co-infected were started on ART¹²

3.2. Human Resource

Most countries in the Region have low levels of trained and untrained health staff. At the same time, workload and staff turnover have increased. The relative lack of health workers is a function of production, deployment and retention of health care providers, especially at peripheral primary health care level. Outflows of staff are accelerated by labour migration into the private sector, NGOs, and to industrialized countries. The HIV/AIDS and TB epidemics are also having a toll on health workers¹³.

In 2003, inadequate HR ranked first within the top five constraints to achieving global TB control targets in 17 of the 22 HBCs¹⁴. Lack of skilled and/or motivated staff, inadequate distribution of staff, poor retention, deficiencies of staff at central level, inadequate supportive technical support of staff at district or provincial levels following decentralization and staff with inadequate qualifications, were all reported to be prevalent. The situation remained the same in the 2005 WHO Global TB control report and HR constraint was ranked second to the HIV influence on TB at a consultative meeting for the development of a TB control strategic plan for Africa¹⁵. Up to 50% of health human resource work outside the public health facilities in most African countries, yet most private facilities do not take part in the delivery of TB services.

3.3. Weak Health System Infrastructure

Weak and malfunctioning health delivery infrastructure and systems are common place in the African Region. This poses a great challenge to access to services. In particular, access to primary health care upon which TB services depend is still limited. In some countries, it is estimated that only 53% of the population has access to general primary health care services. Even where health infrastructure exists, poor functionality remains a significant problem.

On related operational level, with the increase in complexity and scope of TB control, programme managers are finding it more and more difficult to manage their programmes. There is need to increase the capacity of central TB control units to manage the different areas of TB control, such as human resource, the CB-DOTS, PPP DOTS, TB/HIV collaboration, and TB to special areas.

3.4. Funding

During the past few years, funding for TB control activities at country level has improved considerably due to increased inflows of additional funding, especially through the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and other bilateral and multilateral agreements. Despite these inflows, significant funding gaps still remain relative to National TB Programme budgets. In 2003, 22 National programmes reported a budget gap of 35%. Government allocations for TB control are particularly insufficient (<10% of need) and not sustained over time. At a recent consultative meeting for the Regional Strategic Plan it was recognised that the other issue of funding was related to limited capacity of countries to utilise the increased funding now available.

Funding constraints are also exacerbated by the stringent requirements of some funding agencies that often challenge further the capacities of NTPs to meet diverse and often uncoordinated reporting demands. In addition, the direct support of international and national NGOs by some international aid agencies outside the NTP

¹² Global tuberculosis control: surveillance, planning, financing. WHO Report 2005. Geneva, World Health Organization (WHO/HTM/TB/2005.349).

¹³ Chen L, Evans T, Anand S et al. Human resources for health: overcoming the crisis. Lancet 2004; 364:1984-90

¹⁴ Global tuberculosis control: surveillance, planning, financing. WHO Report 2003. Geneva, World Health Organization, 2003 (WHO/CDS/TB/2003.316).

¹⁵ November 2005, Harare, Zimbabwe.

structure poses particular difficulties of co-ordination, especially where operational technical guidelines are at variance with national and WHO policies.

3.5. Laboratory network

A poor laboratory network is a great challenge in nearly all countries. Most countries do not have a functioning National Reference Laboratory or adequate equipment. There is poor access to laboratory services by the population due to few and far dispersed diagnostic centres. Culture and drug susceptibility testing (DST) services are not available in most countries and there is a low number of trained laboratory staff. The complex diagnosis of extra-pulmonary and HIV related smear negative TB; and TB in children challenges the capacity of laboratories further.

3.6. Political Commitment

Political commitment has increased in most countries in line with increased international and region declarations. However, it is still a problem with regard to low capacity to utilize available funding and unwillingness to release commensurate local funds for TB control purposes by governments. Often, stated commitments are not translated into actual resources commensurate with the size of the TB epidemic.

3.7. MDR-TB

The true prevalence of multi-drug resistance TB (MDR-TB) is unknown in many countries and the assessment is still too costly for many countries to perform as a routine. Second line drugs cost 300 – 1000 times more than first line drugs and most countries cannot afford such costs. In addition, a few countries have tried to access second line drugs through the Stop TB Partnership Green Light Committee (GLC) but the stringent criteria for accessing these drugs has generally denied easy access to treatment for most patients in the Region. By December 2004, the GLC had approved 30 DOTS-Plus pilot projects for a total of 10,133 MDR-TB patients in 23 countries; only two of these (Kenya and Malawi) were in Africa¹⁶. Of the African countries, only South Africa has a national policy for diagnosis and treatment of MDR-TB and manages MDR-TB under the NTP.

3.8. DOTS coverage and quality

While most countries in the Region have DOTS in more than 85% of public health facilities, the quality is still poor. Scaling up of DOTS expansion using new initiatives such as community based DOTS, involvement of private sector and DOTS in special situations, is still in its infancy in most countries. Countries in the Region still have to improve on case detection, patient adherence to treatment, and patient loss to follow up. There is also need to find practical ways to measure disease incidence to facilitate monitoring progress to set targets. There is a need for much better data: both routine data and special studies. Ways of measuring TB incidence in countries should be found.

3.9. Public and Community Awareness and Involvement

Low knowledge of TB, its treatment and control in communities also contributes to the low detection rates and treatment outcomes. Involvement of communities in TB detection and treatment is minimal in most countries. [develop this section a bit more]

3.10. TB and poverty

TB is a disease of the poor and the one who gets it becomes poorer because of the costs of a protracted process of diagnosis and treatment. A 2004 joint report by the African Union and the Economic Commission for Africa estimated an economic loss of 4-7% of GDP annually in countries with a high burden of TB¹⁷. Deliberate linkages between TB control and anti-poverty initiatives such as 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) must therefore be developed to place financing for TB control in a sustainable and flexible long-term developmental framework. All socio-economic groups, especially the poor and hard to reach members of society should be facilitated to have unfettered access to TB diagnostic and treatment services. Debt relief of highly-indebted poor countries (HIPC) could also contribute to this by freeing up domestic resources. There is an urgent need to increase the visibility of TB as one of the major health problems influencing economic development and, thus, to enhance concerted action to tackle it

¹⁶ Global tuberculosis control: surveillance, planning, financing. WHO report 2005. Geneva, World Health Organization (WHO/HTM/TB/2005.349).

¹⁷ Economic Commission for Africa. Scoring African Leadership for Better Health, ECA, Addis Ababa, Ethiopia. July 2004

3.11. Declaration of TB as an Emergency in Africa

Responding to an epidemic that has more than quadrupled the number of new TB cases in most African countries since 1990, killing more than half a million people every year in the continent, the 55th session of the WHO Regional Committee for Africa meeting in Maputo Mozambique in August 2005, declared tuberculosis an emergency in the region¹⁸. The resolution urges Member States to commit more human and financial resources to strengthen DOTS programmes and scale up collaborative interventions to fight the TB/HIV dual epidemic. These and other measures recommended by the Committee encompass those laid out in the Global Plan to Stop TB 2006-2015 and the new WHO Stop TB Strategy. Member states need to develop and implement urgent and extraordinary actions to rapidly increase DOTS coverage and improve its quality. The resolution also calls upon governments, WHO and other partners to hasten research on new drugs and diagnostics and to mobilise additional resources for TB control in the Region.

4. PRIORITY AREAS

Based on the issues and challenges identified, the following emerge as priority areas of action for TB Control in the African Region:

1. Rapid acceleration of DOTS coverage, access and quality to quickly increase case detection and treatment success rates towards attainment of the regional and global TB control targets including those of the MDGs.
2. Role out of TB/HIV collaborative activities to contain the TB epidemic in the context of the HIV epidemic.
3. Ensure availability of sufficient numbers of trained human resources for delivery of health services including TB services.
4. Strengthen and expand national laboratory networks to contribute efficiently to TB control, including drug resistance surveillance
5. Improve political and community commitment and involvement in TB control, particularly at district levels.
6. Meet the technical and financial needs for tackling TB as a public health emergency in the region;
7. Strengthen surveillance systems to measure and monitor selected indicators and targets
8. Forging new partnership, especially public –private partnerships at national and district levels.

18 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.

5. OPPORTUNITIES

Despite many issues and challenges, there is great optimism for TB control in Africa. Firstly, there is increasing commitment of African political leaders in improving the health of African populations. The African Union (AU), the United Nations Economic Commission for Africa, the sub-regional economic communities and the New Partnership for Africa's Development (NEPAD) provide opportunities for considering the broader determinants of health. Specific commitments to TB control are contained in the Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases of April 2000; the Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases of July 2003; the AU/NEPAD Health Strategy of 2003, and AU the Assembly Decision 55(IV) on the Interim Report on HIV/AIDS, TB, Malaria and Polio of Abuja, January 2005.

In the Gaborone Declaration of October 2005¹⁹, the member countries of the AU committed themselves to the achievement of Universal Access to Treatment and Care by 2015 through the development of an integrated health care delivery system based on essential health package delivery close-to-client, the scaling up of the treatment of AIDS, Tuberculosis and Malaria through proven effective drug combinations, to strengthen Health Systems to promote universal access by implementing the Abuja Recommendation of allocating at least 15% of the national budget to health and to strengthen partnerships, among many other actions.

Together with the Millennium development goals and the World Health Assembly targets, all these provide opportunities for mobilization of political, technical and financial resources for improved health in Africa. These opportunities hold the promise of improving the environment within which health should evolve, particularly in relation to economic growth and poverty reduction. TB has been prioritized in most of these frameworks and stands to gain from their implementation.

The current global environment also gives concrete evidence of willingness by developed countries to increase their development assistance to Africa. This is found in the Poverty Reduction Strategic Plans (PRSPs), the extended Highly Indebted Poor Countries (HIPC) initiative and the debt cancellation announced by the G8, the World Bank and the International Monetary Fund (IMF). The increased partnerships to address specific health problems, such as TB and HIV, and renewed attention to funding health development plans in Africa are positive. Financing agencies are also positioning themselves to increase their support to Africa. In addition, there is currently an international consensus that health is important for socioeconomic development and poverty reduction as well as the global partnerships to fight diseases of poverty such as the Global Fund.

