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# REPORT OF THE AD HOC COMMITTEE ON THE TUBERCULOSIS EPIDEMIC

London, 17-19 March 1998

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# **Report of the Ad Hoc Committee on the Tuberculosis Epidemic**

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## **I. Introduction**

1) Dr Carlyle Guerra de Macedo, chair of the Committee opened the meeting with expression of sorrow on the death of Dr Karel Styblo. It is because of Dr Styblo's work that the Committee could start from a firm base. That is:

- a) TB is a priority health problem because of its burden of human suffering, incapacity and death, and because there is a proven and affordable strategy to control it – DOTS - with one of the highest cost/benefit ratios among health interventions.
- b) Surveillance and monitoring data from all regions show that much has been done with DOTS to control TB but progress is still slow;
- c) Evidence from many countries shows that it is possible to accelerate progress in TB control with the DOTS strategy.

2) These factors provide the main basis for the convening of the Ad Hoc Committee.

3) Last year, in reviewing the TB situation GTB's Coordination, Advisory and Review Group (CARG) recognised that most of the countries with a high burden of TB will not be able by the year 2000 to reach the targets for TB control established by the World Health Assembly (WHA). CARG recommended nevertheless, that the targets be maintained and work by WHO focus on the countries responsible for most of the burden of disease in order to help them to take the required measures to accelerate progress. Just twenty-two countries account for 80% of TB cases in the world. The WHO/Executive Board (EB) in its 101<sup>st</sup> Meeting accepted the substance of the CARG's recommendations to the Director General which will be considered by the 51<sup>st</sup> WHA, next May 1998.

4) The Ad Hoc Committee has been formed to: a) analyse individual countries abilities to reach the targets by the year 2000; b) make recommendations relating to global strategies to assist countries to achieve global targets as soon as possible; and, c) make specific recommendations relating to the key countries which have the greatest impact on the global TB epidemic.

5) Five documents from the GTB secretariat were prepared for this meeting

- a) A discussion paper -- "What is DOTS";
- b) The TB Monitoring and Surveillance Report, 1998;
- c) Status of Tuberculosis in the 22 High Burden Countries;
- d) A discussion paper -- "The Global Constraints to TB Control";
- e) "Global TB Research Initiative: Position Paper", and "Summary Findings and Recommendations of the first meeting of the Initiative".

6) The chairman noted that, as potentially useful to the struggle against TB, some kind of special contribution by the members of this Committee may be useful to the new Director General of WHO and to GTB. Members were requested to consider how this contribution might best be offered.

## ***II. Statement of Committee Issued at the Conclusion Meeting***

1) The members of the Ad Hoc Committee convened by the World Health Organisation call on world leaders to give their urgent attention to the global tuberculosis epidemic. Progress against the global TB epidemic in nearly 100 countries is being overshadowed by the stalled or slow progress in many of the 22 countries which account for the vast majority of the world's TB cases. The Committee notes with deep concern that even where progress has been good, questions of sustainability and expansion pose risks for the near future in places such as China and Bangladesh. Global targets cannot now be met.

2) Intensified technical efforts will not by themselves bring about the acceleration and expansion needed. This Committee has identified six principle constraints retarding action by health authorities. These are financial shortages, human resource problems, organisational factors, lack of a secure supply of quality anti-TB drugs, and public information gaps about TB's danger. The most fundamental constraint is the lack of political will to develop and sustain effective TB programmes.

3) It is, of course, primarily the responsibility of the political and health leaders of the countries faced with the epidemic to execute an effective response. But, it is transparently in the world's public interest that the global community help fight the epidemic wherever it exists. Since progress has been too slow overall and is stalled in some key countries, extraordinary measures now are needed to reverse the insufficient political will which underpins the other constraints. The keys to effective global action to do this are in the hands of a small number of political, legislative, financial and health leaders in the endemic countries and in the developed nations and the global institutions.

