

**Background document prepared for the meeting  
of the 2nd *ad hoc* Committee on the TB epidemic,  
Montreux, Switzerland, 18-19 September 2003.**

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

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## Global targets for TB control

- **World Health Assembly 2005 targets\***  
to detect 70% of smear-positive cases  
to treat successfully 85% of all such cases
- **G8 Okinawa 2010 targets**  
to reduce TB deaths and prevalence of the disease by 50% by 2010
- **Millennium Development Goals 2015 targets**  
Goal 6 Target 8: to have halted by 2015, and begun to reverse, the incidence of priority communicable diseases, including TB (see Millennium Development Goals indicators 23 and 24)

\*In 1991, a WHA resolution proposed that all countries adopt two TB control targets for the year 2000: to detect at least 70% of all new infectious cases and to cure at least 85% of those detected. During the second half of the 1990s, it became apparent that the year 2000 targets would not be met on time. Thus, WHO convened the 1st *ad hoc* Committee on the TB Epidemic in London in 1998, which made a number of recommendations to strengthen the various elements of the DOTS strategy and accelerate impact. The WHA decided in 2000 to postpone the targets initially set for 2000 until 2005.

## List of abbreviations

CCM	Country Coordinating Mechanism
DEWG	DOTS Expansion Working Group
DHT	District Health Team
DOTS	The global strategy to control TB
GDEP	Global DOTS Expansion Plan
GDF	Global Drug Facility
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GLC	Green Light Committee
GPSTB	Global Plan to Stop TB
HBC	High burden country
HIPC	Highly Indebted Poor Countries
HR	Human Resources
HSR	Health System Reform
IEC	Information, education and communication
ILO	International Labour Organization
IMF	International Monetary Fund
IUATLD	International Union Against Tuberculosis and Lung Disease
MDGs	Millennium Development Goals
MDR-TB	Multidrug-resistant tuberculosis
MoU	Memorandum of Understanding
NICC	National Interagency Coordinating Committee
NGO	Non-governmental organization
NTP	National Tuberculosis Programme
OECD	Organization for Economic Cooperation and Development
PHC	Primary Health Care
PFP	Private-for-profit
PNFP	Private-not-for-profit
PPM	Public-Private Mix
PRSP	Poverty Reduction Strategy Process
QA	Quality Assurance
TBCTA	TB Coalition for Technical Assistance
TDR	Special Programme on Tropical Disease Research
UN	United Nations
UNAIDS	Joint UN Programme on HIV/AIDS
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

## Preface

With 8.5 million new cases and nearly 2 million deaths annually, the global TB epidemic has reached an unprecedented scale. Urgent and effective action is necessary to ensure that all those suffering from TB have access to effective care. Setting the mid-term strategic direction for global TB control requires review of progress so far in implementing TB control and analysis of constraints to further progress. Under the auspices of the DOTS Expansion Working Group (DEWG), the 2nd *ad hoc* Committee on the TB epidemic has reviewed progress in global TB control, examined constraints to improved TB control in high-burden countries (HBCs) and sought solutions to these constraints through a wide consultative process during 2003. The results of this work are set out in this background document prepared for the meeting of the 2nd *ad hoc* Committee in Montreux, Switzerland, from 18-19 September 2003. The report on the meeting will contain the Committee's finalised recommendations.

The document covers fifteen themes, of which five were the subject of consultations held in 2003 (on widening the partnership, social mobilisation and advocacy, primary care providers, health system reform and human resources). The Committee sees the main challenge for global TB control as expanding TB control activities across all health care providers and other stakeholders within the health sector, and across a broader range of stakeholders in sectors beyond health.

The Committee's work is in the context of the United Nations (UN) Millennium Development Goals (MDGs). These provide an unprecedented framework and opportunity for international cooperation in redressing the global injustice of poverty, including improving the health of the poor. The Committee recognises health as both a human right and a contributing factor in poverty reduction. Although the MDGs' strategic perspective is global, the Committee acknowledges the importance of regional approaches to meeting the goals, since the rate of progress towards meeting the MDGs varies between regions (e.g. based on current trends, sub-Saharan Africa will not meet the poverty or health MDGs until half way through the next century). Regional and national Stop TB partnerships are necessary to translate the global perspective into country-level action and accelerate progress towards targets.

Progress in TB control can contribute to improved health and poverty reduction, and depends on actions which are beyond the specifics of TB control. Thus TB control is an integral part of the broad strategy for improving health and reducing poverty. **This implies that for further progress in TB control, the TB constituency must reach out to the broader constituency of governments and agencies committed to accelerating health improvement and poverty reduction. This broader constituency must also support TB control as part of its contribution to achieving the MDGs.**

## 1. Introduction: the problem and need

In 1998 the 1st *ad hoc* Committee on the TB Epidemic issued its landmark report, describing the constraints to global tuberculosis control.<sup>1</sup> There has been substantial progress (see section 2) since the Committee's report. However, much remains to be done. Globally, treatment success under DOTS had reached 82% (for the cohort of patients registered in 2000) yet case detection under DOTS was only 32% (in 2001).<sup>2</sup> If the current rate of DOTS expansion is maintained, the WHA 70% case detection target will be reached not by 2005, but only by 2013.<sup>2</sup> If that target is to be reached, DOTS programmes must improve case detection within designated DOTS areas (including all public and private health providers) and must expand to new areas.<sup>2</sup> Rates of treatment success must be improved under DOTS in some countries, especially those in sub-Saharan Africa, to reach the 85% target for treatment success.<sup>2</sup>

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

The time is now ripe to review progress in global TB control and re-examine the current constraints that are limiting full, effective implementation of the DOTS strategy. The following balance sheet summarises progress.

The positive side of the balance sheet shows the achievement of a crucial sequence of key milestones in international commitment, planning and progress in some regions:

- increased funding flows for TB control, e.g. through the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM);
- a series of implementation steps internationally, e.g. flow of anti-TB drugs through the Global Drug Facility (GDF) and in many countries, e.g. expanded implementation of the DOTS strategy and improved case detection;
- a decreased estimated TB incidence rate from 1997 to 2000 (%/year) in the American (- 4.1%), Eastern Mediterranean (- 1.4%) and South-East Asian (- 1.3%) Regions.

However, the negative side of the balance sheet shows:

- insufficient international commitment to, and planning for, actions beyond the current scope of the main stakeholders in TB control;
- a funding gap for TB control, largely representing the funding necessary to strengthen the general health service infrastructure and to provide high-quality technical support to countries;

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<sup>1</sup> World Health Organization. Global Tuberculosis Programme. Report of the ad hoc Committee on the Tuberculosis Epidemic. London 17-19 March 1998. Geneva, Switzerland, 1998. Document WHO/TB/98.245.

<sup>2</sup> World Health Organization. Global Tuberculosis Control: Surveillance, Planning, Financing. WHO Report 2003. Geneva, Switzerland, WHO/CDS/TB/2003.316.

- inadequate achievement of progress towards the 2005 targets globally for case detection and in particular regions for treatment success (72% in Africa and 77% in Europe);
- an increased estimated TB incidence rate from 1997 to 2000 (%/year) in the African (4.3%) and European (2.8%) Regions, with no change in the Western Pacific Region.

The Stop TB Partnership and WHO in particular thus need a clear strategic direction for full and accelerated implementation of global TB control measures as part of the GPSTB.<sup>3</sup> The purpose of convening the 2nd *ad hoc* Committee is to identify this strategic direction over the next 5 years for the Stop TB Partnership and, through its working groups, to implement global TB control as part of the GPSTB, achieve the WHA 2005 targets and make progress towards achieving the MDGs 2015 targets.<sup>4</sup> The 5 year timeframe allows for the 2nd *ad hoc* Committee to take a realistic approach in making actionable recommendations. It will inevitably be necessary to make further changes in strategic direction in the future beyond the 5 year timeframe. The Committee's recommendations will be relevant to the wide range of stakeholders in global TB control. WHO has a special role as a) the lead UN agency for health, b) the host of the Stop TB Partnership, and c) as the coordinating secretariat of the three implementation working groups (DOTS Expansion, TB/HIV, and DOTS-Plus).

The Stop TB Partnership promotes DOTS expansion and achievement of the 2005 WHA targets mainly through the activities of the three implementation Working Groups. However, to achieve the 2005 WHA targets and, beyond these targets, to make progress towards achievement of the 2015 MDGs, DOTS implementation must face broad health sector issues. These issues include the health infrastructure, human resources (HR), primary health care (PHC) service provision, social mobilization for health, private sector and corporate sectors' contributions, poverty alleviation strategies and equity initiatives. If the targets and goals are to be achieved, the Stop TB Partnership must dramatically widen its current scope to address these issues effectively.

Finally, new TB control tools (drugs, diagnostics and vaccines) are needed to facilitate and improve DOTS implementation. Thus, while energetically promoting DOTS implementation, the Stop TB Partnership also advocates for, and supports, efforts to develop new tools, mainly through the activities of the research Working Groups (i.e. Global Alliance for new TB drugs, TB Diagnostics Initiative and TB Vaccines Initiative).

Section 2 of this document describes progress since 1998 in implementing the 1st *ad hoc* Committee's recommendations, along with issues not covered by the 1st *ad hoc* Committee. Section 3 details the recommendations arising from the consultation process (described in annex 4). Annex 1 provides a summary of the current status of the global TB epidemic and of global TB control. Annex 2 outlines the constraints to achievement of the WHA 2005 targets by the 22 high-burden countries and the challenges in overcoming them. Annex 3 outlines the current approach of the Stop TB Partnership.

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<sup>3</sup> Stop TB Partnership. The Global Plan to Stop Tuberculosis. World Health Organization, Geneva, Switzerland, 2002. Document WHO/CDS/STB/2001.16.

<sup>4</sup> [http://unstats.un.org/unsd/mi/mi\\_goals.asp](http://unstats.un.org/unsd/mi/mi_goals.asp)

## 2. Progress in meeting the 1998 London *ad hoc* Committee recommendations

### Introduction

In 1991, a WHA resolution proposed that all countries adopt two TB control targets for the year 2000: to detect at least 70% of all new infectious cases and to cure at least 85% of those detected.<sup>5</sup> During the second half of the 1990s, it became apparent that the year 2000 targets would not be met on time. Thus, WHO convened the 1st *ad hoc* Committee on the TB Epidemic in London in 1998, which made a number of recommendations to strengthen the various elements of the DOTS strategy and accelerate impact.<sup>1</sup> The WHA decided in 2000 to postpone the targets initially set for 2000 until 2005.<sup>6</sup>

This section reviews the global progress since 1998 in meeting the recommendations of the 1st *ad hoc* Committee.<sup>1</sup> First, there is a review of the milestones in the global response to TB since 1998. Secondly, there is an assessment of the achievements and problems which are still unresolved for each of the main recommendations set out in the report of the 1st *ad hoc* committee: political will and commitment; financing; human resources; organization; management; anti-TB drugs; information; and research. Thirdly, there is an assessment of additional key issues not fully covered by the 1st *ad hoc* Committee: health infrastructure; primary care providers; HIV-related TB (TB/HIV); private (corporate) sector contribution; poverty alleviation strategies and equity initiatives; TB technical assistance; and the special role of WHO.

### Milestones in the global response to TB since 1998

Events in global TB control since 1998 have owed a great deal to the recommendations of the 1st *ad hoc* committee, including the establishment of a global alliance named The Global Partnership to Stop TB,<sup>7</sup> the creation of a Global TB Drug Facility (GDF) providing quality anti-TB drugs to countries in need,<sup>8</sup> a Ministerial Conference in Amsterdam in March 2000 to call for renewed political commitment,<sup>9</sup> and a strategic focus on 22 highest-burden countries, responsible for 80% of the global TB incidence.

In May 2001, a Global DOTS Expansion Plan (GDEP) was published.<sup>10</sup> The GDEP is based on two pillars: the preparation of mid-term (at least 5 years) DOTS expansion plans

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<sup>5</sup> World Health Organization. Forty-fourth World Health Assembly. Resolutions and Decisions. Resolution WHA 44.8. Geneva, Switzerland, 1991. WHA44/1991/REC/1.

<sup>6</sup> World Health Organization. Fifty-third World Health Assembly. Resolutions and Decisions. Resolution WHA 53.1. Geneva, Switzerland, 2000.

<sup>7</sup> Stop TB Partnership. Annual Report 2001. Geneva, Switzerland, 2001. Document WHO/CDS/STB/2002.17.

<sup>8</sup> Stop TB Initiative. Global TB Drug Facility - Prospectus. World Health Organization. Geneva, Switzerland, 2001. Document WHO/CDS/STB/2001.10a.

<sup>9</sup> Stop TB Initiative. Amsterdam 22-24 March 2000 - "Tuberculosis and Sustainable Development". Report of a Conference. World Health Organization. Geneva, Switzerland, 2000. Document WHO/CDS/STB/2000.6.

<sup>10</sup> Global DOTS Expansion Plan - Progress in TB control in high-burden countries 2001, 1 year after the Amsterdam Ministerial Conference. World Health Organization, Geneva, Switzerland, 2001. Document WHO/CDS/STB/2001.11.

in all countries and the establishment of national interagency co-ordination committees, or similar mechanisms, ensuring that all national partners contribute to the implementation of the national plan. In October 2001 the GPSTB was launched, specifying the costed activities in implementation and research needed to reach the WHA targets in 2005.<sup>3</sup>

After the 2000 G8 summit in Okinawa, the leaders of the world's richest countries announced an ambitious commitment to achieve substantial reductions in the global burden of HIV/AIDS, TB and malaria by 2010. Established after the 2001 G8 summit in Genoa, the Global Fund for AIDS, TB and Malaria (GFATM) aims to bridge the funding gap to control these diseases. The disbursement of funds in the first two rounds so far to countries which received approval for their TB control proposals represents a significant step in increasing resource flows for TB control in high TB incidence countries.

