WORLD HEALTH ORGANIZATION

FIFTY-THIRD WORLD HEALTH ASSEMBLY **A53/5**
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Stop Tuberculosis Initiative

Report by the Director-General

BACKGROUND

1. Resolution WHA44.8 set out global targets for tuberculosis control for the year 2000.[1] Resolution WHA46.36 subsequently urged Member States to act rapidly to control tuberculosis through introduction of the strategy of directly observed treatment, short course (DOTS).[2] DOTS not only drastically reduces deaths by increasing the cure rate of treatment, but also cuts the transmission of infection and prevents the development of multidrug-resistant tuberculosis. DOTS has been evaluated by the World Bank to be one of the most cost-effective of all health interventions, as an investment of only about US$ 3 is required per year of healthy life saved, making it one of the best buys available to health and finance ministries.

2. Since the introduction of the DOTS strategy in the early 1990s, the world has witnessed remarkable progress in global tuberculosis control under WHO's leadership. Major achievements are outlined below.

PROGRESS IN TUBERCULOSIS CONTROL, 1991 TO 1997

Indicator/year	1991	1997
Number of countries adopting DOTS strategy	10	110
Global tuberculosis patients treated under a DOTS system (%)	<1	16
Average cost of antituberculosis drug regimen, per patient, in selected high burden countries (US$)[a]	40-60	10-20
External support for tuberculosis control in developing countries (excluding WHO input) (US$ million)	16	Approximately 100
WHO's budget for tuberculosis-related activities (US$ million)	2	25

[a] Tenders from China, India and Indonesia.

[1] Global targets for tuberculosis control for the year 2000 are: successful treatment of 85% of detected infectious cases, and detection of 70% of such cases.

[2] DOTS is a management system that assures that persons suffering from tuberculosis are diagnosed, and that health workers are accountable for successfully curing each patient.

3. Although significant, this progress has not been enough. An estimated one-third of the world's population is already infected with tuberculosis. Each year an estimated eight million new cases are produced from this reservoir of infection, and 1.5 million people die of the disease. The poor and marginalized in the developing world are the worst affected: 95% of all cases and 98% of deaths from tuberculosis occur in resource-poor countries.

4. Tuberculosis remains a significant obstacle to human development, especially in poor countries and among marginalized populations. Of cases in developing countries, 75% are people in their most economically productive years (ages 15 to 45). The disease kills more women of reproductive age than any single cause of maternal mortality. It directly affects the development of families, communities and national economies. Families face significant expenditures on diagnosis, treatment and transport, breadwinners face suspended or lost employment, children face suspended schooling, and employers face decreased labour efficiency. In poor countries, a single case can lead to the loss of between two to three months of family income.

5. Although many small and medium-sized countries are likely to achieve the control targets for 2000, most of the countries which account for the world's highest tuberculosis burden either adopted the DOTS strategy only recently, or have been slow to expand it. As a result, most of them will not achieve the targets by 2000. Unfortunately, global progress depends above all on advances made in the 22 countries that together account for 80% of the global burden. Recently collected data on case detection and treatment success from countries worldwide indicate that, among the highest burden countries, only Peru and Viet Nam have achieved the targets, although Cambodia, Kenya, and the United Republic of Tanzania were identified as other top performers. Resolution WHA51.13 urged Member States, the international community and WHO to give high priority to intensifying tuberculosis control.

6. Reasons for slow progress in many countries are, with few exceptions, no longer technical but of political and economic origin. Like malaria and HIV/AIDS, in many countries the tuberculosis epidemic is viewed as a problem only of the poor, and responsibility for tackling it is confined, wrongly, to the health sector. National health systems are often underfunded. Where resources do exist, drug procurement and distribution systems are often inefficient or nonexistent, implementation is hampered by the lack of managerial capacity, and training and retention of health workers is often a low priority. Underlying all these problems in many countries is the lack of sustained interest in major health issues among politicians, partly engendered by low societal demand to implement and sustain effective disease control programmes within national health systems.