Furthermore, the new WHO AFRO leadership has committed itself to scaling up essential priority interventions to positively impact on populations health in the Region²⁰. The purpose of AFRO's current strategic orientation is to uphold the vision of Agenda 2020: attainment by all peoples in the African Region of the highest possible level of health, as enshrined in the WHO constitution. It recognises health as a human right and as an investment for economic growth and development and is taking up the challenge to explore new and innovative ways for maximizing support for Member states to attain better health outcomes.

19 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH2), Gaborone, Botswana 10 – 14 October 2005

20 Strategic orientations for WHO action in the African Region. 2005-2009. World Health Organization, Regional Office for Africa, Brazzaville 2005.

6. GUIDING GLOBAL AND REGIONAL ORIENTATIONS

The strategy for TB control in Africa is in consonance with and guided by both global and regional strategic orientations and declarations.

6.1. Global Orientations

6.1.1. The WHA TB Control Targets

In 1991, the World Health Assembly (WHA) recognised TB as a major global health problem and adopted a resolution setting targets for TB control to be attained by 2000:

1. To detect at least 70% of new infectious TB cases, and to
2. Successfully treat at least 85% of the detected new infectious TB cases

These targets were set because it has been estimated that attainment of these targets would reduce TB incidence by 5-10 percent per year, effectively halving incidence within 10 years^{21,22}. The deadline was postponed to 2005 when it became clear that most of the countries with the highest burden of disease would not meet the targets²³. In 1993 WHO declared TB as a global emergency and in 1994 the DOTS strategic framework of the WHO was adopted²⁴ as the main strategy to combat TB globally. In 2002, the DOTS framework was expanded and has formed the basis for subsequent refinements to TB control activities²⁵.

6.1.2. The Millennium Development Goals

At the United Nations Millennium Summit in September 2000, world leaders adopted the Millennium Declaration with its 8 Millennium Goals for human development. Tuberculosis is covered under Goal number 6, namely: "Combat HIV/AIDS, malaria and other diseases". The related Target 8 is specified as: "to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases". In order to provide a measurable target, the Working Group on TB within the Millennium Project Task Force on HIV/AIDS, Malaria and Tuberculosis, and Access to Essential Medicines has recommended a refined specific target that reads "Halve the prevalence of TB disease and deaths between 1990 and 2015".

6.1.3. From the First Global Plan To Stop TB through the Second to The Stop TB Strategy

The Global Partnership to Stop TB was launched in Bangkok in November 1998 and now comprises over 400 partners worldwide committed to combating TB. The Partnership coordinates the work of its partners through seven working groups. It launched the first Global Plan to Stop TB (1GPSTB) as a template for mobilizing the human and financial resources necessary to expand TB control as part of the national health system, especially in the 22 countries with the highest TB burden in the world, in order to achieve the global targets for TB control²⁶. The first Global Plan to Stop TB provided the "blueprint" that was followed to control TB globally during 2001 – 2005.

In order to provide a vision of what can be achieved, a tool to implement a new TB control strategy, a guide for advocacy and fundraising, to support long-term national planning, to stimulate research and development, and to make full use of upcoming opportunities, the Global Partnership to Stop TB has developed a and launched a second Global Plan to Stop TB (2GPSTB) at Davos in 29 January 2006. The 2GPSTB calls for about US \$2 billion in annual funding for TB control in Africa during 2006-2015. The vision of the plan is to work towards eliminating TB as a global public health problem by 2050. It provides the activities necessary to reach the Stop TB Partnership's targets for 2015. In support of this plan, a new Stop TB Strategy has been developed which while emphasising DOTS, calls for:

²¹ Report of the Millennium Project HIV/AIDS Task Force Working Group on TB

²² Styblo K, Bumgarner J R. Tuberculosis can be controlled with existing technologies: evidence. Tuberculosis Surveillance Research Unit Progress Report, 2.: 60-72, 1991.

²³ World Health Organization. Fifty-third World Health Assembly. WHA53/2/REC/1. Geneva: WHO 2005.

²⁴ World Health Organization. Framework for effective tuberculosis control. WHO/TB/94.179. Geneva: WHO, 1994.

²⁵ World Health Organization. An expanded DOTS framework for effective tuberculosis control. WHO/CDS/TB/2002.297. Geneva: WHO, 2002.

²⁶ World Health Organization. The Global Plan to Stop Tuberculosis. Stop TB Partnership. WHO/CDS/STP/2001.16. Geneva: WHO 2002.

1. Pursuing quality DOTS expansion and enhancement with additional components of
2. Addressing TB/HIV and MDR-TB
3. Contributing to health system strengthening
4. Engaging all care providers
5. Empowering patients and communities
6. Enabling and promoting research

The Strategy²⁷ has 4 major objectives, namely;

1. To expand access to quality diagnosis and treatment for people with TB
2. To reduce the human suffering and socioeconomic burden associate with TB
3. To protect vulnerable populations from TB, TB/HIV and drug resistant TB
4. To support development of new tools and enable their timely and effective use.

6.2. Regional Orientations

The commitments of African leaders as contained in the Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases of April 2001²⁸ which was reaffirmed in the Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in July 2003, the AU/NEPAD Health Strategy of 2003, and AU Assembly Decision 55(IV) on the Interim Report on HIV/AIDS, TB, Malaria and Polio of Abuja, January 2005 and others have provided “wind in the sail” for this Strategic Plan.

6.2.1. Regional Committee for Africa Resolution on TB Control (1994).

This focused on the adoption and countrywide implementation of the TB DOTS Strategy by all member states²⁹.

6.2.2. Abuja Heads of State Summit on AIDS, Malaria, Tuberculosis and other diseases (April, 2001).

This focused on reducing prevalence and death as well as process indicators of case detection and treatment success rates (as for WHA targets). The African Heads of State committed themselves to take personal responsibility and provide leadership for the battle against HIV/AIDS, TB and Other Related Infectious Diseases (ORID). They further pledged to allocate at least 15% of their countries’ annual budget to the improvement of the health sector. The framework of the plan of action identified these priority areas:

1. Leadership at national, regional and continental levels to mobilize society as a whole to fight HIV/AIDS, TB and ORID.
2. Resource mobilization (national and international)
3. Protection of human rights
4. Poverty, health and development
5. Strengthening health systems
6. Prevention of the diseases
7. Improvement of information, education and communication
8. Access to treatment care and support
9. Access to affordable drugs and technologies
10. Research and development
11. Partnership
12. Monitoring and Evaluation

6.2.3. NEPAD Health Strategy (2004)

The NEPAD Health Strategy was adopted at the first African Union Conference of Health Ministers held in Tripoli in April 2003 and by the African Union in Maputo in July 2003³⁰. The health sector strategy specifically seeks to impact on disease burden through 6 priority areas including scaling up disease control. Two specific actions are identified for TB control, namely:

1. Support the implementation of initiatives that increase access to and improve the quality of TB DOTS services such as community based DOTS, collaborative TB/HIV/AIDS activities and public-private partnerships, and

²⁷ World Health Organization. The Stop TB Strategy. Building on and enhancing DOTS to meet the TB-related Millennium Development Goals. Draft. October 2005.

²⁸ The Outcome of the African Summit on HIV AIDS, Tuberculosis and other related infectious diseases. Abuja Nigeria, April 2001.

²⁹ Regional Committee for Africa Resolution AFR/RC44/R6. September 1994.

³⁰ NEPAD Health Strategy: Executive Summary

2. Develop regional strategies to mobilise human and financial resources for tuberculosis control activities, and to ensure uninterrupted supply of affordable quality anti-TB drugs in all countries.

6.2.4. The WHO Regional Committee for Africa Declaration of TB as an Emergency

In response to an epidemic that has more than quadrupled the annual number of new TB cases in most African countries since 1990 and is continuing to rise across the continent, killing more than half a million people every year, the WHO Regional Committee for Africa declared tuberculosis an emergency in the African region at their 55th session in August 2005 in Maputo, Mozambique³¹. The resolution urged Member States to commit more human and financial resources to strengthen DOTS programmes and scale up collaborative interventions to fight the co-epidemic of TB and HIV. It particularly stressed the development and implementation with immediate effect of emergency strategies and plans to control the worsening TB epidemic, to rapidly improve TB case detection and treatment-success rates, to improve the quantity and quality of staff involved in TB control, to expand national partnership for TB control, especially public-private partnerships and to implement strategies to reduce patient default and transfer-out rates to 10% or less.

WHO AFRO is to

1. provide intensified technical support to Member states for scaling up control interventions
2. hasten research on new effective shorter duration treatment regimens and appropriate diagnostic tools for TB.
3. mobilise additional resources to TB control in the Region.

6.2.5. AU Gaborone Declaration

In the Gaborone Declaration (October 2005)³², the member countries of the AU committed themselves to the achievement of Universal Access to Treatment and Care by 2015 through the development of an integrated health care delivery system based on essential health package delivery close-to-client, the scaling up of the treatment of AIDS, Tuberculosis and Malaria through proven effective drug combinations, to strengthen Health Systems to promote universal access by implementing the Abuja Recommendation of allocating at least 15% of the national budget to health and to strengthen partnerships, among many others.

6.2.6. The Regional Director's Orientations

Tuberculosis is one of three areas of work in the newly established division of AIDS, TB and Malaria (ATM)³³ at AFRO. "The African Region remains the most affected by communicable diseases especially the triad of HIV/AIDS, Malaria and Tuberculosis. Through a better integration of activities in these 3 areas, we will maximize human, financial and material resources, and thus decentralize such resources more to countries. We will actively pursue the attainment of the "3x5" target, the Abuja health targets and the MDGs relating to HIV/AIDS, Malaria and Tuberculosis"³⁴. The Regional Director's orientation for TB for the medium term is as follows:

1. Policy and strategy development for tuberculosis prevention and control based on expanding and advancing DOTS and social mobilisation
2. Technical assistance to countries for:
 - DOTS expansion in accordance with the Global DOTS expansion plan
 - Human resources development
 - Laboratory strengthening
 - Adaptation of DOTS to settings with high HIV prevalence and with high MDR-TB prevalence
 - Application of integrated approach to respiratory diseases at primary care level
3. Support and partnership for expanding access to anti-tuberculosis drugs, including through the Global TB Drug Facility (GDF) and the Green Light Committee (GLC)

³¹ 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.