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

## **Issues covered by the 1st *ad hoc* Committee**

### *1. Political will and commitment*

In general, building political will and commitment among the politicians, government officials, and other key decision-makers at each level (globally, nationally and locally within countries) requires both direct persuasion and popular pressure. In response to direct persuasion by UN agencies, donor governments and agencies, and large foundations, senior political leaders have expressed their political commitment to TB control at a number of international conferences. Convened in response to the 1st *ad hoc* Committee recommendation, the international Ministerial Conference in Amsterdam in 2000 called for renewed political commitment to global TB control, through the "Amsterdam Declaration to Stop TB".<sup>9</sup> Ministerial representatives from 20 HBCs representing 80% of the global TB burden declared that. "The magnitude of suffering and death caused by the global tuberculosis pandemic is both alarming and unacceptable." and made a commitment to, "Ensuring that sufficient human and financial resources are available on a sustainable basis and expanded to meet the challenges of stopping TB".

African Heads of State at the summit in Abuja in 2000 affirmed their political will and commitment to contribute increased resources to control HIV/AIDS, TB, malaria and other diseases. Subsequently, attendees at the Stop TB Partners Forum in Washington in 2001 issued the "Washington Commitment to Stop TB". Representatives of 20 HBCs

committed to further operationalising the Amsterdam Declaration by “undertaking urgent and accelerated action against TB”.

However, in spite of these public pronouncements in international settings, national leaders have not always demonstrated actions to increase resources to control TB commensurate with their stated commitment. Thus, the challenge is not only to obtain high-level public commitments and to generate national political will, but also to translate this political will into appropriate public policy.

Whereas the generation of political will, as described in the 1st *ad hoc* Committee report, involves enhancing public perception of TB, heightening external concern, and using mass media to gain attention, the step of translation requires the application of persistent, public and behind-the-scenes pressure at national and local levels, to ensure that the pledges are kept and appropriate policies are enacted. Ideally, in the case of TB, this pressure should come from advocacy and lobbying activities of national and local TB and other health interest groups. However, few HBCs have well-organized TB interest or activist groups. Organizing *de novo* or activating such groups should be an important activity of national TB partnerships, especially in HBCs.

Although global advocacy must continue to ensure high-level political commitment, much more must be done at the national and sub-national level to enhance advocacy activity to include a broader range of activity to directly persuade (i.e. lobby) governments including their administrative offices and legislative bodies to develop and enact appropriate public policies. Similar to the approaches used to provide programmatic technical assistance, advocacy efforts directed not only to political will but also to appropriate public policy must be developed or mobilized under local ownership and direction.

For efforts to increase political will and develop appropriate public policy to be effective, it has become increasingly clear that communications, social mobilization and advocacy activities cannot be used in isolation from one another. Moreover, securing political commitment should not be the only goal: there must be equal emphasis on the development of policy, as noted above. To secure the political will and the public policy necessary for DOTS expansion, these activities must be integrated into targeted strategies at national and sub-national levels. Understanding the interdependence of these strategies, as well as their application on all levels, is critical to achieving the desired outcomes. Thus, having a coordinated, integrated multifaceted effort to build political will and to translate the political will into effective public policy is an essential prerequisite to the expansion of effective DOTS programmes.

Just as the case detection rate or treatment success rate provide a quantitative indication of the coverage and effectiveness of implementation of the DOTS strategy, it is essential that at least semi-quantitative indicators be used to assess the effectiveness of political will. Such indicators should be developed recognizing the circumstances and policy context, including government administrative structures and legislative bodies, of HBCs.

Innovative efforts in advocacy and communication are also needed. In addition to considering how to implement the DOTS strategy as a technical solution to TB control, creative and strategic thinking is required to identify how communication, social mobilization, and advocacy can be integrated and applied strategically in support of the DOTS strategy that in turn will enhance case detection, improve treatment success rates. Moreover, there is an urgent need for in-country communication, social mobilization, and advocacy directed at the rapid building of political commitment at the national and sub-national levels. Achieving a higher order of commitment and at all administrative levels of the health service delivery system (referred hereafter as “administrative mobilization”) is particularly crucial for TB control.

Strategies are needed to facilitate and empower communities to develop and take ownership of the policy and programmatic agendas for the elimination of TB. The Stop TB movement needs to mobilize whole communities, civil society groups, health sector organizations, and local leadership at the grassroots, to ensure that the poor and the vulnerable are not missed. Efforts from the outside must avoid the danger of undermining local ownership and direction of these groups. To catalyze and facilitate such processes, NTPs need strong, sharply defined and inclusive communication, social mobilization and advocacy strategies. However, a rapid assessment of capacities in the 22 HBCs commissioned by the Stop TB Partnership has revealed that many countries lack communications staff, budgets and well-elaborated country communication strategies. Further, additional effort is needed to fully integrate the continuum of strategies.

Accomplishing the range of advocacy activities required to generate the political climate and appropriate policies to enable the implementation of effective DOTS programmes is a challenge that will require an integrated global and country-by-country effort. The Stop TB Partnership is well positioned to undertake the leadership of such an important effort.

The 1st *ad hoc* Committee recommended the development of a Global Charter on TB, as an instrument to formalise a global public commitment by the wide range of stakeholders to take the actions necessary to control TB. The stakeholders include WHO, the World Bank and other multilateral financial institutions, bilateral development assistance agencies, the IUATLD and other non-Governmental Organizations (NGOs), philanthropic institutions, governments, national NGOs and associations, civil society and the private sector. Progress in the development of the Charter has so far been limited.

## *2. Financing*

### Estimates

The GDEP estimates that at least 1.2 billion US\$ are needed yearly to achieve the 2005 targets. Sixty-nine percent of the need was estimated to be covered (including pledges) by the governments of the endemic countries, while the financial gap was around 300

million US\$ annually.<sup>11</sup> The GPSTB confirmed, using slightly different methods, that a total 6 billion US\$ would be needed during the next 5 years to achieve the targets.

### Funding gaps for HBCs<sup>2</sup>

In 2002, it was estimated that during the period 2001-2005, a total of around US\$1 billion per year was required for the 22 HBCs to reach the global control targets<sup>11</sup>. The funding gap was estimated as an average of up to US\$300 million per year. Recently, these estimates have been revised based on new epidemiological data, new funding announcements, a review of GFATM proposals and data collected through the WHO Global Financial Monitoring Project established in 2002. The revised estimates indicate that around US\$1.3 billion will be required in 2004, and US\$1.4 billion in 2005. The funding gap is estimated at around US\$150-300 million for 2004, and US\$150-350 million in 2005.

There are two main sources of uncertainty in the existing estimates of resource requirements and funding gaps. One is that for several countries, it is not clear to what extent health services have the capacity to manage a large increase in TB patient caseload with existing staff and infrastructure. The second is that for most countries, it is not clear to what extent reaching the case detection target requires only “more of the same”, and to what extent it requires new approaches to case finding and treatment such as public-private mix, public-public mix and social mobilisation initiatives. While data exist on the costs of existing approaches, data on the costs of new strategies (and the funding gaps associated with them) are scarce or non-existent. More precise definition of funding requirements and funding gaps will require a country-by-country analysis of where the missing cases are, what strategies are needed to identify and successfully treat these cases, and what these strategies will cost.

### Global Fund to fight AIDS, TB and Malaria

Since its inception in 2001, the GFATM has made significant funding contributions to TB control. The extent to which the GFATM will meet the necessary additional resources identified in the GPSTB depends on its capacity to mobilise additional resources. In 2002, the GFATM announced in the first round of grants the approval of 16 applications for funding for TB control, for a total of US\$ 176 million over 2 years, including applications from the following HBCs: China, Ethiopia, India, Indonesia, South Africa (for HIV/AIDS and TB), Thailand and Viet Nam. In 2003, the GFATM announced in the second round of grants the approval of 27 applications for funding for TB control, for a total of US\$ 122 million over 2 years, including applications from the following HBCs: Afghanistan (for TB, HIV/AIDS, and malaria), Cambodia, DR Congo, India, Kenya, Myanmar, Mozambique, Nigeria, Pakistan, the Philippines, and Uganda. Except in the case of the Philippines (where more funding is required) acceptance of the above proposals will close or significantly reduce the estimated funding gap for TB control in 2003 in these HBCs. GFATM grants to some countries for joint TB and HIV programme

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<sup>11</sup> Floyd K, Blanc L, Raviglione MC, Lee JW. Resources required for global tuberculosis control. *Science* 2002; 295: 2040-1.

activities should help to overcome the common problem of separate funding of TB and of HIV programmes as a barrier to their collaboration.

#### Financial flows

To sustain and expand NTP activities, NTPs need reliable and regular funding. Unreliable and/or irregular financial flows from funding sources (national budgets and international development assistance partners), constrain effective NTP planning and implementation.

### *3. Human resources*

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

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

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

### *4. Health system organization*

Common themes in health system organization (i.e. health reforms) include integration, decentralisation and increasing privatisation. Exemption of TB diagnosis and treatment from cost-recovery strategies is important, based on the principle that individuals with TB should not have to pay for the community benefits accruing from treatment of individuals. There has been progress in understanding the implications of health reforms for TB control, and ways in which NTP managers can best position NTPs to overcome

challenges and maximise opportunities.<sup>12</sup> Ministries of Health need to ensure that the framework for TB control is tailored to reflect the priorities and strategies of the overall health system, and builds on the strengths of the PHC network for delivery of TB control services. Health reforms vary considerably among countries depending on variables such as the political aim of the government, the influence of donors and other partners, and the current stage of the process. Thus, it is not surprising that NTPs in different countries have met with varying degrees of success in ensuring that the operational practicalities of changing health systems incorporate all the components of the DOTS strategy.

### *5. Management*

Although many NTP personnel and others involved in TB control at different levels exercise considerable managerial responsibilities, few have acquired managerial expertise through “hands-on” training. More formal development of managerial capability among these personnel would help to ensure high-quality managerial performance.

### *6. Anti-TB drugs*

The 1st *ad hoc* Committee stressed the importance of ensuring access to high quality anti-TB drugs for DOTS implementation. At the Amsterdam Conference on TB and Sustainable Development in March 2000, the HBCs called for a new initiative to increase access to high quality anti-TB drugs. In response, the Global Partnership to Stop TB launched the GDF in 2001.<sup>8</sup> The GDF, which is hosted by WHO, is managed by the secretariat of the Global Partnership to Stop TB. It aims to provide anti-TB drugs to treat up to 10 million patients, in assisting countries to reach the 2005 WHA TB targets.

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

The GDF has already made significant progress in fulfilling its mission. In its first year of operation, the main activities of the GDF were to: a) set up systems and processes for applications, review, procurement and monitoring; and b) process the drug orders of the initial countries approved for support. In the second year of operations these systems and processes were finalised and the GDF moved from an interim operation to a full procurement mechanism. The main activities continued in 2002 and additional activities were to: a) set up systems for countries to buy drugs through a direct procurement mechanism; b) set up systems to ensure that countries and agencies (including GDF) can identify quality assured TB products; c) monitor countries that had received drugs.

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<sup>12</sup> World Health Organization. Expanding DOTS in the context of a changing health system. Geneva, Switzerland, WHO/CDS/TB/2003.318.

By August 2003, the GDF had received applications from 70 countries of which 46 have been approved for support. It has placed 37 orders for TB drugs. The number of countries which have received deliveries of TB drugs from the GDF has now risen to 27 whilst the total number of patients approved for treatment stands at 1.9 million. Two countries have purchased low cost TB drugs through the direct procurement mechanism. Other countries are currently negotiating to purchase drugs through the GDF Direct Procurement mechanism. The GDF has established a robust and standardised mechanism for pre-qualification of manufacturers of TB drugs with the assistance of the WHO Department for Essential Drugs and Medicines. The establishment of a stockpile of GDF products has improved the ability of the GDF to respond rapidly to countries needing drugs.

The GDF has also had a catalytic impact on DOTS expansion going beyond the provision of drugs. More countries are developing DOTS expansion plans and introducing policies based on the DOTS strategy, as part of the GDF application process. Furthermore, several countries are developing plans for improving drugs management and others are receiving additional technical and financial assistance which builds on a successful GDF application. However, despite all the established benefits of the GDF, by August 2003 the GFATM had not used the GDF as the means to procure first-line TB drugs for any countries receiving GFATM support, and the GDF is facing a severe funding shortage.

In addition to progress in improving the availability of first-line anti-TB drugs through the GDF, there has also been substantial progress in improving the availability of high quality, second-line anti-TB drugs at low-price. This has been achieved through the Green Light Committee (GLC), which is hosted by WHO and managed by the secretariat of DOTS-Plus Working Group. The six members of the GLC represent WHO, NGOs, HBCs and others. The GLC operates by supporting those MDR-TB endemic countries in preparing and reviewing proposals to tackle MDR-TB, supporting those proposals which meet international standards established by the DOTS-Plus Working Group, facilitating procurement of high quality second-line anti-TB drugs at prices which may be 95% lower than those on the open market, and monitoring their use and treatment outcomes.

## *7. Information*

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

On the one hand, there has been considerable progress in adoption of the WHO/IUALTD monitoring system, as more and more countries have come under the DOTS classification. There has also been considerable progress in global monitoring, with the creation and further refinement of country-specific estimates of TB incidence data, and the on-going collection and analysis of data from all countries resulting in, among other

things, an annual report on epidemiology, planning, and financing. Routine monitoring has enabled measurement of progress toward the global targets.

