The attached working paper is a summary of the progress and plans for implementing the new Stop Tuberculosis (TB) Strategy.

The South-East Asia (SEA) Region as a whole achieved a case detection rate of 64% in 2005, while treatment success rates in excess of 85% have been consistently achieved since 2003. A fall in TB prevalence and mortality rates are being reported in a few Member countries in the Region, while the estimates for TB prevalence and mortality for the Region have decreased by an overall 30% and 22% respectively since 1990.

WHO and its partners have endorsed the new Stop TB Strategy which constitutes the core of the Global Plan to Stop TB (2006-2015). The Regional office, in consultation with national programmes and partners, has developed a Regional Strategic Plan for TB Control 2006-2015, based on the Strategy and focusing on the priorities in the SEA Region. The interventions mentioned in this plan towards achieving the TB targets under the Millennium Development Goals (MDGs) are grouped under four strategic approaches: sustaining and enhancing DOTS to reach all TB patients, improving case detection and treatment success; establishing interventions to address TB/HIV and MDR-TB; forging partnerships to ensure equitable access to an essential standard of care to all TB patients, and contributing to strengthening health systems.

Member countries have also developed national plans in line with the Stop TB Strategy and the Regional Plan. There is a very close link between implementing these plans and good laboratory practices, procurement systems, coordination with related programmes, particularly national HIV/AIDS programmes, health infrastructure and human resource development.

Resolution WHA 60.19 adopted by the Sixtieth World Health Assembly calls on Member States to fulfil their commitments to implement long-term plans for TB prevention and control in line with the new Stop TB strategy, aimed at accelerating progress towards halving TB prevalence and deaths by 2015. WHO was requested to take a leadership role in spurring implementation and intensifying support to Member countries towards reaching these targets.

The Joint Meeting of Health Secretaries and the Consultative Committee for Programme Development and Management reviewed the actions proposed for the consideration of the Regional Committee.
The Joint Meeting made the following recommendations:

**Action by Member States**

1. To fully implement national TB programmes in line with the Regional Strategic Plan 2006-2015, in order to achieve the goal of halving TB prevalence and mortality by 2010 and reaching the MDGs by 2015.

2. Build adequate human resources and infrastructure to deliver effective TB services, including laboratory services under primary health care systems, and take into account the pivotal role of the private sector in service provision.

3. Collect, analyse and use data at the sub-national level for planning and implementing appropriate interventions.

4. Carry out operations research in order to devise appropriate strategies and effective interventions and to improve programme effectiveness.

5. Mobilize additional resources, both domestic as well as external, to sustain the achievements and to expand services such as TB-HIV and DOTS-Plus for the management of drug-resistant TB, to ensure no diversion of financial resources from the routine to new services.

**Action by WHO-SEARO**

1. To mobilize additional resources required for implementing and strengthening TB programmes in the Region.

2. To facilitate continued support of the Global Drug Facility to countries, particularly DPR Korea and Myanmar, for which the Global Fund support is not available.

3. To convene a working group to urgently assess the XDR-TB situation in order to recommend mechanisms to monitor and contain it.

The working paper is now submitted to the Sixtieth session of the Regional Committee for its consideration.
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Magnitude of the problem

1. The South-East Asia Region with 25% of the world’s population, carries a third of the global burden of TB. This represents a case burden of nearly five million cases of TB to which approximately three million new cases are added every year. In addition, it is estimated that nearly 500,000 people die from TB each year in the Region. Five of the 22 countries with the highest burden of TB in the world are in the SEA Region – namely Bangladesh, India, Indonesia, Myanmar and Thailand, accounting for 95% of the burden for the Region. The global HIV epidemic has had a variable impact in countries in the Region. Over 3 million people in the Region are currently estimated to be infected with both HIV and TB. Fortunately, levels of multidrug-resistant forms of TB (MDR-TB) are still low at under 3%. However, in absolute terms, this translates into a large number of TB cases with drug resistance, given the large numbers of TB patients in the Region. Evidence is emerging on the extent of extensively drug resistant forms of TB. Given this burden of disease, progress with tuberculosis control in the five high-burden countries of the SEA Region, will necessarily drive overall global progress in TB control.

Figure 1: Burden of TB in the South-East Region
Progress

2. Substantial progress has been made in achieving the tuberculosis control targets set by the WHO Regional Committee for South-East Asia through the resolution adopted at its fifty-first session in 1998, and with respect to the World Health Assembly targets of 70% TB case detection and 85% treatment success among all newly detected TB cases set in 2000. The Region as a whole achieved a case detection rate of 64% in 2005, while treatment success rates in excess of 85% have been consistently achieved since 2003. Between 1997 and 2004, almost 15 million patients were registered for treatment, six million of these under DOTS programmes in the Region, thereby averting nearly 500 000 deaths. As a result, a fall in TB prevalence and mortality rates are being reported in a few Member countries in the Region, while the estimates for TB prevalence and mortality for the Region have fallen by an overall 30% and 22% respectively since 1990 (Figures 2 and 3).