³² 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH2), Gaborone, Botswana 10 – 14 October 2005. Sustainable Access to Treatment and Care For the Achievement of the Millennium Development Goals. Gaborone Declaration on a roadmap towards Universal access to treatment and care.

³³ See Annex XXX for Organogram of the WHO Regional Office for the African Region, 2005

³⁴ Inaugural Speech By WHO Regional Director for Africa Dr Luis Gomes Sambo 1 February 2005. Available at <http://www.afro.who.int/regionaldirector/speeches/rd20050201.html>

4. Surveillance of tuberculosis burden and trends, including resistance and HIV co-infection; monitoring the implementation and impact of control measures with special reference to the DOTS Strategy and the Millennium Goals
5. Support for priority research relating to TB control and provision of epidemiological and economic analyses to support policy on TB control
6. Advocacy and promotion of partnership approaches to tuberculosis control and research through the Stop TB Partnership at country, regional and global levels

6.2.7. Strategic Orientations for WHO Action in the African Region 2005-2009.

The strategic orientations for the work of WHO in the African Region for the period 2005-2009 reflects the WHO AFRO aspirations, outlines priorities and states the principles, strategies and mechanisms for improving technical cooperation with Member states³⁵. Its general objectives are to assist Member States in reforming their health sectors in the context of owned policies, strategies and plans that strengthen health systems and improve the health status of populations. Emphasis is to be placed on the core functions of WHO, which include:

1. Establishing health policies, technical guidelines, norms and standards
2. Providing technical policy advice
3. Contributing to sustainable capacity building
4. Strengthening management capacity
5. Providing health leadership, and
6. Coordinating at global, regional and national levels

The Strategic Orientations are:

1. Strengthening WHO support to countries
 - a. Technical and managerial functions will be decentralised to country offices with support from intercountry teams and Regional Office.
 - b. The capacity of country offices will be strengthened to generate, manage and share health information and knowledge that should facilitate informed decision-making.
2. Strengthening and expanding partnerships for health
 - a. At regional level to include closer collaboration with the AU, the ECA, regional economic communities, the UN agencies, the World Bank, the IMF, bilateral donors.
 - b. Increase the involvement of communities, civil society organizations, women, private sector, academic and research institutions in supporting health sector reform.
 - c. Increase partnerships and collaboration with all development partners and play an active role in supporting health development partners at the country level.
3. Strengthen health policies and systems particularly at district and community levels.
4. Promoting the scaling up of essential health interventions related to priority health problems
5. Enhancing awareness and response to key determinants of health.

³⁵ World Health Organization. Strategic Orientations for WHO Action in the African Region. 2005-2009. WHO Regional Office for Africa, Brazzaville 2005.

7. GOAL AND OBJECTIVES

7.1. Vision

The long-term vision is a Region where tuberculosis ceases to be a major public health problem through the application of high quality, accessible and affordable TB control services

7.2. Mission

To promote and facilitate the identification, adoption and implementation of efficient and effective TB prevention, care and support strategies and services in all member states.

7.3. Goal

The overall goal of the 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.

7.4. Objectives

The primary objective is to reach and sustain 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.

7.5. Targets and Indicators

A. WHA TB control targets for 2005 extended to 2010:

1. To detect at least 70% of new infectious TB cases, and to
2. Successfully treat at least 85% of the detected new infectious TB cases

B. The Millennium Development Goals

Goal 6: "Combat HIV/AIDS, malaria and other diseases".

Target 8: "to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases".

Target 8 applied to TB: "Halve the prevalence of TB disease and deaths between 1990 and 2015".

C. Indicators

1. DOTS coverage,
2. Prevalence and death rates associated with tuberculosis, and
3. Proportion of tuberculosis cases detected and cured under DOTS (Case detection and treatment outcomes)

7.6. Guiding principles

The following principles should govern the implementation of this strategy:

7.6.1. Country specific targeting and ownership

While there are common TB characteristics between countries, each country has its own peculiar circumstances that necessitate the adaptation of these broad strategies to the country context. Each country should own its programme while WHO provides assistance according to the agreed framework for each country. As guidance to country TB control situation, a summary of the TB control indices for each country as at end of 2004 is shown in **Error! Reference source not found.**

7.6.2. Prioritization.

Countries are prioritised into 2 groups based on the burden of TB cases by numbers and the prevalence of TB cases per unit of population. Globally, 22 countries have been classified as High Burden Countries (G-HBCs) because they make up the bulk (80%) of the global TB burden. Nine of these countries are in Africa: DR Congo, Ethiopia, Kenya, Mozambique, Nigeria, Tanzania, South Africa, Uganda and Zimbabwe. AFRO has further prioritised countries in the Region into African High TB Burden Countries (Africa-HBCs) for those with reported TB prevalence >300 per 100,000. Table 1 shows the prioritised countries. These 34 prioritised countries will be provided special attention with intensified support while not ignoring the needs of the other countries.

With regards to TB/HIV, countries have been divided into two: high and low HIV prevalence countries depending on whether the prevalence (adults 15-49 year) is 4% or more (high), or less (low). These countries are shown in Table 2. Extra priority would be given to those countries that are in both HBCs and high HIV groups.

7.6.3. Phased implementation of evidence-based best practices.

Each country should roll out activities in a phased manner, based on experience, lessons learnt and evidence gathered in and out of country. A well-timed and planned roll out of activities would ensure maximum efficiency and coordination of available resources.

The roll out of the strategy should be seen in 3 phases:

- **Phase 1. 2006-2007.** Emergency Phase during which urgent planning, advocacy and communication, social, partnership and resource mobilization, and initiation of emergency activities occur.
- **Phase 2. 2008-2009.** Acceleration and further expansion phase. This phase is to ensure that targets are met.
- **Phase 3. 2010.** Period of attainment and consolidation of targets.

7.6.4. Partnership building

No one organization or country is able to do all things perfectly and efficiently by itself. WHO and countries would continue to forge partnerships to provide all resources to meet targets. Partners beyond the “traditional” should be sought.

7.6.5. Equitable access to effective interventions

Most people who have TB are of poor socio-economic status and are in areas with minimal health services. A pro-poor and equity based approach is needed to ensure that the needs of the poor and disadvantaged groups are met. Barriers that challenge early diagnosis and effective treatment such as social and financial standing, geographic access to health services, low level of education, living in slums or being homeless, and drug addicts, must be identified and appropriate measures taken to overcome them.

Table 1 Classification of Member States based on TB burden and estimated prevalence of TB³⁶

Rank	Country	Population			Cumulative %	Prevalence 2003
		(1,000)	# Cases	% of Total		
1	Nigeria*	124,009	676,879	19.4%	19%	546
2	Ethiopia*	70,678	377,030	10.8%	30%	533
3	DR Congo*	52,771	297,861	8.5%	39%	564
4	Kenya*	31,987	282,816	8.1%	47%	884
5	South Africa*	45,026	206,110	5.9%	53%	458
6	UR Tanzania*	36,977	193,610	5.6%	58%	524
7	Uganda*	25,827	168,387	4.8%	63%	652
8	Mozambique*	18,863	120,004	3.4%	67%	636
9	Côte d'Ivoire	16,631	109,675	3.1%	70%	659
10	Zimbabwe*	12,891	85,129	2.4%	72%	660
11	Ghana	20,922	79,466	2.3%	74%	380
12	Mali	13,007	77,191	2.2%	77%	593
13	Zambia	10,812	68,996	2.0%	79%	638
14	Malawi	12,105	66,672	1.9%	81%	551
15	Swaziland	1,077	10,687	0.3%	81%	992
16	Sierra Leone	4,971	40,210	1.2%	82%	809
17	Togo	4,909	34,188	1.0%	83%	696
18	Mauritania	2,893	19,324	0.6%	84%	668
19	Rwanda	8,387	55,701	1.6%	85%	664
20	Namibia	1,987	12,630	0.4%	86%	635
21	Lesotho	1,802	10,598	0.3%	86%	588
22	Burundi	6,825	38,090	1.1%	87%	558
23	Central African Republic	3,865	21,197	0.6%	88%	548
24	Congo	3,724	19,382	0.6%	88%	521
25	Botswana	1,785	9,202	0.3%	88%	515
26	Liberia	3,367	17,073	0.5%	89%	507
27	Chad	8,598	39,188	1.1%	90%	456
28	Eritrea	4,141	18,405	0.5%	91%	444
29	Senegal	10,095	43,652	1.3%	92%	432
30	Guinea	8,480	34,528	1.0%	93%	407
31	Gambia	1,426	4,865	0.1%	93%	341
32	Madagascar	17,404	57,622	1.7%	95%	331
33	Burkina Faso	13,002	40,946	1.2%	96%	315
34	Guinea-Bissau	1,493	4,659	0.1%	96%	312
35	Niger	11,972	32,998	0.9%	97%	276
36	Angola	13,625	36,997	1.1%	98%	272
37	Gabon	1,329	3,566	0.1%	98%	268
38	Sao Tome & Principe	161	410	0.0%	98%	256
39	Cameroon	16,018	38,598	1.1%	99%	241
40	Benin	6,736	9,713	0.3%	99%	144
41	Mauritius	1,221	1,666	0.0%	99%	136
42	Comoros	768	795	0.0%	99%	103
43	Seychelles	81	53	0.0%	99%	65
44	Algeria	31,800	16,774	0.5%	99.9%	53
45	Equatorial Guinea	494	1,846	0.1%	100%	374
46	Cape Verde	463	1,526	0.0%	100%	329
Africa		687,405	3,486,914	100.0%		507

³⁶ Calculated from: Global TB Control, WHO report 2005, WHO/HTM/TB/2005.349

Above blue line are countries that contribute to 80% of estimated total TB cases in Africa. Countries above the red line are High TB Density Countries, have estimated prevalence >300,000 population (except Cape Verde and Guinea Bissau which have low populations and are not reporting cases) and contribute more than 95% of cases in Africa.