4) The Committee believes that many of the world's leaders are unaware of the dimensions and costs of the TB epidemic and the urgency of controlling it. It also believes that most citizens in the affected countries are unaware of the risks they face and the fact that these can be eliminated by concerted use of the DOTS strategy, supported by effective research to improve the strategy and its tools in the medium and longer term. The world cannot be protected from TB as long as countries with a high burden of TB do not make progress. Because of HIV's impact on TB and emerging drug resistant forms of TB, the dangers of national and global inaction are increasing sharply. This Committee has concluded that the insufficient political will to control TB is the greatest single constraint to progress. Political action to make and keep tuberculosis control as a true health, social and developmental priority would allow progress to be made against the financial, human resource, organisational, drug supply and information constraints. The Committee calls on heads of state, parliamentary leaders, and finance, planning and health ministers to exercise their pivotal roles.

5) The global institutions for a coordinated initiative to support committed national leaders exist and must also exercise their mandate. A coordinated partnership of the WHO, the World Bank, bilateral development assistance agencies, the IUATLD and other NGOs and the global research community is needed urgently. These institutions can help sustain the environment to encourage political will. Then they can methodically and persistently alleviate

the other identified constraints through policy and technical collaboration with the endemic countries and by financing and supporting the DOTS strategy, including the research to permit its wider and easier use and to develop new tools.

### ***III. General Review of the Epidemic by the Committee***

- 1) The Committee reviewed available information and noted that many countries are doing well. DOTS has expanded from 11 countries in 1992 to 96 countries in 1997. Patients receiving effective TB treatment consistent with the DOTS approach have increased about 10 fold from less than 100,000 in 1993 to about 1 million in 1997.
- 2) In contrast, the Committee noted that for most of the large and high TB burden countries, progress was fragile or, in at least 16, according to the 1995/96 data, was stalled. Overall, the Committee noted with deep concern that the TB epidemic was still underestimated at policy levels in most governments. There is a wide-spread lack of funding in the right places for the right things. Added risks from multidrug resistant TB, and increased mobility of populations means that tuberculosis in the high burden countries affects all countries.
- 3) The Committee underlines the seriousness of continuing improper use of anti-TB drugs, including over-the-counter sales, poor quality products, procurement and supply-line/distribution problems and the financial or other barriers which cause patients or providers to fail to ensure proper drug regimens are consumed for the proper length of time to ensure cure.
- 4) The Committee notes that in many places the tuberculosis epidemic is wrongly viewed as a problem only of the poor and that responsibility for addressing it is often confined, wrongly, to the health system (it is indeed a social problem). To ensure and sustain societal support the social and health consequences of the epidemic need to be explained and responded to on a broader, intersectoral basis. In some places, and where MDR-TB risks are emerging, TB needs to be dealt with as a subject of top national urgency, requiring well-planned and executed action.
- 5) The need to ensure that the TB epidemic is viewed as an issue outside the health sector was noted as key to it receiving sufficient political attention; instrumental to this may be a comprehensive analysis of the costs of poor global (and national) TB control and the costs required to do it well. There is also a need to monitor the resource flows for TB control, including the purposes for which funds were spent. This work should also identify the gap between the resources available and those required. WHO is recommended to commission the studies needed to undertake these analyses and should ensure that the results are placed before the international community.

#### **IV. General Constraints to Progress Against TB and Main Solutions Reviewed by the Committee**

##### **A. Political Will and Commitment**

1) The Committee discussed extensively and concurred that the overriding constraint to sharply improved and accelerated global TB control is presently weak political will and commitment. The Committee members concurred that probably most political leaders, and most average citizens in the high burden countries were simply unaware of the risks of the TB epidemic and the strategies for its effective control. The importance of and methods for creating and sustaining political will at the global and international levels and at the national and subsidiary levels were discussed.

2) The chairman summarised that political processes across countries are quite similar in nature, even if adjusted in their practice to the specific environments and cultures. Some general conditions are required for political commitment. Internally, political normalcy and a favourable economic situation are often needed. Political stability is a principal characteristic of political normalcy, while the economic situation creates the means for translating formal commitments into effective actions. Externally, an internationally supportive environment is required.

