6.1 Global strategy and targets for tuberculosis prevention, care and control after 2015

Document EB134/12

Secretariat note: “Following extensive consultation, the Director-General presents a comprehensive review of the global tuberculosis situation to-date, as well as new multisectoral strategic approaches and international targets for the post-2015 period. The Board is invited to consider the draft strategy and targets and to provide further guidance.”

Background

In 1993 WHO declared tuberculosis (TB) as a global public health emergency. Many actions were implemented (the DOTS strategy; inclusion of tuberculosis-related indicators in the Millennium Development Goals; development and implementation of the Stop TB Strategy that underpins the Global Plan to Stop TB 2006–2015; and adoption in 2009 of resolution WHA62.15 on the prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis) in order to accelerate the global expansion of tuberculosis care and control.

In May 2012, WHA requested the DG to submit a comprehensive review of the global tuberculosis situation and to present a new strategy for the post-2015 period to the Sixty-seventh World Health Assembly in May 2014, through the Executive Board. The process to prepare this has involved consultation across a wide range of partners.

Document EB134/12 provides an outline of the achievements, challenges and approaches needed in controlling the TB epidemic and a comprehensive description of the draft post-2015 Global TB strategy. Such a strategy, with its vision (a world free of TB), goal and targets (divided into milestones for 2025 and targets for 2035), is articulated around three pillars and their relative components, and four principles. Finally the document gives suggestions on how adapting and implementing the strategy as well as measuring progress and impact through a list of key global indicators, and envisages the role of the WHO Secretariat. The EB is invited to consider the draft strategy and targets.

PHM Comment

Milestones and targets

Considering that TB is a highly infectious disease and every active TB case can infect up to 20 people in its surroundings per year, the incidence rate per 100,000 population is a good indicator of the burden of TB in a population. Whereas, understandably, the WHO’s focus has been on the 22 high-burden countries (22 countries that account for 80% of TB cases in the world), it is now time to pay more attention to countries that might not have a high total number of cases but have a high incidence rate. Of the top-ten countries with highest incidence rates, only three are counted among the 22 high-burden countries: South Africa, Zimbabwe and Mozambique. The danger of not placing more emphasis on these countries and monitoring them more closely is that they become reservoirs of TB that will spill over into
other countries. To successfully reach the 2035 target of 90% reduction in TB incidence rate, we need a strong focus on high-incidence rate countries and not only high-burden countries.

**Pillar One. Integrated patient-centred care and prevention**

Under the first pillar, a lot of emphasis is given to diagnosis and treatment while scarce attention is devoted to the effective cure. Among the illustrative indicators, only one focuses on the treatment success rate but there isn’t a target to be reached; at the same time the document does not mention interventions that get patients cured.

**Pillar Two. Bold policies and supportive systems**

The draft Global strategy clearly recognises the role of social determinants in shaping the epidemic and also states, in its principles, that policies and strategies for addressing the TB response have to explicitly address human rights, ethics and equity. However, the draft strategy fails to identify strong drivers which would promote real change and tackle the root causes of the disease spreading and maintenance such as urbanisation and marginalisation, migration and detention in refugee camps, unhealthy working and living conditions and the health care access barriers that in turn depend on the unequal distribution of resources and the structure of power.

One potential driver to really embed a human rights approach into the strategy would be to provide support for appropriate litigation, seeking to use the authority of the law to advocate for social change on behalf of individuals whose voices are otherwise not heard, including the right to care for TB infected people. It is not enough to call for political will to give TB prevention and care the priorities in financing and management that they need. New accountability structures are needed to investigate and prevent barriers to access and treatment, drug shortages, treatment interruptions, waiting lists and inappropriate marketing of drugs and diagnostic tests. One option for WHO would be to work with the UN Human Rights Council to sponsor public hearings and strengthen the accountability of funders, managers and service providers.

Under the call for action on the determinants of TB, the document fails to mention the ongoing battle to ensure access to diagnostics and medicines which are patented and priced out of reach of the populations that need them most. The bold policies promised in the second pillar should also work towards counterbalancing market tendencies that lead to inequalities by:

- opposing unjustified and excessive profits on critically needed tools and medicines,
- patent law reforms in high burden countries to prevent unfair practices,
- opposing corporate practices that trap governments - and public budgets- into expensive long-term contracts (e.g. exorbitant prices for warranty on GeneXpert modules).

While governments are being called upon and held accountable for their part in ending the TB epidemic, the same should be expected from industry actors.

Universal health coverage is presented as a fundamental tool for effective TB care and prevention, but few words are spent on the paramount importance of health system strengthening and the need for a better integration of TB services into the health system as
well as a better connection with other health sectors, such as paediatrics. Likewise NCDs will increase in importance and relevance over the time period of the strategy.

**Pillar Three. Intensified research and innovation**

While it is valuable that there is a specific pillar on research and innovation, not enough attention is there paid to innovative mechanisms to ensure new and adequate sources of funding and the affordability of products. It could be done through scaling up new and public investment models able to delink innovation from pricing (if not through the WHO, then through some kind of BRICS pooling mechanism).

In terms of drug development and availability, further pressure on drug companies may be needed in order to ensure that appropriate trials are undertaken, including the phase III bedaquiline trials.

At the same time, it would be crucial to focus on the time it takes to implement a new tool or innovation and the barriers are to that. Considering the bedaquiline is still not being used outside the Compassionate Use programmes a year after its registration; it would be important to investigate ways of national programmes working together in regions to facilitate or speed up the implementation of such new tools. In order to track this process, a specific indicator could be added to those listed in Table 2, namely the time to new innovation/tool becoming widely available in the national TB programmes.

In terms of diagnostics, the WHO should set up prequalification systems for TB diagnostics to ensure a more strict control over the chaotic TB diagnostic market which is allowing some poor quality tests to be used in some countries. At the same time, more research is needed before recommending a new diagnostic tool ensuring that its applicability and feasibility, both in financial and practical terms, are considered.

**Adapting and implementing**

The document states that “A prerequisite for adoption of the strategy and preparation for its adaptation will be a detailed assessment of the national epidemiological and health system situation”. To this regard, it is important to recognise that available data are rather poor and, while waiting for countries to set up their surveillance systems, a few massive surveillance studies should be funded in order to get information on the magnitude of the epidemics including information on the real cure rate the programmes are able to achieve.

It is also crucial for countries to set specific national level targets to achieve global goals to reduce TB mortality; this is a priority, in particular for high burden countries.

Moreover, in order to paint a clearer picture of reservoirs and breeding grounds of TB within countries, much light should be thrown on high-risk population groups such as correctional centres, mines, schools and transport systems, centres for detention of illegal migrants. Even though this is a responsibility for governments and health departments, an increased focus from the WHO on these key populations would certainly assist. For example, the WHO European Region is the only region that systematically collects and analyses data from member states on the burden of TB in correctional centres. This needs to happen in all regions and to be expanded to other hotspots like mines, schools, etc.