On the other hand, coordination and comprehensiveness of national monitoring systems is still often lacking, with some sectors (e.g. government institutions, private practitioners, health management organizations, employer health programmes) being incorporated slowly. High TB incidence countries have seen little progress in introducing or adapting existing legislation regarding reporting by all sectors involved in TB control, as recommended by good practice in legislation.<sup>13</sup> Also, country missions and regional discussions suggest that the WHO/IUATLD monitoring system has been implemented with varying levels of understanding, that the classical system of quarterly reporting in aggregate is insufficient for some countries' needs, and that TB data management and transfer in developing countries (with increasing computer access) is not always very efficient. Finally, despite progress at the global level in using available data to make the best estimates possible, most HBCs have no recent prevalence surveys (of infection or disease), and thus rely on routine monitoring data only in interpreting their progress.

## 8. Research

The 1st *ad hoc* Committee stressed the importance of research to improve TB control, including research to contribute to DOTS implementation. In the short term, there is a need to scale up research to determine the best ways to implement and monitor the impact of current interventions of proven effectiveness. Scaling up of implementation of the current interventions to achieve the goals of the GPSTB requires not only use of existing approaches of proven effectiveness, but also operational research to identify new, more effective approaches and strategies suited to local circumstances. Operational research capacity is an essential component of NTPs. Such capacity entails the ability and mechanisms to collect, analyze, interpret, and act on results. Such capacity is essential to enable NTPs to identify existing weaknesses and adapt effectively to new circumstances.

In the longer term, new tools will facilitate the achievement of the GPSTB goals (e.g. a more effective vaccine,<sup>14</sup> better diagnostic tests<sup>15</sup> and preventive<sup>16</sup> and therapeutic<sup>17</sup> approaches). Milestones in supporting and promoting TB research since the 1st *ad hoc* Committee report include the establishment of the new tools working groups under the auspices of the Stop TB Partnership (i.e. the Global Alliance for New TB Drugs, the TB Diagnostics Initiative and the TB Vaccines Initiative) and the increased funding for TB research, particularly from private sources, e.g. the Bill and Melinda Gates Foundation.

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<sup>13</sup> World Health Organization. Good practice in legislation and regulations for TB control: an indicator of political will. World Health Organization, Geneva, Switzerland, 2001. Document WHO/CDS/TB/2001.290.

<sup>14</sup> Young DB. Current tuberculosis vaccine development. *Clin Infect Dis* 2000; June 3 Suppl 3: S254-6

<sup>15</sup> Perkins MD. New diagnostics for tuberculosis. *Int J Tuberc Lung Dis* 2000; 4 (12): S182-S188.

<sup>16</sup> Centers for Disease Control and Prevention. Prevention and treatment of tuberculosis among patients infected with human immunodeficiency virus: principles of therapy and revised recommendations. *MMWR* 1998; 47 (No. RR-20: 1-58).

<sup>17</sup> Barry CE 3rd, Slayden RA, Sampson AE, Lee RE. Use of genomics and combinatorial chemistry in the development of new antimycobacterial drugs. *Biochem Pharmacol* 2000; 59: 221-31.

Widespread recognition of the importance of TB among the basic research community has accompanied major advances in understanding TB biology over the last decade. These advances are now being translated into progress in the search for new tools. Given the current level of activity in these research areas and their relevance to global TB control, the new tools working groups must be in close contact and have collaborative relationships primarily with the DEWG but also with the other two implementation working groups. The Stop TB Partnership provides the framework for this interaction.

A wide range of novel diagnostic tests for clinical tuberculosis is currently under investigation within the framework of the TB Diagnostics Initiative,<sup>15</sup> promoted by the WHO Special Programme for Tropical Diseases Research (TDR) with substantial support from the Bill and Melinda Gates Foundation. A new diagnostic test to identify latent tuberculosis infection has been developed, studied and is currently being marketed.

New drugs are being developed and tested by the Global Alliance for TB Drug Development, a partnership that brings publicly-funded researchers together with researchers from major pharmaceutical and smaller biotech companies.<sup>18</sup> A “Blueprint for TB Drug Development” has been prepared and a pharmacoeconomic analysis has been completed. Both of these documents provide crucial underpinnings for drug development. Testing the potential usefulness of new fluoroquinolones is just getting underway and analogues of current anti-TB drugs are being examined.

There are obvious and enormous potential benefits of a more effective vaccine, especially one that is effective in persons with latent TB infection or who have previously received BCG. There is substantial progress in vaccine development with 3-5 candidate vaccines now entering phase one testing. Preparation of sites for clinical trials is now under way to avoid any unnecessary delays by the time a candidate is ready for phase three trials. The TB Vaccines Initiative has plotted a strategy and developed a work plan, with estimates of necessary funding. The European Community and the National Institutes of Health in the USA are funding major TB vaccine research programmes, with new candidates now entering the early stages of clinical trials. Progress in this challenging area depends on effective partnerships between vaccine developers and trial sites in HBCs.<sup>19</sup>

While the main impact of new tools will occur beyond the 5 year time frame of the new strategic direction for DOTS implementation, substantial support is essential for the current crucial phase of translational research. A key role of the Stop TB Partnership is to provide a forum for aligning the opportunities provided by the research community with the needs of TB control service providers. The DEWG strongly advocates the strengthening of research for global TB control as set out in the GPSTB.

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<sup>18</sup> Scientific blueprint for tuberculosis drug development. *Tuberculosis (Edinb)*. 2001;81 Suppl 1:1-52.

<sup>19</sup> Brennan MJ, Fruth U. Global Forum on TB Vaccine Research and Development. World Health Organization, June 7-8 2001, Geneva. *Tuberculosis (Edinb)*. 2001;81(5-6): 365-8.

## **Additional key issues not fully covered by the 1st *ad hoc* Committee**

Achieving the 2005 WHA targets depends on the Stop TB Partnership addressing additional key DOTS expansion issues not fully covered by the 1st *ad hoc* Committee. Approaches to these issues may go beyond the current scope of Partnership activities.

### *1. Health infrastructure*

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

The Commission on Macroeconomics and Health has estimated the global funding needs for the general health infrastructure and the necessary improvements to provide the essential package of care with full population access.<sup>20</sup> The estimated total annual financial need to deliver the essential package of care globally is \$57 billion (\$26 billion for disease-specific activities and \$31 billion for general health infrastructure improvements). Achieving global targets for health, including TB targets, requires investment in the general health infrastructure as well as in the disease-specific activities which constitute the essential package of health care. Those concerned with TB control must join forces with those concerned with delivering the overall essential package of care to demand the necessary investments in general health infrastructure improvements.

### *2. Primary care providers*

The wide range of primary care providers includes the various branches of the Ministry of Health (and other relevant ministries, e.g. Ministry of Justice responsible for health in prisons), NGOs, private practitioners, religious organizations, employers and community groups. In many countries the main focus of activities to strengthen TB control has been on TB care delivery through government health facilities (and even in some countries on TB care delivery through certain branches of the government health facilities). Increased access to TB care depends on harnessing the full range of primary care providers. This requires certain conditions which many countries have not yet fulfilled. In many countries, Ministries of Health have not yet developed and implemented policies for the full involvement of all branches of the government health services in delivering TB care, developed frameworks of collaboration with non-governmental providers (e.g. private practitioners and NGOs), or developed NTP management capacity to enable them to play a full role in stewardship of primary care activities which contribute to TB control. In many countries, development assistance partners and the governments of high TB incidence countries have not yet ensured adequate funding for TB control as part of the

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<sup>20</sup> World Health Organization. Report of the Commission on Macroeconomics and Health. Macroeconomics and Health: Investing in Health for Economic Development. Geneva, Switzerland, 2001.

essential package of health care. Adequate funding implies the funding necessary to enable NTPs to achieve and sustain the targets for treatment success and case-finding.

### *3. TB/HIV*

The 1st *ad hoc* Committee made no specific reference to the problem of HIV-related TB. Since 1998, the increasing impact of HIV on TB has had implications for all the issues discussed in this report. Recommendations relevant to each issue should therefore take into consideration the specific implications of the impact of HIV on TB.

### *4. Corporate sector contribution*

The Global Partnership to Stop TB has yet to develop strong relationships with the corporate sector, even though this sector has the potential to contribute to global TB control (in DOTS implementation, communications and resource mobilisation). The Stop TB Partnership has produced “Guidelines for workplace TB control activities”, to guide employers on the contribution of TB control activities in the workplace to community TB control. Substantial scope remains for the Stop TB Partnership to develop ways of corporate sector collaboration to maximise this sector’s contribution to TB control.

### *5. Poverty alleviation strategies and equity initiatives*

The drive to achieve the MDGs and in particular the TB targets represents an aspiration to serve the poor. Because TB is a disease of poverty, the DOTS strategy is generally thought of as “pro-poor”. However, increasing evidence of significant socioeconomic differences in apparently homogeneously poor populations<sup>21</sup> highlights the importance of ensuring that implementation of the DOTS strategy serves groups within “the poor”. The use of programme-incidence (or coverage-inequality analysis), a technique to examine socioeconomic disparities in health conditions and service delivery, can determine the distribution of NTP coverage and outputs across socioeconomic groups within the populations the NTPs serve.<sup>21</sup> Global DOTS expansion must include equity initiatives in order to ensure that among the poor, the less well-off benefit as much as the better-off from efforts to extend access to the DOTS strategy and deliver successful NTP outcomes.

### *6. Technical assistance for TB control*

Demand is increasing from high TB incidence countries for technical assistance for TB control, under the overall coordination of the DEWG. The agencies providing technical assistance for TB control rely on donors for adequate funding of high quality assistance.

### *7. Special role of WHO*

As the lead UN agency for health, WHO plays a special role in international public health in general and in the Stop TB Partnership in particular. WHO is both a partner in the Partnership and the agency around which the coalition of Stop TB partners is centred.

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<sup>21</sup> Gwatkin DR. How well do health programmes reach the poor? *Lancet* 2003; 361: 540-1.

### **3. Recommendations arising from the consultation process**

A wide process of consultation during 2003 led to the development of this background document prepared for the meeting of the 2nd *ad hoc* Committee in Montreux, Switzerland, from 18-19 September 2003. The outcomes of the series of five consultations on TB and health system issues held during 2003 contributed to this consultation process. The 2nd *ad hoc* Committee sought recommendations for urgent action by stakeholders to overcome the constraints to achieving the WHA 2005 targets (see Annex 2) and, looking beyond these targets, to reaching the MDGs in 2015. These recommendations are grouped under the headings of the key issues identified by the 1st *ad hoc* Committee and other key additional issues. The report on the meeting of the 2nd *ad hoc* Committee in Montreux will contain the Committee's finalised recommendations, following consideration of the recommendations arising from the consultation process.

The 2nd *ad hoc* Committee will seek endorsement of its report by the DOTS Expansion Working Group and Stop TB Partnership Coordinating Board at their meetings in The Hague on 7-8 October and 10 October 2003 respectively. The six working groups of the Partnership represent the mechanism by which stakeholders will translate the recommendations into action. The Committee's final recommendations will also inform the development of the next GPSTB (2006-2010) and the work of the MDGs project.

#### **Recommendations regarding the 1st *ad hoc* Committee key issues**

##### *1. Political will and commitment*

- a) The Stop TB Partnership Coordinating Board should revise its membership to include high-level political representatives, both from high TB burden and from Organization for Economic Cooperation and Development (OECD) countries.
- b) The Stop TB Partnership Coordinating Board should explore ways of harnessing the contribution to TB control activities of the widest possible range of stakeholders within the health sector and other sectors (e.g. civil society groups, employers, the education sector).
- c) The Stop TB Partnership Coordinating Board should advocate at the highest possible political level for country by country commitment to control TB, including the necessary policy and legislative reforms.
- d) The Stop TB Partnership and the MDGs project should work synergistically: the working group "Combating tuberculosis" (part of Task Force 5 of the MDGs Project) should incorporate and promote the recommendations of the 2nd *ad hoc* Committee; the Partnership should adopt the 2015 MDGs relevant to TB (impact targets), while retaining the WHA 2005 targets as process targets without which it will not be possible to reach the impact targets.

e) The Stop TB Partnership should explore the following “top-down” approaches to enhancing political commitment and its translation into policy and action:

- lobbying of the highest authorities in country governments, international organizations and the donor community through the WHA, the WHO regional committees, and other global gatherings, especially those related to MDGs and GFATM;
- country by country “political mapping” and analysis of constraints to progress in TB control, and of reasons for successes and failures;
- high-level missions to TB endemic and donor country authorities by Stop TB Partnership representatives.

f) The Stop TB Partnership should provide on-going technical assistance to HBCs, in the form of tools, instruments, technical advisers, opportunities for information exchange, and regular, formal assessments to facilitate effective country-level programming of communications and advocacy activities. These activities should be part of national DOTS expansion plans, with the relevant indicators of progress and success. Plans must be developed and implemented to provide training opportunities and specific need-based inputs, to individuals and public sector institutions, towards rapidly strengthening in-country TB communication capacities.

g) The Stop TB Partnership should mobilise communities to exert their right to demand and receive effective health care, including measures against priority public health problems, including TB. The many successful examples of highly effective community based communication initiatives with proven impact should be used to inform and drive country programming. Patients’ associations and other groups most affected by TB offer substantial untapped potential in education.

h) The Stop TB Partnership should advocate at country and global levels for organisational positioning of communication at a high level within ministries, development assistance agencies and NGOs, with communication recognised as a priority for NTPs.