**Figure 2: Changes in Estimated TB Prevalence 1990-2005, SEA Region**

![Graph showing changes in estimated TB prevalence 1990-2005, SEA Region](image)


**Figure 3: Changes in Estimated TB Mortality Rates 1990-2005, SEA Region**

![Graph showing changes in estimated TB mortality rates 1990-2005, SEA Region](image)

3. This progress is attributed to wider coverage; intensified efforts to improve the quality of services, and growing partnerships with other providers particularly NGOs, the private health sector, medical teaching institutions and large public employment sectors and community care interventions. Reports from India, Indonesia and Myanmar indicate that where initiated, private and public partnerships for TB have resulted in increments of up to 25% in cases notified with good treatment outcomes.

4. Interventions for HIV-associated TB have been made available widely in India and Thailand and are being extended in Myanmar. Bangladesh, Indonesia, Sri Lanka and Timor-Leste have plans for commencement of these activities.

5. DOTS-Plus projects to manage drug-resistant TB under programme conditions, are in place in Bangladesh, India and Nepal, and should commence in the remaining Member States during the next biennium.

6. In terms of resources, Global Drug Facility support continues in nine countries including grant of drugs for a further period of three years in DPR Korea and Myanmar. Additional funding through the Global Fund and other multilateral and bilateral donors, has resulted in reducing the funding gap to less than 5% for TB programmes in the Region, with the exception of DPR Korea and Myanmar.

Issues

7. Although there are encouraging signs of reduction in the burden of TB in the Region, Member countries face several challenges which must be addressed in order to sustain current progress and reach the TB targets linked to the Millennium Development Goals set for 2015. The key concerns relate to:

- Uncertainties relating to securing sustainable financial and operational resources for TB to maintain quality implementation;
- overstretched national public health care systems, with limited technical and management capacity to respond to increasingly complex interventions required;
- weaknesses in national laboratory networks and surveillance mechanisms;
- difficulties in establishing interventions for TB/HIV and emerging drug resistance;
- provision of care by un-linked private and public sectors, widespread availability and unregulated use of anti-TB drugs; and
- low community awareness and utilization of services, and traditional stigma attached to TB.

8. Securing sustainable financing for TB control, focusing on building human resource capacity and infrastructure within public health systems through which TB services are primarily delivered are therefore critical. Increasing access to quality-assured smear microscopy services and establishing culture and drug susceptibility testing capacity within national laboratory networks to diagnose all forms of TB, particularly smear negative, extra-pulmonary and multi-
drug resistant forms of TB are essential. In order to objectively report on the impact of national TB programmes towards reaching the MDGs, national surveillance, monitoring and evaluation mechanisms will also need to be significantly strengthened. National TB and HIV/AIDS programmes will need to work much more closely together to deliver joint services through a “one-stop” approach for those dually affected by tuberculosis and HIV. Greater involvement of other sectors, particularly the private sector, is necessary to enhance the reach and access to services. Effective communications and social mobilization efforts and operational research are needed to increase community awareness and utilization of services, and improving service delivery. Intensifying community-based treatment services are critical to further improve case treatment outcomes.


9. In order to effectively address these needs and achieve the TB targets linked to MDGs, which are to halve TB prevalence and mortality and begin to reduce the incidence by 2015, WHO and its partners have endorsed the new Stop TB Strategy². The Stop TB strategy constitutes the core of the Global Plan to Stop TB³ (2006-2015). While the DOTS strategy remains an essential and principal component of the new Stop TB strategy, five additional components have been included: (i) addressing TB/HIV and MDR-TB; (ii) contributing to health system strengthening; (iii) engaging all care providers; (iv) empowering patients and communities, and (v) enabling and promoting research.

10. Towards achieving the TB-related target set under the MDGs in all Member States by 2015, a Regional Strategic Plan for TB Control 2006-2015⁴ incorporating the new expanded strategy to stop TB, but focusing on priorities in this Region has been developed in consultation with the Regional Technical Working Group on TB, national programmes and partners involved in TB control in countries of the Region. The interventions proposed build on what has been achieved during the previous five-year period and are drawn from a range of initiatives and activities in progress in the Region.

11. The objectives for tuberculosis control in all Member countries of the Region are to:

   (1) sustain or surpass the 70% case-detection and 85% treatment success targets set by the World Health Assembly in 2000, in order to

   (2) halve the TB deaths and prevalence by 2010, towards

   (3) “halting and beginning to reverse the incidence of TB” as stated under the MDGs set for 2015.

12. These objectives will be met through four key strategies.

Sustaining and enhancing DOTS to reach all TB patients, and improve case detection and treatment success

13. This calls for intensified efforts to further improve: (i) the quality of implementation, (ii) enhancing access to quality-assured laboratories and treatment facilities, (iii) uninterrupted
supplies of good quality anti-TB drugs, (iv) collaboration between national programmes and all care providers, and (v) strengthening surveillance systems and impact assessments. In this context, considerable investments and attention will need to be focused on addressing the inadequate human resource capacity and overstretched health systems in most Member countries.