3) Political commitment, at national level and within the countries at all levels of the government, is the essential element for effective TB control programmes. Four factors are important to get this commitment and make it effective and sustainable:

- a) Popular perception. TB needs to be popularly perceived as a priority problem with a real solution in order that there be social demand for attention at the political level. Therefore, it is important to promote community organisations (people at risk, their families and other interested actors) to press politicians and governments. The encouragement of (associations of) patients and former patients to achieve this goal should be considered. NGOs can play a significant role in this regard and public information aimed to educate and to empower the people should become a critical strategy.
- b) Technical consensus. It is indispensable to have real consensus among the technical and scientific community in order to have a concerted and synergetic voice -- from the TB specialists and health leaders -- to the governments and other political channels, such as the parliaments and political parties. Achieving acceptance and consensus on DOTS requires convincing people through information and by means of concrete demonstrations such as pilot experiences which can also impact directly on the policy makers. The international community has a relevant role in this regard, specifically strengthening and legitimating the technical concept and policy which, in turn, will result in an increase of political credibility of the domestic health technical establishment. Intersectoral alliances with the help of the private sector and NGOs will boost this credibility, especially if alliances are established with planning and economic sectors at both the global and national levels.
- c) External concern. International advocacy and "demand" for effective programmes, including through direct contacts to endemic country leaders by high level and knowledgeable people and institutions, and the use of the financial incentives and instruments of formal commitment play important

roles. External concern can educate and motivate intersectoral leadership and attention and is a factor to sustain attention over many years. This factor will be most successfully used if it is implemented in a coordinated way by the international or bilateral organisations concerned. International advocacy should be so employed as to encourage (and not diminish) national ownership and support of TB programmes.

- d) Mass media use. In partnership with the private sector and NGOs, use of the media to create a climate of public awareness and concern to sustain interest by the political establishment and the governments is essential.

4) In implementing these four factors, the Committee urges WHO and its partners to recognize the pragmatic nature of the political arena. Usually this requires clear demonstration of results with the best possible cost effectiveness ratio, which will mean also the best opportunity cost (compared to alternative ways funds were being or could be used). It is also vital to be able to identify and to make use of special circumstances which can create the conditions to induce or facilitate political decisions. As economics is the driving force of the political process in most countries, regardless of rhetoric favoring social components of development, it is useful to make use of economic arguments favoring health, and TB control with DOTS, to strengthen political will in their favor.

5) At the international level, a public commitment to ending the global TB epidemic is needed at the highest level of the organisations concerned, including specifically the WHO, the World Bank and other international development institutions. This commitment should be formalised in an appropriate manner taking into account the roles of the United Nations General Assembly, and the governing bodies of the relevant institutions. The process should legitimise and be the lasting basis for a common strategic plan to orient and encourage the actions of all partners. These include WHO (and its Regional Offices), the World Bank and other multi-lateral financial institutions, bilateral development assistance agencies, the IUATLD and other NGOs, philanthropic institutions, national governments, the private sector, national NGOs and associations and civil society.

6) In the Committee's view, the process and instruments of formalised global commitment would have compelling positive influence on countries facing the epidemic to seek appropriate technical and financial assistance and to responsibly begin, sustain and report on effective tuberculosis control. The Committee notes that the need for this approach will not be limited to just a few years, but is certain to be several decades in length. Accordingly, and for the purpose of further discussion of details by WHO and other institutions of this concept, the Committee suggests the term Global Charter on TB.