* Global High Burden Countries that contribute 80% of global TB burden.

Table 2 Classification of Countries according to HIV prevalence rates³⁷

High HIV Prevalence Countries				Low HIV Prevalence Countries			
Country	HIV Rate 2003	TB Cases due to HIV		Country	HIV Rate 2003	TB Cases due to HIV	
		Number ^a (x1,000)	Rate (/100,000 pop) ^b			Number ^a (x1,000)	Rate (/100,000 pop) ^b
Swaziland	38.8		478	Angola	3.9	3.1	56
Botswana	37.3	5.5	724	Guinea	3.2		
Lesotho	28.9	4.8	429	Ghana	3.1	6	64
Zimbabwe	24.6	29.2	501	Eritrea	2.7		
South Africa	21.5	77.8	333	Benin	1.9		
Namibia	21.3	3.1	385	Mali	1.9		
Zambia	16.5	18.9	409	Madagascar	1.7		
Malawi	14.2	16.1		Gambia	1.2		
Central African Republic	13.5	4.9	290	Niger	1.2		
Mozambique	12.2	21.5	258	Senegal	0.8		
United Rep. of Tanzania	8.8	25.2	155	Mauritania	0.6		
Gabon	8.1		82	Algeria	0.1		
Côte d'Ivoire	7	15	197	Cape Verde			
Cameroon	6.9	10.1	147	Comoros			
Kenya	6.7	43.9	295	Equatorial Guinea			
Burundi	6	6.4	228	Guinea-Bissau			
Liberia	5.9			Mauritius			
Nigeria	5.4	49.9	96	Sao Tome Principe			
Rwanda	5.1	7.6	211	Seychelles			
Congo	4.9		128	Sierra Leone			
Chad	4.8						
Ethiopia	4.4	59.2	209				
Burkina Faso	4.2	6.5	132				
Dem. Republic of Congo	4.2	22.6	105				
Togo	4.1	2.4	113				
Uganda	4.1	17.3	173				

^a Rate: the number of TB cases annually attributable to HIV (thousands)

^b Number: the number of TB cases attributable to HIV per 100,000 population

³⁷ Sourced from Joint United Nations Programme on HIV/AIDS. 2004 Report on the Global AIDS Epidemic. 2004.UNAIDS/04.16E

8. STRATEGIES AND INTERVENTIONS

The objectives would be met under the following strategic approaches:

1. Accelerate and achieve universal access to enhanced and expanded quality DOTS services to all TB patients.
2. Health system strengthening to support expansion and extension of quality DOTS services
3. Partnership strengthening for TB control

Interventions and activities for each strategic approach are summarised in Table 3 and discussed below.

Table 3 Summary of the Strategies and Interventions.

<ol style="list-style-type: none"> 1. Accelerate and achieve universal access to enhanced and expanded high quality DOTS services through programme development, increased coverage and diversification of providers to all TB patients. <ol style="list-style-type: none"> 1.1. Improve DOTS quality and coverage in public health facilities 1.2. Implement collaborative TB/HIV activities 1.3. Enhance engagement of NGOs and private sectors 1.4. Strengthened Community involvement in TB and TB/HIV care 1.5. Extend DOTS to special areas 1.6. Improved quality of TB diagnostic services including quality assured laboratory services. 1.7. Implement the Practical approach to lung (PAL) health activities 1.8. Ensure access to high quality anti-TB drugs 1.9. Prevention and management of multi-drug resistant TB 2. Strengthen health systems to support DOTS expansion and quality <ol style="list-style-type: none"> 2.1. Strengthen Human resource capacity 2.2. Strengthened health delivery systems including monitoring and evaluation of programme implementation, outcomes and impact 2.3. Implementation of operational research on effectiveness of DOTS expansion and TB/HIV collaborative strategies and the field testing of new diagnostic tools and drugs 3. Partnership strengthening for TB control <ol style="list-style-type: none"> 3.1. Mobilised political leadership and civil society towards attainment of TB related WHA, MDG and Regional targets. 3.2. Sustainable and increased financial resources for TB control 3.3. Establish Stop TB Partnerships in Africa to expand Regional and Country level partnerships for DOTS expansion
--

8.1. Accelerate and achieve universal access to enhanced and expanded quality DOTS services through programme development; increase coverage and diversification of providers to all TB patients.

The priority is for all African populations to have free universal access to TB diagnostic and treatment services of high quality close to their communities irrespective of the type of TB and service provider. TB control services should be available to 100% of the population to meet targets. Coverage of TB control activities in special areas such as prisons, displaced persons and migrants, the homeless and urban slums would further expand population coverage. The marginalised, the poor, women and children often have special circumstances restricting their access to health care. These should be provided unlimited access in a pro-poor strategy. Financial barrier should be removed by the provision of free TB and HIV services in all countries.

8.1.1. Improve DOTS quality and coverage in public health facilities.

The public health system is the backbone of the NTP in all countries. Experience has shown that unless this is strong, NTP activities involving other partners do not work. Thus, the initial priority is to complete DOTS coverage in all public health facilities down to the communities by Reaching Every Facility (REF). The quality of

DOTS should be strengthened by increasing managerial and technical capacity, improving supervision, improving laboratory diagnosis of TB and increasing human resource. DOTS quality is increased by strategies to reduce unfavourable programme outcomes such as default and transfer out. Efforts should be made to reduce these unfavourable outcomes and also to reduce the number of cases not analysed or unaccounted for.

Recommended Key Strategic Actions:

Countries

- Development of medium to long term (5-10 year, 2006-2015) national TB control strategic plans to achieve the MDG TB targets by all Member States.
- Development of medium term implementation plans (2006-2010) to increase access to quality DOTS services as part of primary health care systems, especially for people living in rural areas and other marginalised segments of society by all Member States.
- Development and implementation of Emergency Action Plans for rolling out national and district level TB control activities to attain district wide coverage with DOTS services and other proven interventions - Reaching Every Facility (REF) in all countries
- Scale up DOTS coverage to all public health facilities
- Provide free TB and TB/HIV services irrespective of type of TB and location of health facility.
- Strengthen the competence of health staff in programme management, drug management, diagnosis and treatment of TB, recording, reporting and supervision.
- Establish and/or improve quarterly reporting through the IDRS system.

WHO

- Provide intensified support, similar to the ISAC initiative, to all countries, especially the high burden countries, for scaling up control interventions
- Strengthen technical support to national TB control Programmes at country level to improve programme management, drug management, recording and reporting and staff competence
- Guide and support countries to develop National Emergency Action Plans of rolling out of national and district level TB control activities to attain district wide coverage with DOTS services and other proven interventions - Reaching Every Facility Everywhere (REFEW) in all countries
- Strengthen country capacity/competence in programme management, supervision, drug management,

Targets:

- **By end of 2006:**
 - ✓ All countries have developed and started implementing national emergency action plans for TB control.
 - ✓ At least twenty countries (including all nine high TB burden countries) developed medium-long term (5-10 year) national TB control strategic plans and medium-term (3-5 year) implementation/action plans to achieve the MDG TB targets.
- **By end of 2007:**
 - ✓ All countries have developed medium-long term (5-10 year) national TB control strategic plans and medium-term (3-5 year) implementation/action plans to achieve the MDG TB targets.
 - ✓ All countries have completed 100% DOTS coverage to all public health facilities
- **By end of 2010:**
 - ✓ All countries have attained 70/85 targets

8.1.2. Implement collaborative TB/HIV activities

Collaborative TB/HIV activities are in conformity to the published WHO interim policy³⁸, WHO AFRO TB/HIV Control Strategy³⁹ and the Stop TB Strategic Plan 2006-2015. The goal of the TB/HIV strategy is to decrease the burden of tuberculosis and HIV in the African population in the context of the MDG targets for TB and HIV. The

³⁸ World Health Organization. Interim policy on Collaborative TB/HIV activities. WHO/HTM/TB/2004.330. Geneva: WHO, 2004.

³⁹ World Health Organization. TB/HIV Control Strategy for the African Region. WHO Office for the African Region, Harare, October 2004.

strategy is to roll out, in an expedited manner, TB/HIV collaborative activities in all countries. The general objectives of TB/HIV collaborative activities in Africa are to implement WHO interim policy and strategies and to provide joint TB/HIV interventions needed to control HIV-associated TB, expand quality DOTS, and to control HIV. The main strategies are strengthening the health system's response to TB/HIV, decreasing the burden of TB among people living with HIV/AIDS (PLWHA) and decreasing the burden of HIV in TB patients. These interventions are to be carried out as part of the health sector response to the intersecting TB and HIV epidemics as part of the essential health package (EHP) in countries. The interventions/actions are summarised in Table 4.