i) The Stop TB Partnership should facilitate the submission of formal global and regional resolutions, within appropriate governing bodies related to financial support for country TB programmes, to secure high-level support, especially for the following specific components:

- adequate, sustained and specific resource commitments for country-level communication programming for TB;
- provision of on-going communication capacity-building opportunities, for individuals at various levels, and public sector institutions;
- reporting by NTPs, of change and impact due to communication interventions.

j) The Stop TB Partnership should urgently facilitate the development, testing and integration of appropriate communication indicators in country data-gathering and reporting mechanisms. Furthermore, NTPs should be encouraged to formally report on these indicators, on a regular basis, along with epidemiological data. Specifically, to

measure and document country progress and commitment to communication programming, and the impact of communication interventions, the Stop TB partnership should facilitate the following in each of the HBCs:

- the development of a national TB communication strategy through broad participation;
- inclusion of dedicated, qualified personnel and budgets for national TB communication programming;
- development of indicators to analyse political and social commitment to TB programmes at national and sub-national levels;
- development of specific monitoring indicators, benchmarks and baseline data to assess impact, progress, cost-effectiveness and social-behavioural change, as a result of communication interventions.

k) The Stop TB Partnership should make special efforts to persuade the media to fulfil their social and ethical responsibility in generating greater awareness of TB, changing behaviour, and promoting advocacy. Mass media campaigns have much to offer provided that their deployment is carefully tailored to specific circumstances.

l) The Stop TB Partnership should document “best practices” on communication and social mobilisation activities for TB control, based on defined criteria, to serve as models of communication activities and community involvement, that can be adapted elsewhere at regional and country levels.

m) The Stop TB Partnership should ensure integration of advocacy, communication, and social mobilisation strategies as central and integral components of the Stop TB Partnership mandate. Sufficient funding should be routinely allocated by the Partnership to advocacy and communication, to reflect their growing and central importance. The structures within the Stop TB Partnership dedicated to advocacy, communication and social mobilisation must be strengthened and formalised, at the global level, by:

- strengthening the Stop TB Partnership Secretariat’s Advocacy and Communication Team;
- formalising the Advocacy and Communication Task Force of the Partnership;
- ensuring representation of the Advocacy and Communication Task Force on the Strategic and Technical Advisory Group (STAG) of WHO and the Coordinating Board of the Stop TB Partnership.

n) The Stop TB Partnership should develop a strategic framework for policy advocacy to secure and enhance political will at the national level and support such activity through the establishment of a global advocacy network.

## *2. Financing*

a) The Stop TB Partnership Coordinating Board should develop a resource mobilisation plan, in seeking financial support from an increased donor budget, from a broadening of the partnership base to include non-traditional funders, and from catalysing additional national allocations. Funding from this wide range of sources, including the GFATM,

should be reliable, predictable and additional to what would otherwise have been funded. Increased funding for TB control from bilateral overseas development assistance agencies and international agencies would help to:

- strengthen current approaches, and support innovative approaches, to improving case detection rates and treatment success rates, in contribution to achieving TB targets;
- secure specified funds to support the activities of TB technical assistance agencies and the coordination of technical assistance by the secretariat of the DEWG.

b) The Stop TB Partnership Coordinating Board should exert pressure on OECD countries to increase the proportion of their development assistance funding on health in proportion to an increase in their overall contribution (as a percentage of GDP) towards the 0.7% internationally agreed target.

c) The Stop TB Partnership Coordinating Board should seek alliances with key agencies and bodies in sectors other than the health sector, in order to widen the range of partners and include those with potential to influence policies in key institutions affecting global economics, e.g., International Monetary Fund (IMF), World Trade Organization (WTO), International Labour Organization (ILO).

d) The Stop TB Partnership should explore with the World Bank, the IMF and the least developed countries the flexible application of regulations capping social sector spending in these countries. Flexible application of these regulations would help ensure the additionality of funding provided by the GFATM and increase the likelihood of countries being able to improve terms and conditions of service (including salary payments) for health staff and other government employees, and thus promote their retention.

e) The Stop TB Partnership should influence Ministries of Finance:

- to devote a greater proportion of funding to Ministries of Health for expenditure on costed plans for achieving targets for priority public health programmes, including TB;
- to work with Ministries of Health to ensure that the benefits of the Poverty Reduction Strategy Process (PRSP) extend to increased resource flows for the control of TB as a priority disease of poverty;
- to ensure adequate funding for TB control where responsibility for health budgets is held at an intermediate level (e.g. regional or provincial) between the central and district levels.

f) The Stop TB Partnership should help countries submitting GFATM proposals to ensure that they fully reflect national financial needs for TB control and are poverty-focused.

g) Countries submitting proposals to the GFATM through the Country Coordinating Mechanism (CCM) should ensure close collaboration between the NICC and CCM.

### *3. Human resources*

The main role of the Stop TB Partnership is to help influence governments (Ministries of Health, Finance and Education) and technical and financial partners to invest in and develop HR. There are three main areas for action: i) building the evidence base for planning and advocacy, ii) positioning, and iii) advocacy;

#### i) Building the evidence base for planning and advocacy

Evidence on the HR development gap derived from methodologically sound studies is the best tool to facilitate the Stop TB Partnership advocacy function and to facilitate assisting countries in developing HR planning capabilities.

The Stop TB Partnership should:

- a) collect, analyse and disseminate lessons learned about HR in TB and other programmes (past and current);
- b) design and promote a research agenda on policy and economic dimensions of HR issues in TB (including economic returns and costs);
- c) develop (and as necessary adapt), disseminate and support the use of tools to build data bases on HR current and future needs based on task and workflow analysis;
- d) assist NTPs to be able to assess their health system environment (political, legal, professional, regulatory, work place) and their HR needs within this environment.

#### ii) Positioning and advocacy

Positioning implies understanding HR for TB control within the current social, economic and political context.

At the international level the Stop TB Partnership should:

- a) link the Stop TB Partnership objectives and strategies to the MDGs;
- b) establish collaborative links and engage in joint activities on HR issues with other programmes (particularly HIV/AIDS) and with departments/ministries with responsibility for HR;
- c) identify opportunities through stakeholder analysis for the support of HR on TB control;
- d) consider a 2nd Ministerial Conference (to review progress generally, and specifically focus on HR gaps);
- e) proactively promote the inclusion of HR issues on the agenda of the international community (regional, international, national conferences and relevant health and development fora);
- f) ensure a specific focus on HR (through a mechanism for mainstreaming HR throughout all the Working Groups or through the establishment of a DEWG subgroup on HR or a working group on HR);

At a national /local level, the Stop TB Partnership should:

- g) assist Ministries of Health to insert HR development and capacity development for health systems (particularly for TB/HIV/Malaria) into other poverty reduction programmes and strategies such as the PRSP/HIPC processes;
- h) ensure that HR issues are considered in the mobilization of the business sector;
- i) support social mobilisation activities aimed at galvanising popular demand for effective TB control and HR issues (improved personnel, quality and quantity);
- j) support lobbying (at regional, international, national and local levels) to convince politicians and other decision-makers to support the provision of effective TB control and the HR needed to achieve this.

### iii) Capacity building

HR development needs to be understood more broadly than as isolated training courses/initiatives and building capacity in HR management and planning is required at national, institutional and individual levels.

At a national level the Stop TB Partnership should:

- a) support HR development capacity through collaboration and co-ordination with other HR departments, programmes and institutions at global and national level;
- b) ensure that at national level HR development capacity for DOTS expansion is developed and maintained;
- c) assist relevant ministries (e.g. Health, Education and Finance) particularly in HBCs to develop HR planning capacity through facilitating task analysis for DOTS expansion;
- d) collaborate with HR departments, Ministries of Education, professional associations and other programmes in developing and sustaining HR capacity at institutional and individual levels;

The Stop TB Partnership should promote the development of sustainable institutional capacity through:

- e) supporting a task analysis for DOTS and HIV (in countries with high prevalence of co-infection) and linking the outcome of the task analysis with the production and deployment of HR;
- f) planning the HR dimension by developing management structures and mechanisms for HR planning and development;
- g) at educational institutions level, influencing medical schools and professional organizations to include the DOTS strategy in curricula;
- h) strengthening links between specific programmes and educational departments, Ministries, institutions and professional organizations up to implementation level.

The Stop TB Partnership should promote the development of sustainable individual capacity through:

- i) developing a comprehensive training plan (including continuing education/development and follow up components), which should be developed in collaboration with HR departments, Ministries of Education and other Ministries, training divisions, professional associations and regulatory bodies;

j) assisting countries to develop mechanisms to regulate the quality of practice in the private sector: using statutory bodies to advise on regulations and authorize/legislate practices;

k) influencing bilateral international development assistance agencies to increase the amount of funding available for training increased numbers of health care staff, including paramedical personnel (e.g. laboratory technicians, nurses and clinical officers) who in many countries provide the largest part of provision of TB control activities;

l) exploring ways to increase numbers of trained staff in key TB control posts, especially in those countries losing staff to economic migration and deaths from HIV/AIDS.

The issue of retention needs a systematic approach taking into consideration the multiple dimensions and complexity of the problem; strategies should be country-specific based on the identification of local threats and opportunities.

m) The Stop TB Partnership should advocate for:

- developing, in collaboration with HR departments, a plan to retain trained staff;
- exploring ways of retaining key national staff, e.g. by devoting extra resources to fund incentive schemes;
- developing staff retention strategies, including continuous education and support, evolving career paths and quality control and accountability mechanisms;
- support discussions on staff retention issues (policies, ethics, economics) both in countries losing their health staff as well as in receiving countries.

#### *4. Organization (Health System Reform)*

The following recommendations mainly arise from the consultation on TB and Health System Reform (HSR) held in Washington DC, USA, on 30 June 2003, and fall under five headings: i) fostering policy, leadership and stewardship; ii) planning and financing within reforming systems; iii) capacity building within reforming systems; iv) supporting implementation; v) informing advocacy, problem-solving and innovation.

##### *i) Fostering policy, leadership and stewardship*

Scale up of the MDGs depends first on good policies, leadership and government and partner stewardship of effective practice, especially within the often disabled and dynamic nature of health systems in high disease burden settings.

Issues:

##### *a) Partners joining “at the table”.*

This means facilitating collaboration of disease control, clients and reform partners in: population needs identification; design of basic service packages; definition of programme functions within system reform processes; and non-programme management and staff roles and responsibilities at national and sub-national levels. Defining the oversight, stewardship and management functions of central public health programme

units and lower-level management will be highly country-specific. Nevertheless, TB programmes that have benefited from representation at the reform table appear to be weathering reform transitions more effectively than disengaged counterparts.

Responsibility: Reform managers, policymakers, donors and Stop TB partners can advocate for disease control participation in design process and NTPs can show full commitment to process.

b) Ensuring responsiveness to client and provider needs and expressed demand.

A range of health reform strategies (e.g., sector programming, public-private partnerships and decentralization) seek to increase client and community demand and engagement in service oversight. The DOTS strategy is sufficiently mature to enable further adaptation to increase case detection without sacrificing quality. Overcoming disabling performance conditions for patients and providers has to be a high priority in “stewarding” low-coverage programmes. Furthermore, engagement with local political and public health leaders is of increasing importance within decentralizing health systems. Revenue management and/or implementation is increasingly the purview of sub-national management teams and driven by local political interests that may change frequently.

Responsibility: Collective responsibility of programme and health system leadership, as well as of donors who can encourage responsiveness.

c) Rewarding innovation and impact

The Stop TB Partnership and government partners should examine TB-specific and system-wide means to reward innovative approaches that expand TB case detection and effective treatment. The FIDELIS fund creates new resources for innovative approaches, while local government and civil society partners can financially or non-financially acknowledge successful work programmes and thereby build and retain leadership.

Responsibility: Donors, Ministries of Health and programmes

ii) Planning and financing within reforming systems

Public health leadership often face great challenges in converting objectives and policy frameworks in reform programmes into practical, realistic plans with accompanying financing.

Issues:

a) Promoting disease control engagement in sector planning, in priority public PRSPs and within central and district budgeting processes as well as articulation within MTEFs.

Stop TB partners will need to actively facilitate joint planning and participation as current practices often mean that public health programmes are invited to the discussions but

often choose not to participate actively, or have no platform to speak, and may see risks in asserting their voice and needs. Pushing for disease-specific financing may sometimes be less important than promoting investment in improvements in underlying human resources, primary care and referral systems required to advance TB services and impact.

Responsibility: Planning authorities, Stop TB partners financing planning processes and strategies and NTPs.

b) Using available or new mechanisms, facilitate coordination among donors and various local stakeholders such that there is common understanding of resources available, gaps in financing for vertical and horizontal oversight and service functions, resource flows, and common estimation of the timeframes required to institute reform policies and processes (e.g. avoid unrealistic speed of decentralization and/or integration of functions).

Responsibility: Ministries of Health with support from Stop TB Partnership, technical and financial partners.

c) Urgently fostering management capacity building at provincial, district or municipal levels and accompanying budgets required by central oversight and training staff. Frequent turn-over and transfer of staff make this objective difficult but countries that put management capacity as a priority appear to marshal resources more effectively.

Responsibility: Ministries of Health, reform donors, and sub-national authorities.

d) Creating constructive dialogue on transitioning from ring-fenced financing for disease control to more integrated sector programmes, with preparedness emphasized.

All countries presenting at the workshop are developing interim plans and/or correcting for past errors in shifting control too fast or, alternatively, in failing engage early enough with new sector wide initiatives and processes.