7) Such an instrument at a global level is needed for framing the growth of political will which has been decidedly fragmented or inconsistent in the past twenty years. The *Global Charter* would be an agreement between international agencies like the WHO, the World Bank and donors on the one hand and the governments of endemic countries on the other, about specific steps to be taken to control the TB epidemic in a time bound manner. Such an initiative can greatly support efforts by the WHO and World Bank in terms of advocacy, public awareness and bringing moral pressure on both donors and national governments of endemic countries for giving high priority to this serious problem. It would focus the international cooperation needed, help stabilize the funding flows, provide for much better coordination of policy and reporting of progress, and provide a benchmark for the degree of national commitment needed, while recognising and opening the channels for participation by the organisations of civil society.

8) A *Global Charter* would also provide a context for "compacts" or contracts developed on a regional or country basis. These could be tailored to specific needs and conditions and could include the consortium of interested donors and could formulate responsibilities for sustained improvements in TB control. National elements of such a compact should include the private sector, NGOs, professional associations and others. The objectives of such an approach would be coordinated action beyond the health sector, long-term obligations and a secure financing plan, benchmarked performance goals, and commitment by all parties.

## B. Financing

1) The Committee noted the following important elements in relation to financing constraints.

2) Many of the poor and middle income countries simply have too few resources allocated to TB control. The poorest may require external assistance to solve this problem. But for some of the poorest, and for most of the middle income and upper-middle income countries with the worst TB epidemic sufficient resources are already available within the health system, sometimes even allocated to tuberculosis control, but ineffective use of resources is accomplishing much less than if they would be reallocated to a DOTS approach. Indeed, the Committee noted that money spent on poor quality TB control programmes is not only an epidemiological tragedy but it represents wasteful current spending the consequences of which will also require higher levels of future spending. Ministries of finance and planning could occasionally encourage health sector spending reviews to determine if the elements of the DOTS strategy are properly funded and whether the expected outcome results (cases found and cured) are in fact being achieved. The GTB, or others, could develop benchmarks and a protocol to stimulate and encourage financial reviews. Performance in a number of the top 22 burden countries could be substantially improved if this principle would be applied.

3) Absence of information. A large part of the inattention paid to the TB epidemic currently is attributable to the fact that the financial and economic costs, potentials and lost opportunities, are not well quantified for decision makers in the health ministries or among those who must support the health sector (ministries of planning, finance and parliamentary bodies). More complete economic and financial analysis must be made of the costs of continuing poor TB control programmes, the realistic costs of improved programmes and the social costs and benefits of both the epidemic and its control. This work should include better estimates of the flows and the sources of funds now being devoted to TB (nationally and internationally). GTB should negotiate a programme of work with the World Bank and other institutions to commission these studies.

4) The world must be made to know that one out of three persons alive today are already infected with the tubercle bacillus. There will inevitably therefore be a several decades long need for ensuring good treatment of TB. Therefore the Committee concludes that the issue of sustainability of TB control must be a basic concern from the beginning of any national or international financing plan and must be dealt with seriously by both international donors and financing authorities in endemic country. While the main responsibility necessarily rests upon the endemic countries themselves, it is in the self-interest of the international community of multilateral/bilateral donors to assist to ensure that periods of initial attention and progress are not followed by inattention and then resurgence of disease, much of it predictably then drug resistant. The Committee requests leaders of endemic countries and the international institutions to act on the fact that the global financial and social implications of



poor TB control cannot be over-stressed because of the beachheads already established by multidrug-resistant strains of TB on every continent as a result of the neglect accorded to the disease over the last decade. To ensure sustainability, the *Global Charter* for TB referred to above would provide a valuable mechanism and forum.

5) The Committee notes that among priority areas for financial support are **DOTS demonstration projects**. In order to build national understanding and commitment for good control in the endemic countries and in particular among their health professionals, pilot approaches can effectively be used to fine-tune the application of the DOTS strategy to the culture and health systems characteristics of the endemic countries. They can also be used as the base for rapid scale-up of the DOTS approach by enabling on-the-job experience to health service staff.

6) **Critical factors and principles related to provision of new donor financing:** Because, inter-alia, of the dangers of drug resistance, the Committee urges that new or accelerated TB control programmes not be initiated by endemic governments or development agencies unless funding is firmly available to ensure that the following factors (details in other sections) will be dealt with safely: drug supply, operational training, competent management, and a good information system.