Table 4 Specific TB/HIV Collaborative Activities for the three strategies

<p>A. Health System Strengthening in response to TB/HIV</p> <ul style="list-style-type: none"> ○ Coordination of TB/HIV activities at all levels ○ Joint TB/HIV planning <ul style="list-style-type: none"> 1. Partnership Development and coordination (National, Community, Public-Private) 2. Resource mobilization and deployment 3. Joint Advocacy, Communication and Social Mobilization 4. Operational Research to enhance TB/HIV collaboration ○ Health system and Infrastructure Development <ul style="list-style-type: none"> 1. human resource development 2. supply management system 3. Health infrastructure ○ Surveillance ○ Supervision, Monitoring and Evaluation (M&E) <p>B. Decrease the burden of TB in PLWHA</p> <ul style="list-style-type: none"> ○ Prevention of TB Infection in PLWHA ○ Intensified TB Case Finding in PLWHA with early diagnosis and treatment of HIV-associated TB ○ Prevention of TB Disease in PLWHA <p>C. Decrease the burden of HIV in people living with TB</p> <ul style="list-style-type: none"> ○ Prevention of HIV in TB Patients ○ Provision of Antiretroviral Treatment for TB/HIV co-infected patients during TB treatment ○ HIV Care and Support for HIV-positive TB patients during and after TB treatment ○ Prevention of Opportunistic Infections in PLWHA with TB
--

Recommended Key Strategic Actions:

Countries

- All countries should accelerate the adoption, adaptation and implementation of TB/HIV interventions in line with the WHO Interim Policy and the AFRO TB/HIV strategy
- Include TB/HIV collaborative activities in development agenda and national health strategic framework
- All Member countries should aim to integrate TB and HIV prevention, care and support activities by 2010. A systematic approach towards **integrated HIV/TB care** is to be undertaken in countries. Integration should be primarily be at the managerial level. Thus, the extent of integration will depend on local circumstances and may vary from strong referral linkages in health facilities where there is separation of the two services, to full integration in institutions where both programs use the same healthcare staff and facilities. A priority for countries is to establish strong links between all the different service providers (TB, HIV, family planning, PMTCT, child health, psycho-social support and other health services) in order to create a **patient-centred approach** to the care of the TB/HIV patient/client.
- **Provision of a basic packet of TB/HIV services in a one stop-shop approach.** As far as possible, a client/patient who enters one programme, through either a DOTS or ART centre, if they exist separately, should provide a basic integrated TB/HIV prevention, care and support service at that entry point. This may consist of:
 - Routine offer of HIV counselling and testing (provider initiated, patient opt out) and diagnostic HIV testing;
 - Early detection and syndromic management of sexually transmitted infections (STIs);
 - HIV prevention measures;
 - Treatment and prophylaxis of OIs,
 - Drug adherence counselling,

- Intensive TB case finding and treatment using DOT,
- Contact and partner tracing,
- Nutritional support,
- Family planning and support,
- Psycho-social support
- Referral to the community HIV/TB services to ensure the use of treatment supporters from PLWHA groups, CBOs, NGOs and community members, who will support patients/clients to improve treatment adherence and community-based DOTS. A strong two-way referral system should be set up between health services and the community including the private sector and special areas such as prisons and refugee camps, schools and workplaces.
- All TB/HIV co-infected patients should have access to free ARV therapy.
- Empower communities to enhance their participation in the planning and implementation of TB and TB/HIV activities.
- TB/HIV Surveillance. Generating evidence through epidemiological surveillance and research is vital for advocacy, programme planning, monitoring performance and impact of programmes. HIV/TB surveillance should be integrated into the existing health information system in countries. Different methods may be used for TB/HIV surveillance:
 - A **baseline survey** of the TB/HIV burden in the country should be established by a one time special survey using representative sampling methods according to international guidelines⁴⁰.
 - Routine surveillance should be systematically and regularly done using the reporting and recording tools. The objective should be to counsel and test more than 90% of TB patients.
 - Sentinel surveys of the TB/HIV prevalence should be linked to the HIV Sentinel Survey (HSS) by the inclusion of TB patients at the HIV sentinel sites every 2-3 years to fine-tune the routine TB/HIV surveillance system.

WHO

- Support countries with technical and financial assistance to implement TB/HIV collaborative activities.
- Support countries to develop national TB/HIV collaborative policy and implementation plans
- Promote and support operational research to enhance TB/HIV collaboration.
- Establish regional TB/HIV working group for the African Region
- Build human resource by supporting and financing training of African consultants, NPOs, key NTP staff in TB/HIV collaborative activities
- Support pre-service schools to include TB/HIV activities in curriculum

Targets

- **By end of 2006:**
 - ✓ At least 20 countries (including all 9 African high TB burden countries) developed and implementing national TB/HIV policies to ensure universal access to collaborative TB/HIV activities including HIV testing for TB patients, active screening of TB among PLWHA and access to co-trimoxazole preventive therapy (CPT) and antiretroviral drugs (ARVs) for HIV infected TB patients.
 - ✓ Research agenda formulated and funds sourced for multi-national TB/HIV research
 - ✓ At least 20 out of 34 high HIV burden countries determined in-country TB/HIV burden
- **By the end of 2007:**
 - ✓ All countries include a TB/HIV component in their long-term (2006-2015) TB Control Strategic plans.
 - ✓ TB/ HIV activities scaled up in at least 23 of 34 high HIV burden countries
 - ✓ African Region TB/HIV working group established and functioning
- **By end 2010**
 - ✓ All countries implementing TB/HIV collaborative activities in all administrative districts

8.1.3. Enhance engagement of NGOs and private sectors

In this TB emergency, all hands in countries should be partnered to be “on deck” to fight the dual epidemic of TB and HIV. Engagement of NGOs, the private sector and others such as Faith Based Organizations (FBOs) in TB

⁴⁰ WHO Guidelines for HIV surveillance among tuberculosis patients, WHO/HTM/TB/2004.339

control is most beneficial. The benefits include efficient utilization of available resources in country, increased access to TB services (resulting in improved case detection and case holding), improvement in treatment outcomes and reduction in the risk of MDR-TB by the use of standardised cases management practices, and reduction of the workload of the over stretched public health services. It, however, needs a strong NTP to provide coordination, technical leadership, logistic support, supervision and monitoring and evaluation. Experience from Ghana has shown that PPP-DOTS implementation works best if the public sector is first strengthened to provide quality DOTS, reoriented and supported to take on the extra and new role of interacting with the private sector and NGOs.

The private public partnership in TB control (PPP-DOTS) should be formed by involvement of all stakeholders in-countries in the planning and implementation of country specific strategic and implementation plans. PPP-DOTS requires a change of paradigm in all partners and establishment of linkage structures to ensure sustainable collaboration. PPP-DOTS is most applicable to urban TB control as most private sector health care delivery institutions are located in these areas. However, FBOs are located in rural areas and can therefore be partnered to provide similar service in those areas.

Recommended Key Strategic Actions:

Countries

- Formulate implementation plans for increased engagement of the private sector in DOTS, TB/HIV and community based DOTS.
- In the next five years scale up implementation of PPP-DOTS in all major cities in each Member country.

WHO

- AFRO has recently formulated a framework for involving the private sector in DOTS implementation⁴¹, which is to be printed and disseminated. This framework will be pursued to support countries to accelerate implementation of the PPP strategy.
- Support countries in the revision of their TB Strategic plans to include PPP-DOTS
- Dialogue with countries supported by GFATM but which do not have a PPP-DOTS component and provide technical support to revise their plans to include PPP-DOTS
- Make inventory of ongoing PPP-DOTS demonstration initiatives in the region and document lessons learnt and best practices.
- Support the incorporation of a PPP-DOTS component in all ongoing TB/HIV and Community TB care initiatives in the Region
- Advocate for more national and international support for private initiatives in DOTS expansion.
- Support the scaling up and sustaining of PPP-DOTS in line with new Stop TB Strategy and Global Plan 2006-2015

Targets

- **By end 2006**
 - ✓ At least all 9 high TB burden countries implementing Public-private partnerships initiatives for TB Control in major cities
 - ✓
- **By end of 2007:**
 - ✓ At least all 34 high TB burden countries implementing PPP-DOTS initiatives for TB control in major cities.
- **By end of 2010**
 - ✓ All countries implementing PPP-DOTS in all major cities

8.1.4. Strengthened Community involvement in TB and TB/HIV care

AFRO has recently published guidelines for community TB care in Africa, based on the results of the “Community TB Care in Africa Project” and lessons from other non-WHO funded and other disease control programme experiences⁴². The experiences of these successful patient-centred and community initiatives have shown the importance of building a partnership between patients, communities and the formal health system.

⁴¹ World Health Organization. Draft: A framework for involving Private Health Care Providers in DOTS Implementation. WHO Office for the African Region. 2004.

⁴² World Health Organization. Draft Guidelines for Implementing Community TB Care Programmes. WHO Office for the African Region. September 2004.

They have demonstrated that this partnership is feasible, cost-effective and acceptable. Moreover, the cultural, traditional and social make-up of African communities offers a very good base to build on to enhance the involvement of patients and communities in addressing the scourge of TB and other killer diseases.

AFRO will therefore pursue the main conclusions and policy recommendations in these guidelines. The aim being to consolidate DOTS and devolve TB care services beyond health facilities to ensure access (especially in rural and poor areas) through forging partnership between communities and the formal health system. The priority is to have best strategies for pro-poor areas. We should first define these areas, identify the obstacles and find strategies to solve them. The community should be involved in planning and in service delivery in a true partnership.

Recommended Key Strategic Actions:

Countries

- Recognise the role of community members in health services through national health policies and promote their contribution through the formulation and implementation of country specific strategic plans which mainstream devolved TB and TB/HIV care into community based health services and initiatives. These plans should include the training and promotion of incentives for community members to empower them to take responsibility for their own health.
- Accelerate the roll out of CB-DOTS in all administrative areas in countries
- Establish a mechanism to ensure a strong link between the formal health system and community members engaged in provision of health services (e.g. institute a salaried focal health worker within the formal public health system to maintain strong link)
- Encourage NGOs and other civil society organisations to promote the involvement of community members in health services and TB care with emphasis of ensuring sustainability.

WHO

- Provide guidance and support countries for the roll out of Community based DOTS (CB-DOTS) in all Member countries.
- Actively pursue the mobilization of new funding for new resources for the implementation of CB-DOTS . New resources include training of care providers, strengthening of health delivery systems such as laboratory services, monitoring and evaluation services and patient follow up. Successful CB-DOTS requires close collaboration between the NTP, the general health care system and the community with the NTP providing technical and other support. This means that the NTP capacity (managerial, logistics, leadership, etc.) must first be built up to take on this extra role. Strong referral, recording and reporting systems, easy access to laboratory services and a secure drug supply system are especially needed to ensure effective CB-DOTS. These should therefore be developed as part of general health system strengthening to ensure smooth and efficient delivery of services.