Responsibility: Ministries of Health, sector-wide planning committees, donors with NTPs and other priority programmes providing evidence of needs and integration strategies in short and medium-term.

### iii) Capacity building within reforming systems

Among the most consistent lessons learned from early and ambitious reform programmes has been the critical role of timely capacity-building at sub-national, service delivery and community levels.

Issues:

a) Promoting overall government or sector wide human resource reforms that aim to increase number, flexibility and preparedness of personnel in primary care, public health programmes, and disease control specifically.

Accompany this attention with monitoring of social sector and human resources improvements pledged and initiated under PRSPs, budgetary support or MTEFs. Describe disease control risks and opportunities given manpower levels, to increase knowledge of the profound impact limited human resources can have in light of worsening health epidemics. Ensure attention to underlying inequities in disease burden and capacity when planning interventions.

Responsibility: Ministries of Health and civil service reform authorities, with stimulus for Stop TB partners and international human resource expertise.

b) Facilitating TB-specific and cross-programmatic training models (i.e. pre-service and in-service) and supervision strategies and informing debates on what functions/areas can be integrated versus those which require focused effort to ensure safety and quality.

Responsibility: NTPs and Stop TB partners, including WHO, TBCTA, IUATLD.

c) Utilising new partners to increase capacity, especially those that will expand coverage, increase demand for proven effective interventions and foster quality of service delivery. These partners may include new public partners (e.g. primary and secondary care hospitals), private partners, communities and patients themselves. Each constituency is often targeted for further development under reform programmes and there may be resources and connections to capitalize upon for TB-specific engagement.

Responsibility: NTPs, local health authorities, Stop TB working groups (e.g. public-private sub-group of the DEWG)

iv) Supporting implementation

Even when policy, planning and financing of work programmes may be well-oriented to advance TB control, obstacles in implementation can mean less impact on outcomes or perverse outcomes, including for disease control. Coordination of stakeholders is crucial.

Issues:

a) Strengthening common supply and logistics systems where appropriate.

NTPs may be among the pathfinders in prioritizing supply systems to achieve DOTS cure rates and case detection and diagnostic efficiency. Gauging where and when supply and logistics can be shared and/or integrated without creating risks to public health and credibility. Reform programmes create momentum for integration but this process should be informed by evidence on what forms integration can take given underlying capacity and burden.

Responsibility: Ministries of Health, GDF, Stop TB Partners involved in broader logistic strengthening systems, other priority programme initiatives focused on supply chain (e.g. GAVI, reproductive health, HIV/AIDS treatment planners, Roll Back Malaria).

b) Engaging partners in ongoing supervision and technical assistance.

Failures in implementation are often not corrected early in the process for lack of supervision and practical technical assistance. Effective engagement and problem identification can transform general plans into specific detailed activities and pacing of interventions. Technically specific insights need to complement aggregated reporting and oversight.

Responsibility: Ministries of Health, priority programmes, technical partners and donors who encourage documentation of effectiveness of processes and impact.

c) Creating communication channels.

Decentralized and/or integrated management systems are often hampered by faulty or insufficient communication technology and/or channels. Gaps in information and/or supply flow can cause serious deficiencies in quality and/or penetration of services.

Responsibility: Ministries of Health and donors as well as project partners that can share results on innovations in communication.

d) Facilitating efficient resource flows, accountability and performance recognition.

Too often the focus is on securing budgets and plans and less attention is given to track allocation and disbursement of funds, resource flows, governance and accountability for use of funds. Furthermore, recognizing performance of rapidly improving national programmes, provincial or district management teams, local services and individuals can stimulate implementation enhancements.

Responsibility: Ministries of Health and Finance, donors requiring reporting, central and local authorities and technical assistance partners.

e) Ensuring coordination of stakeholders

The Stop TB Partnership should influence Ministries of Health to establish or strengthen existing NICCs, and to rationalise planning and budgeting for priority public health problems where there is significant overlap, e.g. by preparing joint costed plans and budgets for the overlapping epidemics of TB and HIV.

Responsibility: Ministries of Health, donors and technical assistance partners.

v) Informing advocacy, problem-solving and innovation.

Reporting, monitoring, evaluation and research are all required to inform efforts to build political, institutional and community engagement, particularly when larger reforms could drown out focus on specific outcomes. In addition, information and analysis are required to solve overarching problems and to innovate to speed up impact. TB control

has benefited more than many programmes in use of data and analysis to inform scale-up, but transmitting information to broader non-TB communities still needs attention.

Issues:

a) Documenting the burden and externalities of TB control as well as benefits of interventions, including equity implications.

In this area it is important not to over-estimate the knowledge base of political, donor and community stakeholders.

Responsibility: NTPs with technical and research partners, Stop TB Partnership and working groups, partners in other public health fields with experience in the area, and supportive donors.

b) Enhancing measurement and evaluation of interventions, including new management, financing and delivery mechanisms.

Given the highly country-specific nature of health reforms and impact on diverse population, operational research will be needed to inform improvement of strategies.

Responsibility: Ministries of Health, WHO, World Bank and range of Stop TB Partners and researchers involved in research and evaluation of health systems.

c) Based on evidence, justifying functional safeguards that will protect and promote public health and MDGs.

Too little information is available to document where and when integrated drug procurement and supply is appropriate or dangerous; or where decentralized and/or integrated supervision makes sense or where burden, social context or capacity need to inform strategy and pacing of reforms.

Responsibility: NTPs and Stop TB partners and other priority public health implementers who can continue to rigorously document practices, lessons learned from failures and Ministries of Health authorities responsible for managing integration and decentralization processes.

d) Sharing information on practices and lessons.

The HSR consultation made clear that high-burden countries do have extensive lessons to offer in how they are managing engagement in reform.

Responsibility: Stop TB Partnership, WHO, IUATLD and donors can support and facilitate documentation and sharing of experiences via established forums, conferences and electronic and print means.

e) Cross-fertilising with other priority public health programmes facing similar challenges and opportunities within reforming health systems, and/or learning from equity-focused strategies.

Responsibility: Stop TB Partnership and partners engaged with multiple programmes and partnerships, as well as organizers of the new MDG Forum.

f) Ensure that information and lessons learned are available and made relevant to local stakeholders, and not only to national and international partners.

The former have increasing control over financing and management processes. They may be prone to other influences in priority-setting in the absence of powerful documentation of means to serve constituencies and achieve impact.

Responsibility: NTPs, Ministries of Health, local technical counterparts and civil society partners, donors who can finance new channels of communication, capacity-building and exchange at local levels.

## *5. Management*

a) The Stop TB Partnership should influence Ministries of Health to provide increased human and financial resources to strengthen NTPs so that they can play their full role in stewardship of TB control activities:

- in coordinating the activities of the full range of health providers within the health care system, and thereby ensuring improved case detection, and recording and reporting of treatment outcomes for all TB patients irrespective of whichever health provider is responsible for their care;
- in ensuring quality control of NTP operations in order to maximise case-finding and the achievement of favourable treatment outcomes;
- in ensuring that the distribution of NTP coverage and outputs is equitable across all socioeconomic groups.

## *6. Anti-TB drugs*

a) The Stop TB Partnership should strengthen its working relationship with the GFATM by establishing a joint GFATM-Partnership standing committee.

b) The Stop TB Partnership should negotiate with the GFATM in order to a) ensure the success of GFATM support to grantees, and b) build on the current arrangements for procurement of second-line TB drugs through the GLC in order to position GDF as a preferred first-line TB drug facility for the GFATM.

c) The Stop TB Partnership should persuade high TB prevalence countries to use the GDF to ensure the procurement of quality-assured TB drugs in standardised formulations and user-friendly packaging, accompanied by technical support to monitor effective use of the drugs by NTPs.

## *7. Information*

The Stop TB Partnership should encourage the partners in the Global TB Monitoring and Surveillance project to:

- intensify collaboration with those groups involved in monitoring and surveillance of other priority public health problems, e.g. HIV/AIDS and malaria;
- intensify efforts to improve the accuracy of estimates of progress towards TB control targets, including strengthening regional and national capacity in monitoring and surveillance;
- undertake analytical work in support of activities directed towards harnessing the contribution of the full range of health care providers to TB control, e.g. by estimating the potential extra contribution to overall case-finding under the DOTS strategy of those TB cases currently managed by providers not in line with the DOTS strategy;
- invest greater efforts in improving the accuracy of estimates of progress towards achieving targets, including strengthening this capacity in the Regional Offices.

## *8. Research*

The Committee will liaise with the new tools working groups under the auspices of the Stop TB Partnership to promote the development of the improved tools for TB control that will be crucial in reaching the MDGs in 2015. The new tools are: a) new, improved diagnostics for the detection of tuberculosis disease, drug resistance, and latent infection, and optimise their cost-effective use; b) new drugs to simplify the treatment of TB disease, and to treat MDR-TB and latent TB infection more effectively; c) more effective vaccination procedures to replace or supplement the existing BCG vaccine.

a) The Stop TB Partnership should work with the research community:

- to advocate for new tools;
- to lobby research funding agencies for increased financing of TB research;
- to lobby pharmaceutical companies for increased involvement and investment in TB research;
- to clearly define the characteristics required for useful tools;
- to define the economic justifications and social benefits for new tools development;
- to foster partnerships between researchers and trial sites, particularly in developing countries.

b) The Stop Partnership should promote the operational research necessary to: (i) address constraints to patient demand and participation in TB care and control; ii) ensure maximum contribution to TB control of the full range of health care providers, e.g. local NGOs and other community groups, private practitioners, employer health services; and (iii) assess progress in ensuring that the distribution of coverage by the DOTS strategy is equitable across all socioeconomic groups.

c) The Stop TB Partnership Coordinating Board should develop and articulate arguments in favour of increased research capacity to encourage Organization for Economic Cooperation and Development (OECD) countries to increase funding for this activity.

## Recommendations regarding additional key issues

### 1. Health infrastructure

The Stop TB Partnership Coordinating Board should promote the inclusion of health infrastructure costs as part of countries' proposals to the GFATM to improve TB control, in order to ensure the contribution of significant funds from the GFATM to support strengthening of general (especially primary) health services.

### 2. Primary care providers

The Stop TB Partnership Coordinating Board should explore ways of harnessing the contribution of the whole range of health care providers (including all branches of the Ministry of Health and all other relevant Ministries, NGOs, employers, private practitioners, religious organizations and community groups) to TB control activities, as part of the integrated delivery of health care. The consultation on primary care providers made the following recommendations.

a) To strengthen the links between the formal (public) primary health system and communities.

This is key both to maintaining high treatment success rates (through community TB care) and increasing case finding, by facilitating awareness and community mobilization. Such *linking* people, usually public health officers, require technical skills, but they must also have time and resources (e.g. means of transport and per diems) to work with communities.

Responsibility: The NTP is to *promote* implementation of this recommendation, while the District Health Team (DHT) is to *ensure* implementation.

b) To survey the range of PHC providers (including large-scale employers, who provide health care to employees) currently working in-country, and their relative capacity to deliver (and interest in delivering) primary health services, including TB care, before large scale engagement in public-private partnerships.

Responsibility: It is the responsibility of the Ministry of Health (or decentralised District Health Teams) to implement this recommendation.

c) To widen at the grassroots level of the health system the groups of people and organizations that are involved in tuberculosis control (including NGOs, private-for-profit).

It is to the government's potential advantage to involve other actors. Some NGOs help to fill a gap in health services delivery, by working in places (or under conditions) where it is difficult for the government health system to function. For example, they may be more effective (or efficient) providers in the setting of complex emergencies (e.g. war, drought,

economic collapse) or in areas that are geographically remote or otherwise difficult to access. In fact, NTPs should be the unit responsible for promoting these public-NGO or private-not-for-profit (PNFP) partnerships. By spearheading an approach that will widen the range of partners and activities, there will be positive externalities (i.e. strengthening of the entire health services delivery system).

Responsibility: The NTP should *promote* implementation of this recommendation, while the DHT should *ensure* implementation.

d) To develop clear Terms of Reference for the various actors involved in TB control activities, including community groups, civil society, NGOs, private-not-for-profit (PNFP) and private-for-profit (PFP) organizations and the public.

The actors will thus have clear, and complementary roles, which will help to ensure accountability (need to establish a *social pact* to provide certain services).

Responsibility: The NTP needs to propose this approach. The DHT is responsible for implementation of this recommendation. Local political authorities to propose a partnership to the civil society as a social pact.

e) To ensure consensus on aims, objectives, strategies and policies among partners/actors who are collaborating in TB control.

In this public-private collaboration, the role of the government is normative (i.e. to establish policies). Government should in addition have a policy that guides partnerships between government (including NTP) and NGOs. NICCs are essential in each country at central level. Similarly, at the peripheral (state/provincial) level, there must be a forum that allows all actors (civil society, NGOs, private-for-profit, and public) to voice concerns or opinions, and to engage in planning TB service delivery through primary care providers.

Responsibility: National governments.

f) As per the Resolution of the Fifty-Sixth World Health Assembly (Agenda item 14.13; document WHA56.25), public-private (NGO, PNFP or private-for-profit) partnerships should take a “contractual approach”, i.e. this is the recommended “modality” (or “tool”) of partnership.

Such a contractual approach should acknowledge the identity and autonomy of the partners. Under this approach, there are certain tools that can help:  
Memorandum of Understanding (MoU) – provides enough security for the NGO to invest (e.g. in HR and equipment) and collaborate with government.  
Service Level Agreement (SLA) – short term agreement on a service that one party (e.g. NGO) is providing on behalf of a second party (e.g. government).