7) In addition, the following general principles which should guide donor support were discussed. The high burden endemic countries can be categorised into middle income, low income and least developed. Similarly, the DOTS programme has three distinct phases: 1) introductory or pilot, 2) expansion, and 3) maintenance. The Committee advised that, on the assumption that political will to deal with the epidemic had been established, the broad criteria for donor assistance may be as follows:

- a) Middle income countries should not normally need financial support except on a limited basis at the introductory stage to convince governments of the effectiveness of the DOTS strategy;
- b) Low income countries would need financial support for both introduction and expansion phases but should generally be expected to support the maintenance of programmes on their own; and,
- c) Least developed countries can be expected to need financial support for all the three phases although they should be encouraged to bear increasingly, at least, a part of the financial responsibility for maintenance.

### C. Human Resources

- 1) It is obvious but must be noted that human resources are a key element for tuberculosis programmes as they are for all effective health services. As TB has been neglected over the last decades it is also true that the human resources, the career structures within health ministries and the general attractiveness of service in national TB programmes has been neglected. Funds for training, career prospects, recognition, and rewards are topics which health ministries must address if they are to successfully manage and sustain the expanded effort against TB which is needed. The international community can both assist with and insist on this.

2) Training is crucial for human resource development. Most training needs can and should be the responsibility of the endemic countries. Both poor and middle-income endemic countries require the benefit of international training courses to develop and maintain TB control and pedagogical skills. The international training programmes of the WHO and the IUATLD must be maintained and expanded for this purpose and some prestigious international training academy or programme may be pivotal for development of special people and special skill in the endemic countries and for recognition/motivation purposes. Most technical training will be better performed at the regional level in order to take advantage of capacity, synergy and experience with existing institutions (a network approach) as long as the content of such training is certified at the international level. At the country level training must not be restricted to "TB specific personnel" as most health personnel at the periphery level need basic TB control knowledge. The vision for the training packages as a whole must be to enable good TB care and prevention to be performed through all levels of the health system.

3) The selection and recruitment of good people and their retention (their stability in their function) are important. In poor and middle income countries, incentives are key to facilitate this. Incentives may be both material and moral/professional (salary, prospects of career advancement, professional recognition, awards, conditions of work, etc.). Special salary or bonus incentives may not be possible within public civil service and alternative arrangements are important to devise and maintain.

4) Lastly, the Committee notes that for each country the leadership and managerial capability of senior technical people to deal with the political dimension of tuberculosis and should be the subject of both the recruitment/promotion criteria and the subject of training. Empowerment and encouragement of good technical leaders and managers to advocate for good policy is paramount.

#### **D. Organisation and Management**

1) Political support for sustained, adequate financial resources for TB control can only be mobilised when there is efficient use of the available resources. The Committee notes that both the endemic countries and the multilateral and bilateral development agencies must ensure that the critical element of good management is provided for as a priority and monitored and the outcomes achieved are reported on regularly.

2) The current situation and trends in Health System Organisation (Health Reforms) affect TB programmes in many critical ways, such as:

- a) Integration with the risks of losing identity, ownership and accountability, and the advantages of offering opportunities for expansion and complementary;
- b) decentralisation, the same risks plus those of disruption of drug supply and quality, of deficient supervision, control and evaluation, and the advantage to expand the reach of TB actions;
- c) public and private mix, in which poorly conceived privatisation and cost recovery strategies, could lead to poor coordination and barriers to detection and treatment, but with the potential benefit that an involved private sector will expand options for providing TB treatment and control;

