



Sustainable financing for tuberculosis prevention and control

Report by the Secretariat

1. At its second meeting, the High-Level Forum on the Health Millennium Development Goals (Abuja, 2-3 December 2004) recognized sustainable financing as essential for progress towards these goals. Under Millennium Development Goal 6 “Combat HIV/AIDS, malaria and other diseases”, target 8 is relevant to tuberculosis: to “have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases”. A global plan for the period 2006-2015 to achieve this target for tuberculosis will be launched towards the end of 2005. The indicators for reaching this target are prevalence and death rates associated with tuberculosis and the proportion of cases of tuberculosis detected and cured under the DOTS strategy for tuberculosis control.¹ This report provides a framework for discussing the promotion of sustainable financing for tuberculosis control within that global plan and in the context of strengthening health systems.

2. Sustainable financing for tuberculosis control is taken to mean the set of financial options that promote equity, achieve efficiency in allocation, distribution and timely use, are compatible with transparency and accountability, and encourage the highest possible level of financial self-sufficiency. The options available that fulfil these criteria include domestic public funds, domestic private funds, external public funds and external private funds.

3. The global targets for tuberculosis control set for the year 2000 by resolutions WHA44.8 and WHA46.36 were to detect 70% of new infectious cases and to treat successfully 85% of detected sputum-positive patients. Countries still need to reach those targets and sustain or improve on these levels of control in order to achieve the reduction in prevalence and death rates indicated in the Millennium Development Goals. Even though considerable progress has been made, the Health Assembly recognized in resolution WHA53.1 that most of the countries with the greatest burden of disease would not meet those global targets by 2000. It endorsed the Amsterdam Declaration to Stop Tuberculosis (2000), which reset targets to 2005. Many countries have made considerable progress towards attaining these targets: the latest global figures for new sputum smear-positive cases indicate a 45% case detection rate (at the end of 2003) and an 82% treatment success rate (for patients registered in 2002).² Based on the figures for case detection at the end of 2003, continuation of the upward trend will result in a case detection rate of 60% by 2005 and achievement of the 70% global target by 2007. Although the treatment success rate is substantially below average in Africa (73%) and in Europe

¹ The DOTS strategy is the internationally recommended control strategy for tuberculosis, which comprises five elements: political commitment, case detection, standardized short-course chemotherapy, regular supply of medicines, and recording and reporting. See document WHO/CDS/TB/2002.297.

² *Global tuberculosis control: surveillance, planning, financing*. Geneva, World Health Organization, 2005.

(76%), the global target of an 85% rate should be attained by 2005. While tuberculosis incidence rate is decreasing or stable in all regions apart from the African Region, the global incidence rate in 2003 was increasing by 1% per year on account of the increasing rate in Africa (fuelled by the HIV epidemic).

4. Drug-resistant tuberculosis and the fuelling of the tuberculosis epidemic by HIV pose particular difficulties in tuberculosis control. Although progress in widespread implementation of the DOTS strategy will help to prevent the further emergence of drug resistance, the application of DOTS-Plus, an adaptation of the standard DOTS strategy, is necessary to stem the current contribution of drug-resistant cases to the overall tuberculosis epidemic. Application of the DOTS-Plus strategy in resource-limited settings has yielded success rates among patients with multidrug-resistant tuberculosis of 77% and 69% for new and previously treated patients respectively (similar to the success rates in industrialized settings). Control of HIV-related tuberculosis depends on collaboration between tuberculosis and HIV programmes in implementing the expanded control strategy, which comprises interventions against tuberculosis (full implementation of the DOTS strategy, intensified case finding and cure, and preventive treatment), and interventions against HIV (and therefore indirectly against tuberculosis), with policy adaptation according to a country's HIV prevalence.¹

5. The progress so far in global tuberculosis control has been based on formation of partnerships, consensus on key policies and strategies, good coordination and improved planning at global, regional and country levels, and on increased financing for implementing the DOTS strategy. More funding, the development of better tools (new drugs, improved diagnostic tools and more effective vaccines) and the application of an international standard of care by all health providers (whether in the public sector or in private practice) hold out the prospect of accelerating progress in global tuberculosis control.