Responsibility: Adoption of Contractual Approach is the responsibility of the Ministry of Health and NGOs.

g) Governments should provide support or subsidise NGO activities when NGO activities are part and parcel of public health service provision (and particularly when it is serving a particularly poor population).

For example, if an NGO/PNFP is providing diagnostic services to a poor population, a population who cannot cover the costs, then a subsidy should be provided.

Responsibility: It is the responsibility of government to implement this.

h) To develop management capacity at all levels within NTPs, to enable them to play a full role in stewardship of activities of a wide range of in-country partners.

Skills that are vital include: management, public relations, technical skills, and an ability to incorporate community concerns/experience into the programme.

Responsibility: The Ministry of Health and the international development agencies are responsible for implementation.

i) To form partnerships with NGOs delivering priority programmes, including HIV/AIDS services (particularly home-based care).

Such NGOs would be well suited for delivering TB services to HIV positive persons with tuberculosis. Ministries of Health should ensure collaboration between National TB Programmes and National HIV/AIDS Programmes in planning and budgeting for collaborative TB and HIV/AIDS activities undertaken by primary care providers, e.g. cross-referral, with HIV-positive TB patients referred for lifelong HIV prevention and HIV/AIDS care, and intensive TB case-finding among HIV-positive people).

Responsibility: Ministry of Health, NTP, National HIV/AIDS Control Programme.

j) To link the full range of health care providers to TB control in urban areas.

There are special challenges involved in extending the reach of TB services (potentially including: less cohesive communities, time constraints of members of the target population, greater stigmatization associated with TB). Thus metropolitan health authorities should be engaged for help in extending TB services in urban areas by linking different providers under the auspices of NTP.

Responsibility: The “Ministry of Local Government” (or equivalent, and the “Metropolitan Health Authority” (or its equivalent), is to be responsible for implementation, with support from the NTP.

j) NTPs, international development agencies and technical assistance agencies should ensure that the distribution of NTP coverage and outputs is equitable across all socioeconomic groups.

Responsibility: Ministry of Health, international development agencies.

k) International development agencies and Ministries of Health should ensure sufficient funding for TB control through the full range of primary care providers.

Responsibility: Ministry of Health, international development agencies.

l) Funds from donors (for TB control) should be accepted as “additionalities”, i.e. on acceptance of additional funds, government should not shift its budgeted funds away from the essential package, including TB control. Applications to donors, e.g. GFATM, should be made conditional on a government’s acceptance of this.

Responsibility: This is to be implemented by Ministry of Finance (or government, more generally), international bi- and multi-lateral aid agencies and GFATM.

m) As much as possible, there should be coordination between existing mechanisms for the flow of funds and the Country Coordinating Mechanism (CCM) established under GFATM, which will be in place over the longer term. There should be a system for interaction and communication between the two.

Responsibility: Ministry of Health to propose it to the relevant parties.

n) To encourage partners in TB control to participate in operations research to explore and evaluate innovation and new approaches in the context of PHC services.

Responsibility: It is the responsibility of the NTP to implement this recommendation when establishing collaboration with new partners.

### *3. TB/HIV*

The Stop TB Partnership and HIV/AIDS partnerships, e.g. those linked to the WHO HIV/AIDS Department and to UNAIDS, should collaborate to:

- identify areas of mutual benefit, taking advantage of their relative strong points, to deliver the strategy of expanded scope to control HIV-related TB;<sup>22</sup>
- support countries in full implementation of the WHO interim policy on collaborative TB and HIV programme activities;
- speed up progress towards the “3 by 5” goal (3 million people on ART by 2005) by making ART available to HIV-positive TB patients;
- encourage ART programmes to make use of lessons learned from TB programmes in the application of sound public health principles to large scale diagnosis and

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<sup>22</sup> World Health Organization. Strategic framework to decrease the burden of TB/HIV. Geneva, Switzerland. WHO document WHO/CDS/TB/2002.296.

treatment of TB as a chronic communicable disease, and NTPs to make use of lessons learned from HIV programmes in social mobilisation and advocacy.

#### *4. Corporate sector contribution*

a) The Stop TB Partnership Coordinating Board should explore ways of increasing collaboration with the corporate sector through:

- organising a secondment programme with corporate sector partners;
- ensuring corporate sector representation on the Stop TB Partnership Coordinating Board;
- appointing a member of the secretariat with specific responsibility for corporate sector liaison;
- use of the WHO/ILO document “Guidelines for workplace TB control activities” as an entry point for partnership discussions.

b) The Stop TB Partnership Coordinating Board should develop, articulate and disseminate to the corporate sector arguments for corporate sector involvement in TB control, e.g. the economic and social benefits of corporate sector activities in contribution to TB control.

c) The Stop TB Partnership Coordinating Board should seek to build corporate sector involvement in TB control activities through links with established corporate sector activities in health, especially in HIV/AIDS programmes. Specifically, the Coordinating Board should seek to include TB in a revision of the UNAIDS/ILO Code of practice on HIV/AIDS and the World of Work.

d) The Stop TB Partnership Coordinating Board should promote the development of NTP stewardship capacity, including the specific capacity to collaborate with the corporate sector.

#### *5. Poverty alleviation and equity initiatives*

The Stop TB Partnership Coordinating Board should promote the provision of technical assistance in the implementation of the DOTS strategy in ways which ensure that the distribution of NTP coverage and outputs is equitable across all socioeconomic groups.

#### *6. Technical assistance for TB control*

In collaboration with national governments and through the coordination of the DEWG, the Stop TB Partnership should help technical agencies to:

- adopt quality control schemes in order to ensure that they deliver high-quality technical assistance;
- expand the intensity of their technical assistance, especially in priority countries, by training and mobilising a dramatically expanded number of national counterparts (who can later become international technical assistance experts);

- expand the scope of their technical assistance by promoting capacity development in social mobilisation, communication and advocacy;
- mobilise significantly increased levels of technical support to those countries which are making particularly slow progress towards achieving the targets.

#### *7. Special role of WHO*

a) The Stop TB Partnership should influence WHO to reflect its stated commitment to TB control as a priority public health problem of poverty by:

- significantly increasing its core budgetary contribution to the Stop TB Department, and by expanding its network of international and national staff in the regions, the HBCs and other selected countries;
- supporting the Stop TB Partnership, e.g. by establishing several regular budget posts to the Partnership secretariat.

b) With the support of the Stop TB Partnership Coordinating Board, WHO should promote a resolution at the World Health Assembly calling for a global charter on TB control and urging countries to establish or revise national legislative frameworks for TB control.

## **Annex 1      Summary of the current status of the global TB epidemic and of global TB control**

### **The current status of the global TB epidemic**

Despite progress in many areas, the Stop TB Partnership faces a huge challenge in reducing the global burden of TB. This section summarises the current status of the global TB epidemic (in terms of the burden of TB morbidity and mortality and the economic burden of TB) and of global TB control.

#### **Burden of TB morbidity and mortality**

The unprecedented scale of the TB epidemic and the human rights approach to TB demand effective and urgent action.<sup>23</sup> TB ranks third among infectious diseases as a cause of disease burden, expressed as disability-adjusted life years (DALYs).<sup>24</sup> WHO has estimated the global burden of tuberculosis and reviewed global trends and interactions with HIV.<sup>25</sup> Worldwide in 2000 there were an estimated 8.2 million new cases of tuberculosis, with an incidence rate of 136/100,000. Table 1 shows the breakdown of global estimates by WHO regions.

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

Multidrug-resistant tuberculosis (MDR-TB) is a serious threat, since it arises wherever there has been, or is currently, inadequate application of anti-TB chemotherapy. Surveys have identified a high prevalence of MDR-TB in specific regions of the world, e.g. Estonia, Latvia, the Oblasts of Ivanovo and Tomsk in Russia, and the provinces of Henan and Zhejiang in China.<sup>26</sup> More representative geographical coverage of global anti-TB drug resistance surveillance, with further data from longitudinal studies, enables more accurate and comprehensive monitoring of global trends in the spread of MDR-TB.

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<sup>23</sup> World Health Organization. Guidelines for social mobilization: a human rights approach to tuberculosis. Geneva, Switzerland. WHO/CDS/TB/2001.9.

<sup>24</sup> World Health Report 2000. Reducing risks, promoting healthy life. Geneva: World Health Organization, 2002.

<sup>25</sup> Corbett E, Watt C, Walker N, Maher D, Williams B, Raviglione M, Dye C. The growing burden of tuberculosis: global trends and interactions with the HIV epidemic. *Arch Int Med* 2003; 163: 1009-1021.

<sup>26</sup> World Health Organization. Anti-tuberculosis drug resistance in the world. Report number 2: prevalence and trends. Geneva, Switzerland, WHO/CDS/TB/2000.278.

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

	AFR	AMR	EMR	EUR	SEAR	WPR	Global
<b>Population</b> (millions)	640	832	485	874	1,536	1,688	6,053
<b>Estimated new cases of TB</b>							
Number of cases (thousands)	1,857	382	587	468	2,986	2,031	8,311
Incidence rate (per 100,000)	290	46	121	54	194	120	137
Change in incidence rate 1997-2000 (%/year)	3.9	-4.1	-1.4	2.8	-1.3	0.0	0.4
<b>HIV-related TB</b>							
HIV prevalence in new adult cases (%)	38	5.9	1.8	2.8	3.2	1.3	11
Number of adult TB cases attributable to HIV (thousands)	421	12	5.2	8.2	53	13	511
Adult TB cases attributable to HIV (%)	31	5.1	1.5	2.6	2.7	1.1	9
<b>Deaths</b>							
Deaths from TB (thousands)	482	55	135	72	727	368	1,839
Deaths from TB (per 100,000)	75	6.6	28	8.3	47	22	30
Deaths from TB in HIV-infected adults (thousands)	203	3.9	3.0	1.6	29	5.7	246
TB deaths attributable to HIV (%)	39	6.5	2.0	2.1	3.7	1.4	12

(AFR = Africa, AMR = Americas, EMR = Eastern Mediterranean, EUR = Europe, SEAR = South East Asia, WPR = Western Pacific)

### Economic burden of TB

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

In addition to alleviation of these human costs, alleviation of the global economic burden of TB also represents a justification for investment in TB control from the health

economics perspective.<sup>27</sup> The economic costs of TB fall into two categories: a) indirect costs to society, the community and the patient's family through lost production; and b) direct costs to the health services and to the patient and the patient's family. The largest indirect cost of TB for a patient is income lost by being too sick to work. Studies suggest that on average three to four months of work time are lost, resulting in average lost potential earnings of 20% to 30% of annual household income. For the families of those who die from the disease, there is the further loss of about 15 years of income because of the premature death of the TB sufferer. Regarding direct costs, the substantial non-treatment costs borne by TB patients and their families are often greater than the costs of treatment borne by the health sector. The case study of India provides an example of the enormous potential economic benefits of investing in TB control.<sup>28</sup>

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

### **The current status of global TB control**

This summary of the current status of global TB control covers implementation of the DOTS strategy (number of countries implementing the strategy, cases detected, treatment success, and the countries achieving the WHA 2005 targets) and financing.

#### Number of countries implementing the DOTS strategy<sup>2</sup>

The number of countries implementing the DOTS strategy by 2001 was 155 (out of 210). By the end of year 2001, 61% of the world's population lived in administrative areas of countries where the DOTS strategy was being implemented (although in practice not all TB patients within these areas had access to the DOTS strategy).

#### Cases detected under programmes implementing the DOTS strategy<sup>2</sup>

In 2001 approximately 2.4 million patients with newly-diagnosed tuberculosis, 1.2 million of whom were smear-positive, have been notified in DOTS programmes. Tuberculosis has been diagnosed and treated in over 10 million patients in DOTS programmes since 1995. However, the 1.2 million smear-positive cases notified by DOTS programmes in 2001 represent only 32% of the estimated number, and the rate of progress in case finding between 2000 and 2001 was not significantly faster than the average since 1995, a mean annual increment of 137 000 cases. Globally, DOTS programmes would have to treat an additional 360 000 smear-positive patients each year to reach 70% case detection by the end of 2005.

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<sup>27</sup> World Health Organization. The economic impacts of tuberculosis. The Stop TB Initiative 2000 Series. Geneva, Switzerland WHO/CDS/STB/2000.5.

<sup>28</sup> Dholakia R. The potential economic benefits of the DOTS strategy against TB in India. World Health Organization, Geneva, Switzerland, 1996. WHO document WHO/TB/96.218.