- d) community participation, which would be an important positive factor.
- 3) It is fundamental that in managing TB programmes, a proper balance be established between integration and specificity, and between decentralisation and centralised functions. No old-fashion verticalization is acceptable, but key functions must remain specific to the programme and be carried out on national/regional basis, such as assessment of the magnitude of the problem (surveillance), regular supervision, drug procurement/supply and rigorous monitoring/evaluation of programme performance.
- 4) A control and surveillance unit at the Ministry of Health, as well as identifiable and accountable staff at regional and district level are indispensable for effective application of the DOTS strategy.
- 5) Private sector participation in good TB control (e.g., physicians, health care organisations, hospital ambulatory services) should be promoted. The Committee noted that the public health elements of TB control activities, including especially the supply of drugs, must remain a public service to be provided free of charge except in cases where patients are well-insured or wealthy. In countries where a large proportion of patients receive care through the private sector, it needs to be invited by health authorities to become active in developing plans to implement the DOTS strategy, and other elements of TB care and prevention.
- 6) Managerial capability must be part of the training for personnel who will have responsibilities for guiding programme implementation at national or regional/district level.
- 7) There is the need to deal with two main categories of personnel -- the general health workers and administrators who need limited TB knowledge, and the specialised TB staff to support and ensure the quality of the work of those in the health services.

#### **E. Anti-TB Drugs**

- 1) The background papers for the Committee reviewed the essential importance of the quality, timeliness, security and supply and presentational form considerations for the anti-TB drugs without which progress against the epidemic cannot be made. The spread of resistant strains of the bacillus is a threat to be taken very seriously. Monitoring is essential and authorities should adopt all necessary measures for the proper use of drugs. In this regard the enforcement of regulations to restrict the commercial sale and to regulate the use of anti-TB drugs is required.
- 2) The Committee noted that any deficiency in drug provision not only has adverse effects directly on treatment outcomes and peoples' lives but creates immediate risks of infection spread for the community, and adds to long term national and global risks and costs of MDR-TB. In the Committee's view, the consequences of this are so severe that there must now be an extraordinary international effort to establish special arrangements for drug financing, procurement and distribution to avoid disruption in the availability of drugs.
- 3) Specifically, Fixed Dose Combinations (FDCs) of anti-TB drugs should receive much more attention and their use be expanded rapidly, taking in account:
  - a) the assurance of quality and especially the bio-availability of the component drugs;

- b) the interests and cost-effectiveness of national industry where it exists;
- c) the prevailing prices of FDCs and formulation of measures or methods of purchase to reduce the price and to ensure no financial disincentives (to patients or the health services) arise for use of FDCs.

4) Accordingly, as an adjunct to the *Global Charter for TB*, the Committee recommends that WHO, the World Bank and other appropriate governmental and non-governmental organizations establish a *Global Drug Facility*. This *Facility* should serve as an effective mechanism for procurement and distribution of anti-TB drugs. It could potentially operate any or all of three mechanisms: a) as a revolving fund and mechanism of procurement for those countries which would want to make use of it and have the resources to pay for the drugs; b) as a mechanism between donors and recipient countries to ensure timely, quality procurement and distribution of drugs; c) as an international technical resource to assist countries in strengthening their own capacity in procurement. In addition, the *Facility* could monitor and report information about prices. WHO should initiate discussions to establish such a *Facility* with the World Bank, bilateral development agencies and others with a view to its operation before the year 2000.

5) In support of the *Facility*, WHO should develop a system for certification of quality of FDCs at the level of production (manufacturers). WHO should also promote tests of bioavailability at the country level, where possible, through accredited laboratories and networks.

## F. Information

- 1) The Committee emphasised the importance of information without which no DOTS programmes are possible.
- 2) The Committee recommends the incorporation of key TB indicators in the routine of the Health Information System. Two indicators will be needed: one to measure the problem (approximated by monitoring case detection) and the other to measure the outcome (proportion of patients cured among those detected).
- 3) Governments should adopt and implement the WHO/IUATLD TB information system, and ensure that data from all sectors involved in TB services is reported to the national TB programme. Appropriate legislation should be introduced where necessary and feasible.
- 4) WHO should continue to collect data from countries and report on global TB surveillance annually; and should provide support to national governments to modify national methods of monitoring surveillance as necessary.