Targets

- **By end 2006**
 - ✓ at least all 9 high TB burden countries implementing CB-DOTS in some areas in all administrative districts
 - ✓
- **By end of 2007:**
 - ✓ At least all 34 high TB density countries implementing CB-DOTS in all administrative areas.
- **By end of 2010**
 - ✓ All countries implementing CB-DOTS in all districts

8.1.5. Extend DOTS to special areas

The principle of universal access to TB services means that TB control activities should be extended to all areas in countries. There are certain areas that provide unique challenges and opportunities for health service provision and TB control. These areas include prisons, migrants (nomads) communities, internally displaced peoples, refugee camps, the homeless and urban slums. TB control services must include such areas to reduce the herd of infection which invariably affects the whole society. These areas provide specific challenges such as lack of access to health services, poor infrastructure, upheaval, overcrowding and poor environmental sanitation, etc. Very few countries have health services specifically targeting these populations and therefore TB services to them is minimal. Improving health to these populations, however, brings with it many opportunities and benefits. In

addition, health can also be a tool to strengthen respect of human rights and address inequalities to these populations. Work place TB control in an additional area that provides opportunities for TB control to the benefit of NTP that should be taken where necessary.

Recommended Key Strategic Actions:

Countries

- Develop implementation plans for DOTS expansion into special areas in countries.
- Establish partners and provide support for their implementation of DOTS to special areas

WHO

- Support countries to develop implementation plans for DOTS expansion into special areas in countries.

Targets

- **By end 2006**
 - ✓ At least 5 countries implementing DOTS in special areas as part of DOTS expansion.
- **By end of 2007:**
 - ✓ At least 10 countries implementing DOTS in special areas as part of DOTS expansion.
- **By end of 2010**
 - ✓ At least 25 countries implementing DOTS in special areas as part of DOTS expansion.

8.1.6. Improve quality of TB diagnostic services including quality assured laboratory services.

The laboratory is a neglected component of TB control in most countries in the Region. In order to meet targets a massive influx of both technical and financial resources is required to scale up laboratory services and quality. Great emphasis in promoting and strengthening the laboratory network should be placed in implementing this TB control strategy.

Recommended Key Strategic Actions:

- Formulate and implement national strategies for laboratory strengthening with clear plans of action, roles and responsibilities, budget and timeframe, targeting technical and managerial shortcomings with the overall aim of reaching the MDGs. The strategy should include plans for the upgrade of laboratory infrastructure and equipment whenever needed, increase in the use of culture and drug susceptibility testing (DST) according to the new Global Strategy to Stop TB and transfer of appropriate technology and implementation of new tools whenever available. Strengthen the culture capacity in countries for specific indications and research in a phased manner at intermediate level as an essential component of DOTS expansion such that there is a culture facility per ~ 3 to 5 million population in each country by latest 2015. It is important that countries strengthen the external quality assurance (EQA) of smear microscopy in regions/provinces earmarked for culture first before embarking on strengthening culture capacity.
- Design and implement country-specific internal quality assurance (IQA) and external quality assurance (EQA) programmes for sputum smear microscopy.
- Reorganisation/Rationalisation of the TB laboratory networks. Integration/strong collaboration of NTP (public health) laboratories, private sector and other non-public health laboratories and the national reference laboratory (NRL) as a unified country laboratory network would ensure uniformity, efficiency and standardization of laboratory services in countries. Involvement of all key players in the planning and implementation of the reorganization will ensure ownership and belonging leading to full cooperation. This integration/collaboration entails support (financial and material) of non-public health facilities by governments and other donors. However, the benefits of a unified national laboratory network in the early diagnosis and treatment of TB, increase in human resource capacity and efficiency justify this investment.
- Adoption of national standards for methods and laboratory techniques in accordance with the international guidelines
- Decentralization of diagnostic laboratories to all levels so that, on the average, 1 microscopy centre serves 100,000 rural population or 200,000 urban population, while maintaining high efficiency and quality. This is to be ensured by effective supervision and quality control from the immediately superior levels.

WHO

- Elaborate and disseminate a Regional strategy for strengthening TB laboratory services.
- Promote and lead all member countries to formulate national strategies for laboratory strengthening with clear plans of action, roles and responsibilities, budget and timeframe, targeting technical and managerial shortcomings with the overall aim of reaching the MDGs. The strategies should be in conformity with the Global Strategy and the Regional Laboratory Strategic Plan (which is to be formulated in 2006). These include standardization of laboratory documents, implementation of QA system, strengthening the laboratory network capacity by training and supervision, evaluation and reorganization of the TB laboratory networks, upgrade of laboratories, technology transfer and introduction of new tools, scaling up human resources, increase and sustain financial resources, advocacy and communication and monitoring and evaluation of progress.
- Identify, establish and support supra national reference laboratory networks which should collaborate with national reference laboratories.
- In collaboration with member countries, identify and establish/strengthen national reference laboratories in all member countries, starting with the 9 global High burden countries.
- Strengthen regional and/or sub-regional office laboratory human resource capacity
- Build regional laboratory human capacity by sponsoring laboratory management training courses (training of trainers).

8.1.7. Practical Approach to Lung (PAL)Health

The practical approach to lung health is a new initiative that recognises that TB is only part of diseases of the respiratory system and seeks to strengthen the diagnosis of common respiratory diseases including TB. It integrates the recognition of symptomatic presentation of respiratory diseases in the primary health care (PHC) system. Experience has shown that it improves the early detection/diagnosis of TB and improves the diagnosis of sputum smear negative TB which is more common in HIV positive cases⁴³. The implementation of PAL in TB control, particularly when treatment quality is good, would increase the case detection rate, improve outcomes and increase the detection of HIV in TB cases. PAL will be introduced in countries and administrative areas in countries (particularly HBC and high HIV countries) where treatment outcomes are satisfactory to improve CDR.

Recommended Key Strategic Actions:**Countries**

- Develop implementation plans for PAL according to guidelines.

WHO

- Support countries to develop implementation plans for PAL.

Targets

- **2006**
 - ✓ PAL implemented in 5 HBCs
- **2007**
 - ✓ PAL implemented in 10 HBCs
- **2010**
 - ✓ PAL implemented in 20 HBCs.

8.1.8. Ensure Access to high quality Anti-TB drugs

A regular uninterrupted supply of low-cost and high-quality drugs for TB treatment is essential for effective TB control. Since 2001, the Global Drug Facility (GDF) has provided an effective regular supply of such drugs for TB treatment to 1.5 million patients in 30 African countries. It has also provided a direct procurement service of drugs for countries that have sufficient finances but which lack adequate procurement or quality assurance systems. This is to be intensively pursued in the immediate- to mid-term in the Region. However, in order to ensure longer-term sustainability of a regular supply of anti-TB drugs, local capacity in manufacturing, drug management and procurement needs to be strengthened. This is to improve access and ensure sustainability to low-cost and high-quality anti-TB drugs. The use of adequate and standardised drug regimens of fixed dose

⁴³ World Health Organization. Practical approach to lung health (PAL). A primary health care strategy for the integrated management of respiratory conditions in people five years of age or over. WHO/HTM/TB/2005.351. Geneva:WHO, 2005.

combinations (FDC) containing rifampicin throughout the duration of treatment according to WHO treatment guidelines is important for the adequate treatment of TB and prevention of MDR-TB.

Recommended Key Strategic Actions:

Countries

- Ensure access to free high quality anti-TB drugs (both first and second line drugs) to all TB patients.
- Ensure the use of short course Rifampicin based FDC drug regimen throughout treatment according to WHO guideline
- National TB control strategic and implementation plans should include specific activities to enhance local capacity to manufacture anti-TB drugs and enhance technical capacity for drug management.
- Governments should encourage and enhance the capacity of local manufacturing plants to produce quality anti-TB drugs.
- Ministries of Health and Finance should allocate a regular budget to procure anti-TB drugs through the Drug Procurement Service of GDF or other quality assured affordable source according to the national guidelines.

WHO

- Advocate and support the wide scale application of short course Rifampicin based FDC drug regimen throughout treatment according to WHO guidelines
- Support all Member countries to access and use the GDF.
- Support and facilitate, local capacity in manufacturing, management and procurement of anti-TB drugs (both first and second line) in the region.

Targets:

- **By end of 2006:**
 - ✓ 50% of countries using short course Rifampicin based FDC drug regimen throughout treatment according to WHO guideline
 - ✓ At least five countries initiate country specific activities to enhance local capacity to manufacture anti-TB drugs and promote technical capacity of drug procurement and management.
 - ✓ All high burden TB countries assessing services of the GDF.
- **By end of 2007:**
 - ✓ All countries providing access to free high quality anti-TB drugs (both first and second line)
 - ✓ All countries using short course Rifampicin based FDC drug regimen throughout treatment according to WHO guideline
 - ✓ All countries, at the minimum, introduce country-specific activities in their long-term strategic plan (2006-2015) to enhance local capacity in drug procurement and management.
- **By end of 2010**
 - ✓ All countries assessing services provided by the GDF.

8.1.9. Prevention and management of multi-drug resistant TB

The best method of preventing multi-drug resistant TB (MDR-TB) is high quality DOTS which this strategy aims to achieve. However, as TB control programmes have been in existence in the region for many decades there are cases of MDR-TB most of which are not detected or recorded. The vision of the Regional TB Control strategy, which is in line with that of the Stop TB Working Group on DOTS-Plus for MDR-TB, is to integrate drug resistance surveillance (DRS) and the management of MDR-TB as routine components of NTP in order to provide access to diagnosis and treatment for all TB patients (DOTS and DOTS PLUS). Access to TB treatment is a human right and no patient should be denied this even though the costs of MDR-TB treatment are some 300 times those of first line drug treatment.

Recommended Key Strategic Actions:

Countries

- Include TB drug resistance surveillance systems for multi-drug resistant TB in National TB control strategies and implementation plans.
- Develop and implement DOTS-Plus policy
- Build capacity for DRS and DOTS-Plus implementation

WHO

- Provide technical direction and strategic planning for the management and coordination of MDR-TB surveillance and control in the Region in collaboration with the Stop TB Working Group on DOTS-Plus for MDR-TB and other working groups.
- Develop and disseminate Regional strategic plans for DRS and DOTS-Plus
- Establish a Regional GLC for Africa for reviewing and monitoring DOTS-Plus programme implementation
- Support the determination of the magnitude of the problem in Africa by DRS according to international guidelines in selected countries beginning in the high burden countries.
- Build capacity for DRS and DOTS-Plus by training key NTP staff, all NPOs and regional TB consultants.