**Establishing interventions to address TB/HIV and MDR-TB**

14. HIV-associated TB and anti-TB drug resistance threaten to reverse hard-won gains in TB control. Myanmar, Thailand and some states in India are reporting generalized HIV epidemics, while Indonesia and Nepal have concentrated epidemics. Planning and implementing interventions to address TB/HIV in order to sustain the hard-won gains in TB control particularly in Member States with high HIV prevalence, are crucial. National TB and HIV/AIDS control programmes will need to work very closely to accelerate efforts to address the needs of the increasing numbers of patients dually affected.

15. While the implementation of quality DOTS remains the first and foremost priority to halt and reverse the development of further anti-TB drug resistance, national TB programmes must, at the same time, begin to extend diagnosis and treatment to TB patients who already have multidrug-resistant-TB (MDR-TB). Countries in the Region have limited laboratory culture and drug susceptibility testing capacity to diagnose cases and monitor trends in the levels of drug resistant TB; only India, Nepal and Thailand have internationally quality-controlled culture and drug susceptibility assured facilities. National laboratory networks and national reference laboratory capacities have to be rapidly enhanced, through linkages and provision of intensive technical assistance by the global network of supra-national reference laboratories, two of which are situated in the Region, namely at the Tuberculosis Research Centre, Chennai, India and the National Reference Laboratory, Bangkok, Thailand. Existing DOTS-Plus projects in India and Nepal need to be scaled up, while other countries must rapidly establish these services in accordance with national and international guidelines.

**Forging partnerships to ensure equitable access to an essential standard of care to all TB patients**

16. Building partnerships at global and regional levels with policy makers, as well as development and technical partners will be essential to mobilize the necessary resources for national TB control programmes in the Region. While initial inter-sectoral collaborative initiatives, both public and private, are reporting success, these are presently insufficient to make a significant impact on case-detection and treatment success rates at the national level. Ensuring the quality of services within the programme as well as through these collaborative interventions as they expand beyond initial pilots will require considerable inputs. The International Standards of TB Care, developed to set a benchmark for the standard of care for all TB patients, must be more widely disseminated and applied to engage and ensure access to quality services through all providers.
17. Similarly, community awareness and utilization of available services and civil society involvement in TB control continue to be inadequate. NTPs need equally to ensure equitable access to services for all TB patients, particularly the poor and the marginalized, in urban slums, remote border areas and among displaced communities. Advocacy, communication and social mobilization efforts (ACSM) have not been satisfactorily addressed by most national TB programmes. High profile, well designed and sustained ACSM campaigns are required to have a substantial impact.

**Contributing to strengthening of health systems**

18. Primary health care systems in most Member countries are overstretched. Most suffer from inadequate infrastructure and a lack of sufficient numbers of adequately skilled staff to provide essential services, including those for TB. In addition, poor preparation for health sector reform has led to prolonged and difficult transition periods for traditionally vertical TB control programmes in some countries. Steps must therefore be taken concurrently to enhance the performance of TB programmes in the context of health systems development through effective integration and streamlining of TB services within primary health care services, and by identifying and addressing health systems bottlenecks that will prevent the achievement of TB control programme targets.

19. In the context of effectively implementing the above strategies, securing and sustaining adequate financial, technical and operational resources for improved delivery of TB services in line with World Health Assembly Resolution WHA58.14 on “Sustainable Financing for TB Prevention and Control”, through both increasing domestic resource allocations and sustained external financing, is essential.

**The way forward**

20. Health Secretaries of the Region at their 11th Meeting in June 2006, discussed and committed themselves to support the new Stop TB strategy and Regional Strategic Plan for TB control 2006-2015. They requested WHO to facilitate the submission of a draft resolution on the progress and plans for TB control in the Region for consideration by the Regional Committee.

21. The resolution WHA 60.19 adopted by the 60th World Health Assembly also calls on Member States to fulfill their commitments to implement long-term plans for TB prevention and control in line with the new Stop TB strategy, aimed at accelerating progress towards halving TB prevalence and deaths by 2015. WHO was requested to take a leadership role in spurring implementation and intensifying support to Member countries towards reaching these targets.

**Actions proposed for the consideration of the Regional Committee**

- Endorse and commit to the full implementation of the new Stop TB strategy, Regional Strategic Plan 2006-2015 and multi-year country plans for TB control towards reaching the goal of halving TB prevalence and mortality by 2010 and the MDGs in 2015;
• Strengthen political commitment for TB control, ensuring sustainable financing as well as necessary human and operational resources through increased domestic resource allocations;

• Urge Member States to focus on building adequate human resources, and infrastructure to deliver effective TB services, including laboratory services under primary health care systems, incorporating TB programme expansion into health systems in the context of strengthening of health systems; and

• Call on the international community to mobilize the necessary additional external technical and financial resources for effective implantation of TB control in countries of the Region, particularly those with the highest burdens of disease and least ability to raise these additional resources.

References

6. Report of the Eleventh Meeting of Health Secretaries of Member States of the South-East Asia Region, WHO Regional Office, New Delhi, June 2006 (SEA-HS Meet-11)