7. The world's ability to control tuberculosis is at a crossroads, and WHO has acted quickly to mount an effective response. Tuberculosis control is among the highest priorities of the Organization which, during 1999, launched the Stop Tuberculosis Initiative. Stop Tuberculosis is geared to accelerating global action against one of the world's major infectious killers by working across WHO and the organizations of the United Nations system, and forging new partnerships across health, social and economic sectors. The following goals guide the work of the Initiative:

- to ensure that every tuberculosis patient has access to treatment and cure;
- to protect vulnerable populations, especially children, from tuberculosis and its multiple drug-resistant form;
- to reduce the social and economic toll that the disease exerts on families and communities.

8. The priority areas of work for the Initiative in 2000-2001 include:

- creating high-level political support to tackle tuberculosis within the broader context of health, social and economic development, by convening the **Ministerial Conference on Tuberculosis and Sustainable Development** (Amsterdam, 22-24 March 2000);

- exploring partnerships and options for enhanced access of all Member States to safe, high quality antituberculosis drugs; building up capacity within national health systems of developing countries for drug procurement, distribution and monitoring; brokering tender of second-line regimens to equip pilot projects for control of multidrug-resistant tuberculosis with necessary drugs; and promoting the development of new drug formulations.

9. In Amsterdam, delegations comprising ministers and other high-level health, finance and planning officials from 20 of the countries with the highest burden of tuberculosis declared their commitment to work in concert with WHO and other partners in the Stop Tuberculosis Initiative in order:

- to expand DOTS coverage in their countries to reach at least 70% detection of all infectious cases by 2005 – the first and most important measurable step in providing global access to life-saving tuberculosis medicines and meeting the targets for tuberculosis control;

- to participate actively in setting up a global partnership agreement to stop tuberculosis that would put into place a framework for action for operationalizing the declarations made during the Conference;

- to promote expanded national partnerships to stop tuberculosis, and multiyear, multisectoral plans of action so that the foundations for accelerated action may be built up and maintained.

Ministerial delegations called upon international development partners to establish a global fund for tuberculosis in order to mobilize and direct new, additional financial support to countries in need, with a special focus on ensuring universal access to life-saving tuberculosis treatment and cure.

ISSUES

10. The emergence of drug resistance signals that control strategies employed by national health systems are failing and that urgent remedial action is required. Drug resistance is a major obstacle to effective treatment and control because sufferers require costly treatment that is well beyond the resources available in most developing countries. In the several locations around the world where prevalence of multidrug-resistant tuberculosis is high, the future ability of national health systems to control the disease is severely threatened. These locations constitute international public health emergencies, requiring immediate action to improve control. At the global level, new, additional elements to the DOTS strategy need to be developed in order to identify faster and to treat drug-resistant cases – in resource-poor settings.

11. Tuberculosis and HIV have synergistically fuelled each other's spread. HIV multiplies by 30-fold the speed at which a tuberculosis-infected person can develop disease and become infectious. Tuberculosis is the leading cause of death among HIV-positive people, and accounts for one-third of AIDS deaths worldwide. In many sub-Saharan countries, the number of persons with the disease has quadrupled since 1990, mainly because of HIV. Effective tuberculosis control is one tangible

intervention that can extend the life of HIV-infected persons. From a public health perspective, it can quickly render individuals noninfectious, and reduce further spread of the infection in regions where HIV is rampant.

12. Effective management of tuberculosis through DOTS is an integral part of primary health care. It is a positive contributor to the overall development of national health systems. It strengthens decision-making, action and evaluation at district level, and can improve the efficiency and cost-effectiveness of integrated service delivery for lung health services in general. Reforming health sectors rightly focuses on the achievement of measurable health outcomes. The DOTS strategy is one of the few health strategies that incorporates basic recording and reporting requirements and allows for evaluation of individual and cohort outcomes.

ACTION BY THE HEALTH ASSEMBLY

13. The Health Assembly is invited to adopt the draft resolution contained in resolution EB105.R11.

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