Targets

- **By end 2006**
 - ✓ At least 8 countries conducted drug resistance survey (DRS) on previously treated cases
 - ✓ At least 8 countries formulated DOTS-Plus policy and implementation plans.
 - ✓ Four countries implementing DOTS-Plus
 - ✓ 18 Consultants, NPOs and NTP staff trained in prevention and management of MDR-TB
- **By end 2007**
 - ✓ Regional GLC established
 - ✓ At least 16 countries conducted drug resistance survey (DRS) on previously treated cases
 - ✓ 12 countries implemented DOTS-Plus strategy
 - ✓ 32 Consultants, NPOs and NTP staff trained in prevention and management of MDR-TB
- **By end 2010**
 - ✓ All countries conducted drug resistance survey (DRS) on previously treated cases
 - ✓ All countries implemented DOTS-Plus strategy
 - ✓ 92 Consultants, NPOs and NTP staff trained in prevention and management of MDR-TB

8.2. Strengthen health service to support DOTS expansion and quality

8.2.1. Strengthen Human resource capacity

Countries and partners need to think “beyond the box” and be innovative to formulate and implement policies to attract and keep human resource for health development and NTP activities. Such innovative package could include the use of part of the “enablers package”⁴⁴ in facility and programme management levels for TB activities and as reward for achieved targets. The strategies to strengthen HR include: planning and formulation of human resources policy ; education, training and skills development ; human resources management; managing the migration of skilled health personnel ; advocacy, and resource allocation.

Recommended Key Strategic Actions:

Countries

- Need to strengthen the managerial and technical capacity of district medical officers in Member States in order to contribute to improved program performance, including an increase in case detection and a reduction in morbidity and mortality due to TB.
- Human resource policies in countries should include introduction of teaching on TB control in medical, nursing, pharmacy and laboratory staff training schools⁷. This involves cooperation with and support for the pre-service training institutions.
- Joint training of TB and HIV staff in TB and HIV control activities.

⁴⁴ The “enablers’ package” is funds specifically budgeted to enable TB patients who have been assessed to be poor, to be supported to continue treatment until cured. It includes funds to support the patient: travel costs, meals, additional non-TB health costs such as blood transfusion, surgical and medical care and other laboratory tests, and support of family to visit patients in hospital. In addition, health care staff are supported to visit patients’ homes before and during treatment (particularly, the critical months of 2, 5 and completion of treatment) to ensure correct addresses and to bring back those patients who have missed DOT or clinic attendance. Provision of meals, drinking utensils, audio-visuals, minor refurbishment etc at DOTS centres and incentives for laboratory staff may also be included in the package.

- Develop and implement HR development and retention plans taking into consideration the health system reform (HSR) and health system integration. To this end, countries should train/sensitise as many health care workers involved in general health care at facility level and not necessarily directly in TB control programmes. This will ensure mitigation of the effect of the high turnover of trained programme staff, reduce stigmatization of TB patients, increase awareness of TB as an important health problem and improve the case detection and management of TB at health facility levels.
- Member countries to rapidly increase the managerial capacity of central management units of the NTP to cater for the many different aspects of TB control. As far as possible, there should be a schedule officer each for human resource development, PPP-DOTS, CB-DOTS and HIV/TB collaboration.
- Countries should partner academia and qualified persons in the private sector in human resource development and monitoring and evaluation of training and programme activities. The involvement of academia in NTP activities would have an added benefit of appropriate pre-service training of health staff.
- Partner with the private sector (see PPP DOTS) to increase the in-country pool of health staff available for TB control activities.

WHO

- Provide technical support for planning and implementing the country actions and for advocating for support from other sectors and partners, both nationally and internationally; the resource mobilization efforts of countries; for countries to address issues that include the review of government policies impacting on human resources, the valuing of health workers and good stewardship, and establishing a task force comprising representatives from countries, institutions, professional associations, or councils, the World Bank and other relevant bilateral and multilateral agencies to give advice on issues concerning health worker mobility and brain drain.
- Identify, train and recruit National Professional Officers (NPOs) to support country offices and NTPs. The NPOs should be seen as part of an extension of the “intensified support and action in countries” (ISAC) initiative⁴⁵ to all Member countries. Experience in Nigeria and India among many others have shown that NPOs generate further momentum towards the MDG targets. The NPOs should be proactive “trouble shooters” who identify weaknesses in programmes and provide solutions. They should be well resourced to help programmes and programme managers while performing advocacy and political mobilization and commitment at all levels in countries. The number of NPOs in each country will vary depending on the country size, the burden of disease and how well the country’s NTP is doing (not too good programmes need more help).
- Scale up the appropriate training of local African consultants in member countries to provide a pool of consultants for NTP human resource development and the monitoring and evaluation of training and programme activities.
- Scale up training of District Medical Officers/District Health Directors in NTP activities. It is at district levels that NTP implementation occurs, yet not all health staff in charge at this level are trained or sensitised on NTP activities. WHO would intensify support for countries to provide local and/or international short course training for such calibre of health staff. Such training would be in collaboration with the HIV/AIDS unit to include TB/HIV collaborative activities.
- Provide support to countries to identify and train teachers of TB control in medical, laboratory and nursing schools in NTP activities. The programme of cooperation with medical, nursing, and laboratory schools and other institutions of training of health staff in the region will be scaled up in order to incorporate the extended DOTS strategy into their curricula.

8.2.2. Strengthened health delivery systems for monitoring and evaluation of programme implementation, outcomes and impact

The routine WHO recording and reporting mechanisms are used to report country data to WHO AFRO and HQ. These will need to be revised and simplified to take into account the new approaches and strategies. M&E should be harmonized in every country with standard minimum information and indicators for all countries to monitor progress towards achieving the MDGs. The Stop TB Department of WHO HQ has recently developed new

⁴⁵ World Health Organization. Intensified support and action countries. Stop TB Partnership. WHO 2004. “The Intensified support and action countries (ISAC) is a special emergency initiative to accelerate DOTS expansion and reach the 2005 targets, within the Global Plan to Stop TB, and ultimately to achieve the 2015 target of reversing TB incidence. ISAC focuses international assistance on and support efforts by the Stop TB Partnership in selected countries through the DOTS Expansion Working Group (DEWG), in order to reach, first, the 2005 targets and, subsequently, the MDGs”.

recording and reporting forms that define a generic, standardised minimum set of essential indicators and optional additional information. They were based on the ‘Styblo’ approach and aligned with TB and TB/HIV indicators and policies.

There is the need to undertake tuberculosis prevalence surveys, to determine the annual risk of infection, (ARI) in at least all high tuberculosis burden countries, to determine the TB/HIV co-infection prevalence in countries, and to monitor drug resistance in countries (particularly high HIV prevalent countries). Regular periodic surveys will enable assessment of progress towards the MDGs.

Countries

- Adapt and implement the new WHO Stop TB recording and reporting forms
- Determine the annual risk of infection of TB, the prevalence of TB and the prevalence of TB/HIV according to international guidelines.

WHO

- Encourage and support the introduction of electronic recording and reporting systems for countries.
- Conduct regular evaluation, reviews of tuberculosis control activities in countries. Best practice cases will be published and disseminated.
- Support the strengthening/development of national TB surveillance systems capable of quarterly feedback through the IDSR system (including e-mail connectivity for data exchange and transfer).
- Support the conduct of TB prevalence surveys, the determination of ARI, the TB/HIV co-infection rates.

Targets

- **By end 2006**
 - ✓ At least 20 high TB density countries using the adapted Stop TB recording and reporting forms
 - ✓ TB and TB/HIV burdens estimated in at least 50% of the high TB and TB/HIV burden countries (HBCs)
- **By end 2007**
 - ✓ New standard WHO recording and reporting system in place in all 46 countries
 - ✓ All countries submitting annual surveillance reports on case finding and treatment outcomes on a regular and timely manner.
 - ✓ TB burden determined in 20 countries including all 9 Global HBCs.
 - ✓ DRS performed in at least all 9 Global HBCs in Africa
- **By end 2010**
 - ✓ DRS and trend determined in at least 50% of member countries
 - ✓ TB burden determined in all high TB density countries.

8.2.3. Implementation of operational research on effectiveness of DOTS expansion and TB/HIV collaborative strategies and the field testing of new diagnostic tools and drugs

The policies, plans and their implementation must be based on sound evidence generated locally, regionally and internationally. To this end, all partners must support and encourage operational and other research that will provide the evidence base for efficient and effective implementation of the strategy. Research should be an integral part of the implementation plans in all countries – an operational and utilization research approach to the planning and implementation of NTP programmes.

WHO

- In collaboration with partners and HQ should set the research agenda according to the needs of the region and countries and source appropriate new funding for such research.
- Ensure that research findings (both local and international) are disseminated, translated into policy and implemented in countries.
- Provide the portal for the field testing of new tools and drugs that are on the horizon.

Targets

- **By end 2007**
 - ✓ Research agenda produced

8.3. Partnership strengthening for TB control

8.3.1. Mainstreaming TB in national development agenda and initiatives

There is a need to increase the visibility of TB as one of the major health problems influencing economic development and, thus, to enhance concerted action to tackle it. Advocacy, communication and social mobilisation activities must be intensified to mobilise political leadership and civil society towards attainment of TB related WHA, MDG and Regional targets.

Recommended Key Strategic Actions:

Countries

- Ministries of Health of Member States to advocate and discuss with ministries of Finance and Economic Planning and Partners Fora to include TB strategies and interventions in the development and revision of development strategies such as PRSPs, METFs, SWAPS and HIPC Initiatives.

WHO

- Liaise with the African Union to ensure that TB control is in the topmost list of African health initiatives, such as the upcoming Health Forum of the African Union.
- Liaise with the Regional Economic Communities (CEN-SAD, COMESA, ECCAS, ECOWAS, IGAD, SADC and UMA) to bring health and TB as a development agenda.
- Advocate for an African Union TB declaration that affirms the extent of the problem and recommends regular reporting to the Heads of State Summit.
- Support Member Countries to mainstream TB as a major item in member countries' development agenda by the production of a toolkit for this purpose and supporting training workshops to write the health component including TB and HIV of their PRSPs.
- Solicit unprecedented level of political commitment and multisectoral involvement at all levels so as to accelerate the implementation of regional TB recommendations and strategies to achieve the MDG TB targets by 2015, and to work towards eliminating TB as a global public health problem by 2050.