## G. Others

- 1) Decentralisation, health sector reform and sector-wide approaches to health sector financing. The Committee discussed the ongoing trends in foreign assistance and in health sector financing by which both national governments and financiers are often taking a basket-approach and providing non-earmarked funding for the health sector. Local authorities are often charged with responsibility to determine the needs and best uses of available resources.

While these approaches have many potential advantages, the Committee is concerned that, in practice, country level observations from the IUATLD and WHO are showing that things are not working safely. In particular, the Committee calls on the World Bank and WHO to carefully assess problems occurring specifically with TB control. Negotiations between multilateral or bilateral development agencies and developing country governments establishing decentralisation or health sector reform approaches should include specific safeguards to ensure tuberculosis is not made worse. Reform and decentralisation initiatives should be carefully assessed at both national and international level against the following risks:

- a) loss of economic scale in drug procurement and severe problems with maintenance of drug quality and the supply chain;
  - b) difficulty in ensuring accountability for funds to be used for TB;
  - c) local political pressures or personalities, who may change priorities determined at a higher level;
  - d) corruption in purchases, which may be more difficult to control;
  - e) potential loss of data flows for performance monitoring, surveillance, progress reporting and trouble shooting, which may be hard to overcome;
  - f) cost recovery from TB patients, which may be demanded locally.
- 2) Financing constraints faced in and by the TB endemic countries are so varied, and so much affected by policy changes relating to decentralisation of health financing and health sector reform that there is need for monitoring of the impact of financial changes. There is also a clear need for better coordination overall of development assistance flows for TB control (i.e., donor coordination). As noted elsewhere in this Report the Committee recommends that WHO commission the analyses to underpin this monitoring in partnership with others, including the World Bank in particular. The Committee notes that a *Global Charter for TB* would provide a framework for coordinating financial assistance for TB and tracking its flows, analysis of sectoral financing changes, and reporting of consequent developments, while minimising costs and the need to create any new institutions.
- 3) Research: The Committee acknowledged that research was essential to make DOTS easier and more widely available, to improve the currently available tools and to go beyond DOTS to develop vaccines and new medicines. The Committee did not elaborate on research related matters because the topic has already been explored in depth at the first meeting of the Global TB Research Initiative. The Committee recommends that WHO continue the Global TB Research Initiative and that it should form a component of an eventual strategic plan for global TB control and its processes be provided for in the framework of a *Global Charter*.

## H. Priority Countries, criteria and approaches

- 1) For all countries facing the TB epidemic, and especially for the top twenty-two burden countries, the Committee calls to the attention of the Director General of WHO and the President of the World Bank the importance of augmenting and accelerating assistance to support the countries. The breadth of issues to be confronted and the general fragility of support for TB control in these countries suggests that the international institutions need to deliberately focus and encourage international attention and assistance. In particular, the Committee recommends that these two global institutions seriously consider the proposals described in this Report to establish *Global Charter for TB* and an associated *Drug Facility* to help all endemic countries deal much better with the political will and technical challenges of the TB epidemic.

2) **China:** The Committee considered the important issues facing China. The excellent performance of the 13 provinces using the DOTS approach must be sustained after completion of the World Bank loan project and this will require either new external resource flows or increased/reallocated central and provincial government financial commitments to TB. Failure to secure this will result in many of the risks listed in the section above becoming serious problems at the local level which will inevitably cause a deterioration in performance and a resurgence of disease. For the half of China not covered by the DOTS approach currently, the Committee expresses its deepest concern about the global implications for increased drug resistance, and large numbers of avoidable cases and deaths. The Director General of WHO and the President of World Bank should seek a joint approach to discuss with the Chinese government assurances to pursue safe expansion and sustaining of effective TB services for the whole of China.