6. At the global level, the Stop TB Partnership now provides an effective vehicle for promoting and coordinating the contributions of a wide and increasing range of stakeholders. The Global Plan to Stop Tuberculosis for 2001-2005 identified the funding needed for global tuberculosis control (implementation and research). The DOTS Expansion Working Group, in collaboration with the working groups on tuberculosis/HIV and DOTS-Plus, coordinates the implementation of the DOTS strategy. The Working Group on Advocacy and Communications promotes support for, and awareness of, the Partnership's activities. Progress in the regions in partnerships, coordination and planning has been varied.

7. At the country level, more national Stop TB partnerships are being formed in order to support the implementation of plans for long-term expansion of DOTS through national interagency coordination committees. Five new national partnerships have been established by the time of writing (in Brazil, Indonesia, Mexico, Pakistan and Uganda).

8. So far, in countries with high tuberculosis incidence rates, financing of tuberculosis control has come from governmental and other domestic sources as well as external sources (including bilateral, multilateral and nongovernmental organizations and foundations). Of the funding available for global tuberculosis control in 2004, 84% came from domestic and 16% from external sources. The commitment of Member States in the 2000 Amsterdam Declaration to ensuring sufficient and sustainable domestic resources was renewed in the 2001 Washington Commitment, and further invigorated at the 2004 Stop TB Partners' Forum in New Delhi, India. Now, the Global Fund to Fight

¹ Document WHO/HTM/TB/2004.330.

AIDS, Tuberculosis and Malaria is making substantial financial contributions, and other multilateral and bilateral sources have also increased financing. Total commitments from the Global Fund for proposals for the control of tuberculosis (including HIV-related tuberculosis) in the first four rounds of proposals from 2002 to 2004 were US\$ 1218 million. Other new mechanisms to increase financing for disease control include poverty-reduction strategy papers and associated grants, credits and loans.

9. Despite recent progress in tuberculosis control, important constraints remain. Those most commonly identified by countries with a heavy tuberculosis burden in 2004 included the human resources crisis, insufficient management capacity, inadequate infrastructure, weak political commitment, weak laboratory services, and poor monitoring and evaluation. In addition, there is the limited engagement in tuberculosis programmes of the full range of health providers (including private practitioners and branches of public providers) and the insufficient mobilization of communities and patients to demand, and to contribute to, tuberculosis care. In those countries with both HIV and tuberculosis epidemics, especially in sub-Saharan Africa, the impact of HIV has exacerbated many of these limitation on tuberculosis control, and is impeding achievement of global tuberculosis control targets. Globally, only a small proportion of patients with drug-resistant tuberculosis have access to adequate management. Finally, despite the mobilization of more resources for tuberculosis control, existing gaps in funding and uncertainty about future financing continue to impede planning and implementation. The total financial resources needed for global tuberculosis control – for implementation (including capacity development) and research – were US\$ 2200 million per year for 2004 and 2005, with an estimated annual shortfall of US\$ 800 million. This increased funding will need to come from both countries with high incidence rates of tuberculosis and from external sources.

10. To achieve the Millennium Development Goal relevant to tuberculosis (target 8 under Goal 6) long-term planning and associated funding are needed for the period 2006 to 2015. To accelerate progress will require broad improvements in health systems,¹ as recommended by the second ad hoc committee on the tuberculosis epidemic,² the Commission on Macroeconomics and Health,³ and the High-Level Forum on the Health Millennium Development Goals. National governments need to work with a range of partners and stakeholders to implement the main recommendations of the Second Ad Hoc Committee: (1) to consolidate, sustain and advance achievements; (2) to enhance political commitment; (3) to address the health workforce crisis; (4) to strengthen health systems, particular primary care delivery; (5) to accelerate the response to the tuberculosis/HIV emergency; (6) to mobilize communities and the corporate sector; and (7) to invest in research and development to shape the future. Plans for implementing these improvements will need to be backed by sound financial planning, supported by sustainable financing to close all projected funding gaps, with coordination among funding sources.

ACTION BY THE HEALTH ASSEMBLY

11. The Health Assembly is invited to consider the draft resolution contained in resolution EB114.R1.

¹ See document A58/5.

² *Report of the meeting of the second ad hoc committee on the TB epidemic; recommendations to Stop TB partners* (Montreux, Switzerland, 18-19 September 2003). Geneva, World Health Organization, 2004.

³ *Report of the Commission on Macroeconomics and Health. Macroeconomics and health: investing in health for economic development*. Geneva, World Health Organization, 2001.