Targets:

- **By end 2006:**
 - ✓ At least twenty three of the 46 Member States (including all the nine global high-TB burden countries ⁴⁶) to have mainstreamed TB strategies and interventions in development strategies
 - ✓ All countries to have mainstreamed TB strategies and interventions in their development strategies.
 - ✓ An African Union TB resolution that recommends regular reporting to the annual African Heads of State Summit completed.
 - ✓ At least three Regional Economic Communities recognise health and TB as a developmental issue and committed support.
- **By end 2007:**
 - ✓ All Regional Economic Communities recognised health and TB as a developmental issue and committed increased support.
 - ✓ The first TB regular report to the African Heads of State Summit conducted.

⁴⁶ Democratic Republic of Congo (DRC), Ethiopia, Kenya, Mozambique, Nigeria, Tanzania, South Africa, Uganda and Zimbabwe.

8.3.2. Establish Stop TB Partnerships in Africa to expand Regional and Country level partnerships for DOTS expansion

Effective TB control requires broad-based involvement of national stakeholders' in partnership with the Ministry of Health. National Stop TB Partnerships create the platform for agencies and stakeholders to contribute towards the national TB response and raise awareness for greater engagement and commitment. The establishment of these partnerships is essentially country-specific and need to be sensitive to the cultural and organizational diversities in the country. These Stop TB partnerships, however, need to include HIV/AIDS stakeholders, stronger participation of academic institutions and activist/community representatives.

The aim of establishing the partnership is to consolidate regional and national level political commitment and strengthen partnership among different stakeholders in the regional and countries to improve TB control and accelerate action to achieve the MDG TB targets. The partnership should also provide a forum for the coordination of TB control activities, the planning and implementation of national TB control activities and the sourcing and equitable distribution of funds in a clear and transparent manner.

Recommended Key Strategic Actions:

Countries

- To establish National Stop TB Partnerships in order to accelerate the national response for the TB epidemic.

WHO

- To work closely with the Global Stop TB Partnership in order to establish a Stop TB Partnership for Africa.
- Contribute in the organisation of Stop TB Partner's Forum (2007)

Targets:

- **By end 2006:**
 - ✓ At least five countries of the global high TB burden countries establish National Stop TB Partnerships.
- **By end 2007:**
 - ✓ Stop TB Partner's Forum conducted in Africa.
 - ✓ At least fifteen countries (including all 9 HBCs) established National Stop TB Partnerships
- **By end 2010**
 - ✓ At least 30 countries established National Stop TB partnerships.

8.3.3. Sustainable and increased financial resources for TB control

Unprecedented amounts of aid and efforts are needed to address TB as a regional emergency. This is particularly important as the prospect for reaching the TB-related Millennium Development Goals (MDGs) in a timely manner looks achievable in most parts of the world except for the African continent. This also calls for the international community to take a "bold and comprehensive approach" to aid⁴⁷. This comprehensive approach stated in the Africa Commission Report emphasises: the establishment of partnerships and support to existing pan-African initiatives such as NEPAD; urges the rich countries to provide unprecedented amounts of aid; and calls on Africa to take the lead in the whole process.

Recommended Key Strategic Actions:

Countries

- Commitment of adequate financing from internal resources for TB control activities in all Member States.

WHO

- To mobilise new financial resources and solicit renewed commitments among major donors and stakeholders, and to enhance financial sustainability for TB control in Africa to achieve the MDGs.

⁴⁷ Africa Commission. Our common Interest. Report of the Commission of Africa.
http://www.commissionforafrica.org/english/report/thereport/english/11-03-05_cr_report.pdf

Novel ways to ensure the inclusion of TB control in broader financial and planning frameworks such as PRSPs, MTEFs, PRSCs, SWAPs and HIPC would be sought.

- Would help in the organisation of the high level summit involving major donors, regional agencies and other stakeholders to explore new funding and also reassure the commitment of major donors for sustainable TB funding.

Target:

- By the end of 2006:
 - ✓ African TB financing summit conducted.

9. EXPECTED PROGRAMMATIC PERFORMANCE TARGETS BY 2010

- Stable and strengthened capacity of Regional TB area of work
- All countries supported to maintain up to date TB control medium term plans that include strategies for monitoring progress towards the MDG targets
- Population-wide coverage with DOTS services in all high burden countries as well as in all other member states with less than 100% population coverage with DOTS services by reaching every facility (public, private and special situations) with DOTS services through DOTS expansion initiatives and decentralised delivery of high quality services
- Preventable unfavourable TB treatment outcomes (combined default and transfer out rates) reduced to less than 10% in all countries
- Prevalence and trend of tuberculosis disease determined in all global high burden countries (Ethiopia, DRC, Kenya, Mozambique, Nigeria, Tanzania, South Africa, Uganda and Zimbabwe) and in selected high TB density countries (prevalence rates > 300 per 100,000 population) through representative TB surveys.
- Minimum recommended collaborative TB/HIV activities implemented in all countries according to prevalence of HIV infection in the general population
- Functional National TB microscopy Quality Assurance schemes operational in all high burden countries
- Prevalence of MDR-TB determined in at least one country per epidemiological bloc
- All eligible countries technically supported to apply to the Global Fund Against AIDS, Tuberculosis and Malaria (GFATM) and Global Drug Facility (GDF)
- Regular annual report on regional progress towards WHA and MDG targets developed through a joint meeting of partners and National TB Control Programme managers
- Funding gap for TB control reduced by 50%
- Functional regional and country level inter-agency coordinating committees for TB control
- Operational research on identified priority TB and TB/HIV issues carried out

10. ACTIVITIES, TIMELINES AND MILESTONES

Strategic Area	Activities/Indicators	2006	2007	2008	2009	2010
Improve DOTS coverage and quality in public health facilities	# Countries with 5-10 year (2006-2015) national TB control strategic plans	20	46			
	Development of medium term implementation plans (2006-2010) to increase access to quality DOTS services as part of primary health care systems	20	46			
	# Countries providing universal access to DOTS	10	20	30	40	46
	Development and implementation of National Emergency Action Plans of rolling out of national and district level TB control	46				
Implement TB/HIV collaboration	# Countries which have established national TB/HIV coordinating bodies and started implementing TB/HIV collaborative activities	20	46			
	#Countries with national coverage of TB/HIV collaborative activities	5	20	30	40	46
	# Countries with a TB/HIV component in their long-term (2006-2015) TB Control Strategic plans	20	46			
	# Countries conducted baseline survey of their TB/HIV burden	20	30	40	46	
	# Countries reporting TB/HIV data including surveillance data to WHO	20	30	40	46	
	# Countries providing universal access to ART	20	40	46		
	Human resource capacity building (train each year):					
	Regional and/or sub-regional office	2	2	1		
Consultants	2	2				
NPOs	6	10	10	10	10	
NTP staff	12	10	10	10	10	
Enhance engagement of NGOs and private sectors	# Countries that have formulated strategic and implementation plans for enhancement of the private sector in DOTS, TB/HIV and community based DOTS.	20	46			
	# countries which have scaled up implementation of PPP-DOTS in all major cities	10	35	46		

Strategic Area	Activities/Indicators	2006	2007	2008	2009	2010
Strengthened Community involvement in TB and TB/HIV care	# Countries that have developed and implementing National Emergency Action Plans of rolling out CB-DOTS in all districts	20	46			
	# Countries implementing CB-DOTS in all administrative areas	10	35	46		
	# Countries completed full scale up of CB-DOTS to cover whole population	4	10	20	35	46
Extend DOTS to special areas	# Countries that have developed and implementing National Emergency Action Plans of rolling out DOTS to special areas as part of general DOTS expansion	5	10	15	20	25
Improve quality of TB diagnostic services	Formulate and disseminate a Regional laboratory strategic plan.	Yes				
	# Countries with national strategies for laboratory strengthening	15	46			
	Regional supra national reference laboratory (SNRL) network established	Yes				
	# Countries implementing country-specific internal quality assurance (IQA) and external quality assurance (EQA) programmes for sputum smear microscopy.	15	35	40	46	
	Laboratory human resource capacity building:					
	Regional and/or sub-regional office	1		1		
	SNRLs	2	2			
	NRLs	6	6	6	6	
	Laboratory Training School staff	6	10	10	10	10
	# Countries with functioning NRLs	15	25	35	41	46
	# Countries with rationalised and integrated/unified country laboratory network	15	25	35	41	46
	# Countries with decentralised diagnostic laboratories to all levels meeting targets	5	10	20	30	46
# Countries who have expanded access to rapid TB culture methods	5	10	15	20	30	
# Countries using short course Rifampicin based FDC drug regimen throughout treatment according to WHO guidelines	30	40	46			

Strategic Area	Activities/Indicators	2006	2007	2008	2009	2010
Ensure Access to high quality Anti-TB drugs	# Countries which have initiated country specific activities to enhance local capacity to manufacture anti-TB drugs.	5	10	15	20	25
	# Countries with country-specific activities in their long term strategic plan (2006-2015) to enhance local capacity in drug procurement and management.	20	46			
	# Countries using short course Rifampicin based FDC drug regimen throughout treatment according to WHO guidelines	30	40	46		
	# Countries accessing and using the GDF.	35	46			
Prevention and Management of Multi-Drug Resistance TB	# of countries from which Drug resistance survey (DRS) data on previously treated cases available	8	16	32	40	46
	AFRO strategic plans for DRS and DOTS-Plus formulated	Yes				
	# Countries that have formulated DOTS-Plus Policy and implementation plans	8	16	32	40	46
	# Countries implementing DOTS-Plus	4	12	30	38	46
	Development of Regional GLC		Yes			
	Capacity building:					
	NTP staff trained in DOTS-Plus	8	16	32	40	46
TB consultants trained in DOT-Plus	4	4	4	4		
NPOs trained in DOT-Plus	6	12	30	40	46	