3) **India:** The Committee recognised the commitment and progress made by India to adopt new national policies, provide wide scale training in the DOTS strategy, increase the national budget for TB several fold, allocate substantial external resource flows to TB (World Bank, DFID, DANIDA) and to prove that India could capably implement the DOTS strategy in 20 pilot projects covering 18 million people in 13 states. The Committee also noted the urgent and very adverse social and epidemiological consequences due to the long delay in procurement of drugs to allow the national programme to expand. The Committee calls upon the new Government in India to give urgent priority attention to this serious problem and arrange the procurement of anti-TB drugs immediately in order that the DOTS programme can be expanded as planned without further loss of time. The Committee also urges the WHO and the World Bank to render all possible assistance to the Government in accomplishing this task quickly. The Committee notes that the proposed *Drug Facility* could be utilised by the Government for this purpose if and when the *Facility* becomes operational. It notes that the proposed *Global Charter* provides a mechanism for India to sustain the high and consistent commitment to TB control which will be needed for the next several decades.

4) **ASEAN countries:** While the tuberculosis epidemic in Indonesia and parts of other countries in the ASEAN region was severe before the recent financial crisis, the situation could now deteriorate into a health crisis affecting the entire region. Experience with the explosion of TB in the states constituting the former Soviet Union provides ample evidence of what will happen if the health sector financing (and TB management) is neglected, especially in Indonesia, and in the Philippines where decentralisation factors have several years ago already caused deterioration in programme performance. The Committee notes the need for urgent discussion of the issue with planning and finance authorities in the ASEAN countries so that the health ministries can be supported and held accountable for sharply improved TB control performance over the coming months of 1998 and 1999. This suggestion is related to and further underpins the need for a *Global Charter* and *Drug Facility* as described in this Report.

5) The Committee accepted that without additional resources and capacity any additional effort by GTB or its partners could be made in the near future in only a few selected countries among the 22 considered. The Committee recommends the selection of countries be made by GTB according to the following criteria: a) proportion of global burden of TB in the country; b) potential for progress; c) regional coverage; and d) containment of drug resistance. The Committee expressed also its expectation that all countries be provided with normative and technical guidance and, as possible, that efforts be made to mobilise technical support for them.

***V. Special Follow-up Action to be taken***

- 1) Briefing of WHO's Director-General-elect. The Committee agreed that the Director General-elect should be informed of the meeting, and the Committee's concerns. Dr C. Guerra de Macedo, chairman, will seek an appointment for briefing purposes early in the month of April. The Ad Hoc Committee considers itself dissolved on the day the chairman presents this Report to the Director General-elect. Various suggestions (below) were made about the ways in which the Committee members, collectively and individually, could assist in the follow-up of the Report. This is reflective of the commitment every member felt for the need to much better support global TB control. The members of the Committee unanimously expressed their willingness to make themselves available for this global cause should the WHO need their assistance in any manner.
- 2) Activities for Key Countries. The Committee took note of the delicate situation for sustaining and expanding the TB programme in China and resolving the drug supply problem in India. It noted that progress in other countries was also fragile. There may be potential for Committee members to help with these problems. They could build political support and attention through visits to key countries, and could use their networks of contacts, to encourage progress and concerted effort in the endemic countries in general. If there is general acceptance of this activity by the new Director General-elect, GTB will make available funds for the Committee to engage in this process. Modalities and principles would be worked out by the chairman, with support from the secretariat, as may be requested.
- 3) Contact to World Bank and Key Donors: In the same spirit as above, Committee members through their contacts with the World Bank and with leading development assistance organisations, could facilitate a dialogue on an improved global partnership, its elements, roles to be played and next steps. This could substantially augment the capacity of the secretariat in the level and breadth of dialogue and could help to remove misperceptions of secretariat-driven growth or mandate. If this process would have the general acceptance of the Director General-elect it could be handled as proposed under 2 above.
- 4) Report to CARG. The work of the Committee should be reported to the CARG meeting in 1998.

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**The Ad Hoc Committee On the Global Tuberculosis Epidemic**  
**London, 17-19 March 1998**

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