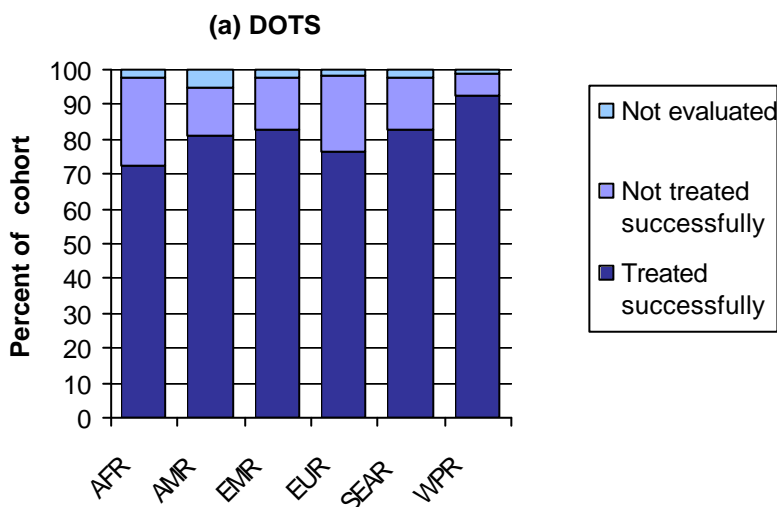
Two thirds (67%) of the additional smear-positive cases reported under DOTS in 2001 (as compared with 2000) were found in India alone. There were smaller but marked improvements in case detection in Myanmar, the Philippines and Thailand. Other HBCs made minor gains in case detection, though Pakistan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

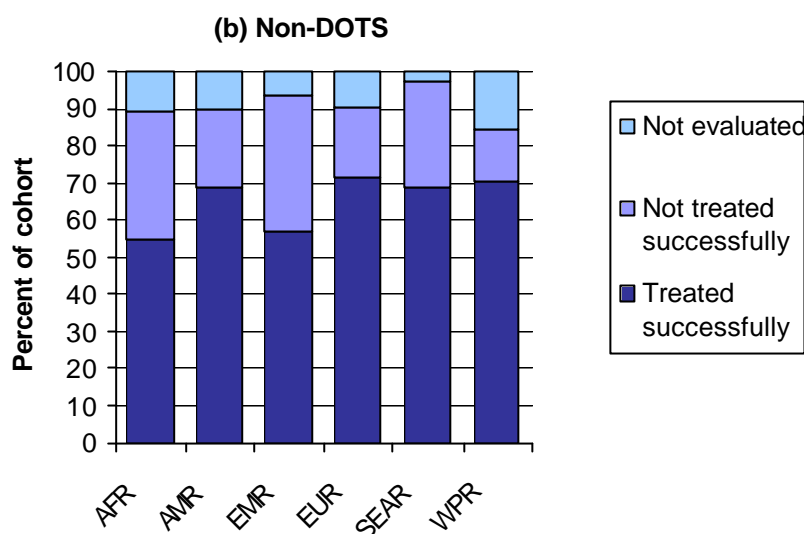
As DOTS programmes have expanded geographically, the proportion of estimated cases found within DOTS areas has remained constant at 40-50%. Overall, DOTS programmes in the 22 HBCs are not increasing case detection towards the 70% target within designated DOTS areas.

### Treatment success<sup>2</sup>

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

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





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

#### Countries achieving the WHO targets<sup>2</sup>

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

#### Financing<sup>2</sup>

Annual external aid for TB control in developing countries stood at \$210 million in 2002 (an increase from \$16 million in 1990, and \$40-50 million in 1995).<sup>29</sup>

<sup>29</sup> Maher D, Kochi A. Combating tuberculosis. RT International 1997; 80-81 and 110.

## **Annex 2. Achievement of the WHA 2005 targets: constraints and challenges**

This section describes the specific constraints identified by the NTP managers of the HBCs and challenges in overcoming them, presented at the DEWG meeting in Montreal in 2002. Table 2 shows for each HBC the key indicators of TB control (i.e. DOTS population coverage and success rate under DOTS), national HIV prevalence, and main constraints and challenges in overcoming them. DOTS population coverage is defined as the proportion of the population living in the official catchment areas of administrative/operational health service units designated as units implementing DOTS.

### Main identified constraints in the 22 High-Burden Countries (HBCs)

22 High TB Burden Countries	Cumulative proportion of burden (incidence) 2001 (%)	DOTS population coverage 2001 (%)	Sputum smear-positive case detection rate under DOTS 2001 (%) <sup>30</sup>	Success rate under DOTS 2000 (%) <sup>30</sup> (Sputum smear-positive)	HIV/AIDS prevalence (15-49 y) 2001 (%) <sup>31</sup>	Main identified constraints	Challenges in overcoming constraints
1 India	22	45	23	84	0.8	1) Insufficient financial support at State level, uncertainty of future ext. funding 2) Private sector handling large TB case loads but not following DOTS strategy	1) How to advocate at State level for higher commitment on TB control? 2) How to involve NGOs, private practitioners and large hospitals in DOTS strategy?
2 China	39	68	29	95	0.1	1) Insufficient cooperation between TB institutions and general hospitals 2) Insufficient political and financial support at local level in some Provinces for expanding or maintaining DOTS 3) Lack of TB staff and TB programme managers	1) How to pilot different scenarios for the involvement of general hospitals in DOTS implementation? 2) How to establish multisectoral leading groups and hold NICC meetings to improve political and financial support at Provincial level? 3) How to advocate national and local Government to post additional staff on TB control, train staff?

<sup>30</sup> World Health Organization. Global Tuberculosis Control: Surveillance, Planning, Financing. WHO Report 2003. Geneva, Switzerland. WHO/CDS/TB/2003.316.

<sup>31</sup> UNAIDS. Report on the global HIV/AIDS epidemic 2002. Geneva, Switzerland.

3	Indonesia	45	98	21	87	0.1	1) Decentralization with insufficient commitment at local level and limited staff capacity at central and provincial level 2) Poor drug management and quality control 3) Weak reporting and supervision 4) Limited involvement of public hospitals and private sector	1) How to strengthen central and provincial TB teams and train staff on management and supervision? 2) How to establish drug quality control system and train staff on drug distribution? 3) How to strengthen quarterly reporting and supervision? 4) How to engage public hospitals and private sector in DOTS strategy?
4	Bangladesh	49	95	26	83	<0.1	1) Interruption of main DOTS activities while in the process of health sector reform 2) Lack of skilled staff, poor infrastructure	1) How to advocate at national and regional level? 2) How to train staff and involve NGOs and private practitioners?
5	Nigeria	53	55	16	79	5.8	1) Insufficient budget for TB control; poor condition of health care infrastructure at PHC level 2) Lack of supervision; low staff motivation 3) Limited involvement of hospitals 4) High level of TB/HIV with limited collaboration between programmes	1) How to obtain commitment of Federal and State level for increased financial support and mobilization of external support? 2) How to strengthen supervision? 3) How to engage hospitals in DOTS strategy? 4) How to develop and implement TB/HIV collaborative strategy?
6	Pakistan	56	24	6	74	0.1	1) Lack of human resources at local level 2) Large involvement of private sector with no guidance	1) How to recruit, train and retain staff? 2) How to train private sector practitioners (PPM)?
7	South Africa	58	77	72	66	20.1	1) No national policy for diagnosis and treatment 2) Inadequate recording and lack of monitoring 3) High level of TB/HIV with limited collaboration between programmes	1) How to establish national policy (national guidelines and training manual)? 2) How to train staff and develop of electronic information system? 3) How to develop and implement TB/HIV collaborative strategy?

8	Philippines	61	95	58	88	<0.1	1) Underdeveloped partnership with private sector to deliver DOTS 2) Lack of monitoring and supervision	1) How to develop a public-private mix (PPM) project? 2) How to establish supervision guidelines and strengthen central team?
9	Russian Federation	63	16	5	68	0.9	1) Lack of coordination and resistance to DOTS policy implementation 2) Lack of financial and human resources 3) High level of MDR-TB in certain areas	1) How to advocate at Federal level? 2) How to improve resource allocation (e.g. through donor meeting), recruit, train and retain staff? 3) How to develop guidelines and implement DOTS plus?
10	Ethiopia	66	70	42	80	6.4	1) Inadequate HR (quantity and quality); high staff turn over 2) Weak access to PHC and TB services 3) High level of TB/HIV with limited collaboration between programmes	1) How to increase number of health staff and limit turn-over? How to train staff? 2) How to involve community in pilot areas? 3) How to develop and implement TB/HIV collaborative strategy?
11	Kenya	68	100	47	80	15.0	1) Lack of trained staff at local level 2) High level of TB/HIV with limited collaboration between programmes	1) How to improve recruitment, training and retention of staff? 2) How to develop and implement TB/HIV collaborative strategy?
12	DR Congo	69	70	61	78	4.9	1) Lack of TB units in large cities 2) Poor access to TB services 3) Lack of TB staff at provincial level	1) How to mobilise resources to establish additional centres in large cities? 2) How to promote community involvement? 3) How to advocate for and train new TB staff?
13	Viet Nam	71	100	85	92	0.3	1) Limited health services in remote areas 2) Large TB activity in private sector with little guidance and no reporting	1) How to improve outpatient TB services in PHC units? 2) How to regulate and involve private sector?

14	UR Tanzania	73	100	47	78	7.8	1) Insufficient number of diagnostic services 2) Lack of trained health and lab staff  3) High level of TB/HIV with limited collaboration between programmes	1) How to increase number of diagnostic centres? 2) How to increase number of staff and improve staff training? 3) How to develop and implement TB/HIV collaborative strategy?
15	Brazil	74	32	8	73	0.7	1) Lack of political commitment at state level  2) Poor reporting and monitoring	1) How to advocate with new government to obtain full commitment and implement DOTS at all levels? 2) How to train staff on reporting and monitoring?
16	Thailand	75	82	75	69	1.8	1) TB division has no control over budget  2) Potential breakdown of monitoring and reporting system	1) How to advocate for TB at provincial level? 2) How to develop TB targets for Provinces? How to ensure accuracy of reporting in central office?
17	Zimbabwe	76	100	47	69	33.7	1) Lack of TB health staff and TB managers  2) Insufficient funding 3) High level of TB/HIV with limited collaboration between programmes	1) How to advocate for increased number of staff? How to increase staff training and retention? 2) How to mobilise financial resources? 3) How to develop and implement TB/HIV collaborative strategy?
18	Cambodia	77	100	41	91	2.7	1) Poor access to TB services in rural areas 2) Low adherence to DOTS in the private sector and hospitals	1) How to promote and increase community contribution to TB control? 2) How to develop pilot PPM projects?
19	Myanmar	78	84	59	82	n.a.	1) Insufficient financial resources 2) Inadequate HR (quality and quantity)  3) Weak infrastructure for implementation	1) How to increase resource mobilisation? 2) How to increase number of health staff and improve staff training and retention? 3) How to build infrastructure with donors and partners?

20	Uganda	79	100	52	63	5.0	<ul style="list-style-type: none"> <li>1) Poor access to TB services</li> <li>2) Insufficient laboratory capacity, no quality assurance (QA) system</li> <li>3) Staff limited due to quotas set by government</li> <li>4) High level of TB/HIV with limited collaboration between programmes</li> </ul>	<ul style="list-style-type: none"> <li>1) How to promote and increase community contribution to TB control?</li> <li>2) How to train more lab staff, improve equipment of labs, and identify lab focal points?</li> <li>3) How to organise secondment of staff from other institutions and partners?</li> <li>4) How to develop and implement TB/HIV collaborative strategy?</li> </ul>
21	Afghanistan	79	20	15	86	n.a.	<ul style="list-style-type: none"> <li>1) Poor health infrastructure</li> <li>2) Inadequate HR, weak NTP capacity</li> <li>3) High stigma and low community involvement</li> </ul>	<ul style="list-style-type: none"> <li>1) How to reconstruct health system?</li> <li>2) How to increase number of health staff and improve staff training and retention? How to strengthen NTP?</li> <li>3) How to develop and implement IEC strategy and promote community-based care?</li> </ul>
22	Mozambique	80	100	68	75	13.0	<ul style="list-style-type: none"> <li>1) Funding gap for NTP budget of \$5.3 million in 2003-09-05</li> <li>2) DOTS expansion plan not completed</li> <li>3) Lack of trained staff at peripheral levels following decentralisation</li> </ul>	<ul style="list-style-type: none"> <li>1) How to mobilise necessary funding?</li> <li>2) How to ensure completion of DOTS expansion plan?</li> <li>3) How to ensure enough trained staff at peripheral levels?</li> </ul>

### **Annex 3. The current approach of the Stop TB Partnership**

This section outlines the current approach of the Stop TB Partnership in addressing the key issues for DOTS expansion and achievement of the 2005 WHA targets.

#### **Implementation working groups of the Stop TB Partnership**

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

In addition to the activities of the Working Groups, the Partnership secretariat is actively encouraging and assisting countries to develop country-level partnerships which have a structure that is suited to country needs and circumstances. Having such country-level partnerships is critical to implementation of the full range of control measures in both the public and private sectors. It is anticipated that these partnerships will play a major role in the development and implementation of the national 5-year plans, described below.

#### **DOTS Expansion**

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

#### **International coordination**

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

## National 5 year DOTS expansion plans

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

## National Interagency Coordinating Committees (NICCs)

At the national level, the DEWG assists countries in establishing NICCs with the aim of promoting the coordination of an often large number of stakeholders. By 2002, 18 HBCs had established functional NICCs. In countries submitting proposals to the GFATM through the Country Coordinating Mechanism (CCM), NICCs should complement the work of the CCM.

## TB/HIV

The Global TB/HIV working group (established in 2001 under the auspices of the Stop TB Partnership) provides a mechanism for coordinating the global response to HIV-related TB as part of global DOTS expansion activities. The Working Group has endorsed the global strategic framework to decrease the burden of TB/HIV<sup>22</sup> (which addresses *what could be done*) and the guidelines for implementing collaborative TB and HIV programme activities<sup>32</sup> (which address *how to implement these activities*). The interim policy document on collaborative TB/HIV activities sets out *what should be done, under what circumstances*.

The TB/HIV Working Group has also been instrumental in promoting sound collaboration between TB and HIV programmes and other stakeholders, both nationally and internationally, and in establishing the evidence base for collaborative TB/HIV activities. For example, preliminary results from TB and HIV programme collaborative initiatives confirm the feasibility of this collaboration, which can help to increase TB case detection through expanded access to voluntary counselling and testing (VCT) for HIV. The likely impact on HIV incidence of expanded access to VCT for HIV should ultimately contribute to decreased TB incidence. Progress in the country-level implementation of collaborative TB/HIV activities is relatively slow, although several countries with a high burden of TB and HIV have developed national plans for collaborative TB/HIV activities. Constraints to progress include an incomplete evidence base to inform guidance for policy makers at country level and weaknesses in the general health system provision of TB care and HIV prevention and care. The TB/HIV Working Group is responding by: a) encouraging information exchange among members of the working group; b) prioritising the expansion of country-level collaborative TB/HIV activities; c) developing a communication strategy; d) paying more attention to information sharing and networking between different stakeholders.

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<sup>32</sup> World Health Organization. Guidelines for implementing collaborative TB and HIV programme activities. WHO/CDS/TB2003.319 WHO/HIV/2003.01.

The box shows the recommended essential activities to control HIV-related TB in the countries badly affected by TB/HIV.

<b>A. To establish the mechanisms for collaboration</b>
A.1. A coordinating body for TB/HIV activities effective at all levels
A.2. Surveillance of HIV prevalence among tuberculosis patients
A.3. Joint TB/HIV planning
A.4. Monitoring and evaluation
<b>B. To decrease the burden of TB in PLWHA</b>
B.1. Intensified TB case finding
B.2. Isoniazid preventive therapy
B.3. TB infection control in care and congregate settings
<b>C. To decrease the burden of HIV in TB patients</b>
C.1. HIV testing and counselling
C.2. HIV prevention methods
C.3. Cotrimoxazole preventive therapy
C.4. HIV/AIDS care and support
C.5. Antiretroviral therapy

### **DOTS-Plus**

Anti-TB drug resistance surveys conducted by WHO and IUATLD since 1994 through a supra-national laboratory network have unveiled foci of high MDR-TB prevalence in various settings worldwide. In response to the seriousness of MDR-TB as a global public health problem, the DOTS-Plus Working Group was established in 1999 to promote improved management of MDR-TB in resource-limited countries. The Working Group aims to assess the feasibility and cost-effectiveness of the use of second-line anti-TB drugs within the DOTS strategy, building on the five principles of DOTS. Since 2000, the Working Group's GLC has successfully negotiated with the pharmaceutical industry substantial concessional prices for second-line drugs that otherwise were unaffordable in poor settings. As a result, prices of the most expensive regimens have dropped by 95%.

Through the GLC, by 2003 pilot projects were under way in Costa Rica, Estonia, Latvia, Malawi, Mexico, Peru, the Philippines, and the Russian Federation. Data from these projects feed into the development of policy guidelines on MDR-TB management in resource-limited countries.<sup>33</sup> An effective response to MDR-TB contributes to achievement of the global targets by identifying and curing MDR-TB cases, which in some countries constitute a substantial fraction of all TB cases. The Working Group is currently fostering the inclusion of MDR-TB management plans within DOTS expansion/strengthening plans in those settings where NTPs have the capacity to respond to a documented and urgent need to address MDR-TB.

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<sup>33</sup> Management of Chronic and Multidrug-Resistant Cases. In: Treatment of Tuberculosis: Guidelines for National Programmes (3rd Edition) 2003. WHO: Geneva.

**Annex 4      The 2nd *ad hoc* committee on the TB epidemic: consultation process and timetable, members of the Committee and participants in the series of five consultations on TB and health system themes**

**Consultation process and timetable**

- (1) By April 2003, the DEWG secretariat in the WHO Stop TB Department had prepared a first draft background document with input from all the 2nd *ad hoc* committee members.
- (2) The DEWG secretariat presented the initial draft document to the members of the TB subgroup of Task Force V of the MDGs Project and to the Stop TB Partnership Coordinating Board at their respective meetings in Brasilia in early April 2003.
- (3) From June to August 2003, the DEWG secretariat convened a series of five consultations involving selected groups of public health experts for input in key health systems areas (primary care, human resources, social mobilisation, expanding the Partnership and health system reform/PRSP).
- (4) In June 2003 WHO's Strategic and Technical Advisory Group on TB (STAG-TB) reviewed and approved the process and the draft document presented.
- (5) In September 2003, the secretariat circulated the draft document to the Core Group of the DEWG and other selected individuals.
- (6) The document provided the background material for the meeting of the 2nd *ad hoc* Committee in Montreux, Switzerland, 18-19 September 2003.
- (7) In October 2003, the secretariat will circulate the 2nd *ad hoc* Committee's draft report to all HBCs. The Committee will seek endorsement of the report by the DOTS Expansion Working Group and Stop TB Partnership Coordinating Board at their meetings in The Hague on 7-8 October and 10 October 2003 respectively.
- (8) The secretariat will distribute and publicise the Committee's report at the Stop TB Partners' Forum in early 2004 for broad political endorsement. The report will be one of the products of MDG Task Force V.
- (9) In 2004, the Committee's report may form the basis for revisiting the Global Plan to Stop TB as part of the MDG Task Force V initiative.

## **Members of the 2nd *ad hoc* Committee on the TB epidemic**

Dr N Billo, International Union Against Tuberculosis and Lung Disease, Paris, France  
Dr A Bloom, United States Agency for International Development  
Dr J Broekmans, Royal Netherlands Tuberculosis Association  
Dr M Dayrit, Secretary for Health, Philippines  
Ms F Dumelle, American Lung Association, Washington DC, USA  
Dr G Elzinga, National Institute of Public Health and Environmental Protection, Netherlands (Chair, TB/HIV Working Group)  
Dr S England, Stop TB Partnership Secretariat, Switzerland  
Dr M Espinal, Designated Executive Secretary, Stop TB Partnership Secretariat, Switzerland  
Dr A Kutwa, National Tuberculosis and Leprosy Programme, Kenya  
Dr D Maher, Stop TB Department, World Health Organization, Switzerland  
Dr PR Narayanan, Tuberculosis Research Centre, Chennai, India  
Professor F Omaswa, Ministry of Health, Uganda  
Dr M Raviglione, Stop TB Department, World Health Organization, Switzerland (Chair, DOTS Expansion Working Group)  
Dr A Robb, United Kingdom Department for International Development  
Dr K Shah, National Tuberculosis Programme, Pakistan  
Dr R Tapia, National Tuberculosis Programme, Mexico  
Dr K Vink, Estonia (Chair, DOTS-Plus Working Group)  
Ms D Weil, World Bank, Washington DC, USA  
Professor D Young, Imperial College, London, UK

## **List of participants in the five consultations on TB and health system themes**

### **Broadening the Stop TB Partnership, Durban, 9 June 2003**

Dr B Alli, International Labour Organization, Geneva, Switzerland  
Dr N Billo, International Union Against Tuberculosis and Lung Disease, Paris, France  
Mr P DeYoung, World Economic Forum, Geneva, Switzerland  
Mr E van Druten, Telkom, Durban, South Africa  
Mr E Hall, Unilever Foundation for Education and Development, Durban, South Africa  
Ms N Mayet, BMW, Durban, South Africa  
Dr V Nantulya, Global Fund to Fight AIDS; TB and Malaria, Geneva, Switzerland  
Ms J Nelson, Prince of Wales International Business Leaders Forum, UK  
Mr S Simpson, Chevton Texaco, Angola  
Dr K Taylor, World Economic Forum, Geneva Switzerland  
Mr S Vanderborght, Heineken, The Netherlands

### **Communication and Social Mobilisation, Cancun, Mexico, 29 June – 1 July 2003**

Dr H Acero Velaquez, Subsecretario de Seguridad de Boyo Li, Colombia  
Dr B Aldana Gonzalez, Presidente Municipal de Amatitan, Mexico  
Dr R Beltran Luis, Johns Hopkins University, Bolivia

Dr N Billo, Stop TB Partnership, Geneva, Switzerland  
Dr K Bissell, IUATLD, Paris, France  
Sr M Broking, Instituto de Salud, (INSED), Lima, Peru  
Dr T Cerqueira, OPS/OMS, Washington, USA  
Dr J Deane, PANOS Institute, London, UK  
Dr C Garcia de Leon, President, AVE Mexico, Mexico  
Dr A Gumuncio Dagon, Development Communications Specialist, Guatemala  
Mr R Head, BBC World Service Trust, London, UK  
Ms P Heitkamp, Stop TB Partnership, Geneva, Switzerland  
Dr E Jaramillo, Stop TB, WHO/HQ, Geneva, Switzerland  
Ms S Krenn, Johns Hopkins University, Baltimore, USA  
Professor L Benajamin, Johns Hopkins University, Baltimore, USA  
Dr M Maldonado Vazquez Moises, Jefe de Jurisdiccion Sanitara V11, Mexico  
Mr M Mahalingham, UNAIDS, Geneva, Switzerland  
Ms M Ntombekhaya, GFATM, Geneva, Switzerland  
Dr L Palma Escalante, Ministry of Health, Nicaragua  
Dr J E. Paluzzi, Partners in Health, Boston, USA  
Dr W Parks, CPE/SMT, WHO HQ, Geneva, Switzerland  
Professor E Rodgers, University of New Mexico, USA  
Mr S Satyajit, Stop TB Partnership, Geneva, Switzerland  
Ms L Shimp, BASICS, USA  
Dr R Tapia, Vice-Minister for Health, Mexico

**Health Sector Reform and the Poverty Reduction Strategy Process, Washington, USA, 30 June – 1 July 2003**

Dr G Abbassi, Deputy Chief Health, Islamabad, Pakistan  
Ms D Barry, Partners in Health, Boston, USA  
Dr A Bloom, USAID, Washington, USA  
Dr J Broekmans, KNCV, The Hague, The Netherlands  
Dr C Chanfreau, Partnership for Health Reform Plus Project, Bethesda, USA  
Dr H Cossa, Directorate of Planning and Cooperation, Maputo, Mozambique  
Dr M del Granado, national TB Control Programme, La Paz, Bolivia  
Ms C Hain, World Bank, Washington, USA  
Ms C Hanson, World Bank, Washington, USA  
Mr R Hecht, World Bank, Washington, USA  
Dr K Janovsky, World Bank, Washington, USA  
Dr G Kombe, Partnership for Health Reform Plus Project, Bethesda, USA  
Dr J Lagahid, Ministry of Health, The Philippines  
Ms D Lans, USAID, Washington, USA  
Dr R Levine, Center for Global Development, Washington, USA  
Ms S Lwin, Global Fund, Geneva, Switzerland  
Dr A Luna, Washington, USA  
Dr A MacArthur, Ministry of Health, Maputo, Mozambique  
Dr D Maher, Stop TB, WHO/HQ, Geneva, Switzerland  
Ms J McLaughlin, World Bank, Washington, USA

Dr D Mueller, World Bank, Washington, USA  
Dr V Oliveira-Cruz, London School of Hygiene and Tropical Medicine, London, UK  
Dr C Powell, USAID, Washington, USA  
Dr L Rogando, Center for Health Development, Philippines  
Dr B Sakagawa, USAID, Washington, USA  
Dr K Shah, National TB Control Programme, Rawalpindi, Pakistan  
Professor R Skolnik, Center for International Health, Washington, USA  
Dr J Uribe, World Bank, Washington, USA  
Ms D Weil, World Bank, Washington, USA

### **Primary Health Care Service Providers, Kampala Uganda 3-4 July 2003**

Dr F Adatu, National TB programme, Kampala, Uganda  
Dr D Giusti, Uganda Catholic Medical Bureau, Kampala, Uganda  
Dr J Imoko, WHO Country Office, Kampala, Uganda  
Dr D Lans, USAID, Washington, USA  
Dr J Odaga, Uganda Martyrs Catholic University – Nkozi, Uganda  
Ms G Oling, The AIDS Support Organization, Kampala, Uganda  
Professor F Omaswa, Ministry of Health, Kampala, Uganda  
Dr K Ranson, London School of Hygiene and Tropical Medicine, UK  
Dr S Santini, International College for Health Cooperation in Developing Countries,  
Kampala, Uganda  
Ms M Verhallen, Public Health Consultant, Amsterdam, The Netherlands

WHO secretariat:     Dr O Walker, WHO Representative, Kampala, Uganda  
                           Dr L Blanc, WHO Stop TB Department, Geneva, Switzerland  
                           Dr G Gargioni, WHO Stop TB Department, Geneva, Switzerland  
                           Dr D Maher, WHO Stop TB Department, Geneva, Switzerland

### **Human Resource Development for TB Control, WHO Headquarters, Geneva 27-28 August 2003**

Ms S Bacheller, USAID, Washington, USA  
Dr C Basri, Ministry of Health, Indonesia  
Dr S Egwaga, Ministry of Health, United Republic of Tanzania  
Dr G Elzinga, National Institute for Public Health & Environment, The Netherlands  
Professor G Dussault, World Bank, Washington, USA  
Dr T Ghebrehwet, International Council of Nurses, Geneva, Switzerland  
Dr P Hornby, Keele University, UK  
Professor D Sanders, University of the Western Cape, South Africa  
Dr A Romualdez, Friendly Care Foundation, Philippines  
Ms C Wiskow, International Labour Office, Switzerland  
Dr A Pablos-Mendez, Rockefeller Foundation, USA  
Dr K Wyss, Swiss Centre for International Health, Switzerland

WHO secretariat: Mr O Adams, WHO/HQ, Switzerland  
Dr M Aregawi, WHO/HQ, Switzerland  
Ms K Bergstrom, WHO/HQ, Switzerland  
Dr L Blanc, WHO/HQ, Switzerland  
Dr M Dal Poz, WHO/HQ, Switzerland  
Dr J Figueroa, WHO/HQ, Switzerland  
Dr D Maher, WHO/HQ, Switzerland  
Dr M Raviglione, WHO/HQ, Switzerland  
Ms J Sheppard, WHO/HQ, Switzerland  
Ms M Youssef-Fox, WHO/HQ, Switzerland