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UNIVERSAL ACCESS TO HIV/AIDS, TB AND MALARIA SERVICES BY 2010: UPDATE ON TUBERCULOSIS IN AFRICA

LIST OF ABBREVIATIONS AND ACRONYMS

ARVs: Anti-retrovirals
CPT: Co-trimoxazole Preventive Therapy
DOTs: Direct Observable Treatment short-course
GDF: Global Drug Facility
GFATM: Global Fund to fight AIDS, TB and Malaria
GLC: Green Light Committee
GNP: Gross National Product
MDGs: Millennium Development Goals
MDR-TB: Multi-Drug Resistant Tuberculosis
ORID: Other Related Infectious Diseases
PITC: Provider-initiated testing and counselling
TB: Tuberculosis
WHA: World Health Assembly
WHO: World health Organisation
WHO/EMRO: World Health Organisation Eastern, Mediterranean Regional Office
XDR-TB: Extensive Drug Resistant - Tuberculosis

EXECUTIVE SUMMARY

Over the years, many targets have been adopted to reverse the challenge posed by TB globally and Africa in particular. As was requested by Heads of State and Government, the Status Report on TB was prepared with the support of WHO and submitted to the Special Session of Ministers of Health, in Geneva, May 2009.

The 2008 Report had expressed concern that "despite the progress in tuberculosis control, northern African countries have failed in achieving the global targets for tuberculosis control. While DOTS has expanded, covering 94% of the regional population and treatment success is high (82%), the case detection rate is only 44%. To improve case detection, the regional plan to Stop TB was developed as part of the global plan 2006–2015. The budgetary need for the period of 2006 to 2015 indicated in the Plan is US$ 3.1 billion in the WHO/EMRO Region. Support to countries was enhanced and partnership development promoted."

This update is based on the 2008 Report to the Special Session of AU Health Ministers, but with some updates WHO and UNAIDS documents. The challenges to address include: the increasing estimated prevalence, incidence and death rates; the inadequate status of case detection and treatment success rates; **drug Resistant TB; especially multi-drug resistant TB (MDR-TB), and Extensively Drug Resistant TB cases (XDR-TB**); limited status of implementation of TB/HIV Interventions; in spite of availability, limited access to essential anti-TB medicines; in addition to challenges related to health sector development.

Tuberculosis control in Africa has improved during the last decade but the continent still lags behind on major TB Control targets. Financial resources are no longer a major factor as the Global Fund to fight AIDS, TB and Malaria (GFATM) grants, GDF grants (for standard TB treatment), GLC support (for drug resistant TB), bilateral donors support and several Partnership mechanisms provide technical and financial assistance to cover most needs. However, in order to achieve Universal Access by 2010 and the MDG targets by 2015, much remains to be done, especially to:

- Increase treatment success rate for smear positive TB cases;
- Increase case detection rates;
- Detect, treat and prevent Drug resistant TB;
- Scale up TB/HIV collaborative activities; and to
- Address Health Systems challenges.

The following recommendations are reiterated:

i. All countries should periodically review their TB Control performance;

ii. Member states should decentralize and strengthen TB laboratory services in the public and private sectors ;

iii. The AU should advocate with national governments in the 10 countries without local capability for TB culture and drug susceptibility testing for first line anti-TB drugs to establish this capacity in order to facilitate diagnosis and treatment of **MDR-TB and XDR-TB cases;**

iv. National TB Control Programmes should prioritize implementation of strategies to expand DOTS diagnosis and treatment services This includes strengthening the capacity of the Health;

v. Member States with generalized HIV epidemic (5% or higher) in the general population should programme and implement in full the Regional Strategy for controlling TB-HIV with particular emphasis on universal access to HIV testing for TB patients, ART for eligible HIV positive patients and other interventions to reduce the burden of TB on People Living with HIV & AIDS, and reduce the burden of HIV &AIDS on dually infected TB patients.

vi. Member states should allocate sufficient resources to ensure uninterrupted supply of first line anti-TB drugs at central and peripheral levels;

vii. For drug resistant TB cases, national programmes should determine the burden of MDR-TB and initiate treatment programmes for all confirmed cases. National programmes should also mobilize sufficient quality assured second line drugs including concessionary priced drugs through the Stop TB Partnership Green Light Committee;

viii. Member states should respect their pledge to allocate at least 15% of the national budget to health development and allocate a sufficient amount of that for delivery for TB control interventions. Further, Member States should expend approved GFATM grants in time and submit proposals for more funding to meet funding gaps for scale up of activities towards universal access;

ix. Regional cooperation should be promoted to meet the needs of mobile populations through cross-border programmes.

UNIVERSAL ACCESS TO HIV/AIDS, TB AND MALARIA SERVICES BY 2010: UPDATE ON TUBERCULOSIS IN AFRICA

BACKGROUND

1. It will be recalled that a number of targets have been set and commitments made with direct relevance to TB Control in the African continent over the past 10 years:

i. The 1991 World Health Assembly (WHA) adopted a resolution urging countries to detect 70% of new smear-positive TB cases arising annually, and successfully treating 85% of them by 2005. These targets remain relevant for all counties that have not yet attained these targets;
ii. The 2000 Millennium Development Goals that seek to halt by 2015 and begin to reverse the incidence of HIV/AIDS, malaria and other major diseases. Incidence, prevalence and death rates associated with tuberculosis, and proportion of tuberculosis cases detected and cured under DOTS as specified by the WHA were reiterated. By way of operationalising the TB related MDG targets, the Stop TB Partnership confirmed the WHA targets for case detection and successful treatment. In addition, it called for 50% reduction in global TB burden relative to 1990 levels by 2015, and elimination of TB by 2050;
iii. The 2001 Abuja Declaration and Framework for Action on HIV/AIDS, Tuberculosis and Other related Infectious Diseases (ORID) called upon Member States to strive to allocate 15% of national budgets to the improvement of the health sector, and to allocate appropriate and adequate portions of this amount for the fight against HIV/AIDS, TB and ORID;
iv. The 55th Session of the Ministers of Health of the WHO African Region (2005) declared TB an emergency in the Region calling upon Member States to implement urgent and extra-ordinary actions to rapidly improve tuberculosis case detection and treatment success-rates; and accelerate implementation of interventions to combat the TB/HIV epidemic, including increased access to ARVs by doubly-infected patients;
v. The May 2006 Special Summit on HIV/AIDS, Tuberculosis and Malaria, to review the status of implementation of the 2000 and 2001 Declarations and Frameworks for action to Roll Back Malaria, and the 2001 Abuja Summit on HIV/AIDS, TB and ORID. They adopted the "Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria services" that pledged collective dedication to a comprehensive remedial effort anchored on an implementation mechanism that responds to the continent's health and developmental challenges and imperatives. The Summit reaffirmed previous global and regional targets for TB control as well as called for universal access to TB prevention, treatment, care and support services, including of key TB-HIV interventions.
vi. Furthermore, a later call to allocate 34USD per capita for health is yet to be adopted by the majority of countries.

2. The Call for Accelerated Action collectively re-dedicated African Leaders to a comprehensive remedial effort based on set targets and an implementation mechanism that addresses the following priority areas:

i. Leadership at National, Regional and Continental Levels
ii. Resource mobilisation
iii. Protection of Human Rights
iv. Poverty Reduction, Health and Development
v. Strengthening Health Systems
vi. Prevention, Treatment, Care and Support
vii. Access to Affordable Medicines and Technologies
viii. Research and Development
ix. Implementation at national level
x. Partnerships
xi. Monitoring, Evaluation and Reporting

The 2007 WHO Regional Committee addresses TB and HIV

3. Because TB cases had more than trebled in many countries over the past 10 years, especially where HIV prevalence is high and recognizing the public health importance of the two epidemics, the 57th session of the Regional Committee for the African meeting in Brazzaville in August 2007 adopted a resolution calling for further strengthened and improved mechanisms of collaboration between the Tuberculosis and AIDS Control Programmes in order to increase prevention, case finding and treatment of TB among PLWHA, improve access to HIV Testing and Counselling among TB patients and infection control to reduce transmission.

Prevalence of Drug Resistant TB (as per 2008 Report from WHO)

4. In 2008, nearly half a million MDR-TB cases were reported worldwide. These cases "are more difficult and more costly to treat than drug susceptible cases". To reverse these challenges, the Stop TB Partnerships and WHO Strategies should be implemented.

5. "*Drug resistant TB constitutes a silent component of the TB epidemic in the region. Until an outbreak of XDR-TB was reported in early 2006, little attention was being paid to identification and treatment of drug resistant TB, even though evidence shows that it exists everywhere it has been surveyed for*".

6. Regular case notification initiated in 2007 yielded 8,474 MDR-TB cases from 28 countries. Four countries, namely, Botswana (2 cases), Lesotho (1 case), Mozambique (1 case) and South Africa (536) also reported 541 XDR-TB cases. By the end of 2007, there were still 10 Member States without facilities for TB culture and drug susceptibility Testing, constituting 78.3% coverage with culture and drug susceptibility testing coverage by country.

Status of implementation of TB/HIV Interventions

7. The Abuja special Summit set targets for TB/HIV interventions are to test 100% of TB patients for HIV and commencing 100% of eligible co-infected TB patients on ART. During 2006, only 22% of notified cases (287,945 TB cases) were tested for HIV, 150,739 (52.3%) of which tested positive. This compares to 11.2% and 52.0% respectively for 2005. By country, Of those who tested positive, 37.1% were started on Anti-Retroviral Therapy (ART), increasing from 27.3% in 2005 but still far short of the

100% target. At this rate, the region is unlikely to reach the 100% target by 2010 set by the special summit.

8. However, 11 countries recorded ART coverage of 30% and above, ranging from 30.8% to 56.9%. Furthermore, 89.1% were started on Co-trimoxazole preventive therapy (CPT), a 23.4% increase compared to a figure of 72.2% for 2005. Based on this trend, it is likely that 100% coverage with this intervention could be achieved by 2010. At this rate, Universal access to CPT is likely to be achieved by 2010. Table 4.2.5 shows coverage for the three interventions by country for 2005 and 2006. Based on the recorded figures, the proportion of TB cases tested for HIV had doubled between 2005 and 2006 but falls far below the Universal Access target of 100%.

9. Some countries had achieved the target in both years, while a few others had consistently tested over 80% of notified cases and should easily reach the set target by 2010. Others were also making sufficient progress from year to year to reach the target by 2010. However, updates on these statistics are called for.

Access to essential anti-TB medicines

10. Uninterrupted supply of first line anti-TB medicines is a basic requirement for effective DOTS based TB Control Programmes. With the set up of the Global Drug Facility (GDF) for access to free quality anti-TB first line drugs to all DOTS based programmes with a GNP of less than 3,000 USD, the availability of first line anti-TB drugs has improved tremendously. By the end of December 2007, all 36 eligible countries from the region that applied to the GDF secured 3 year first line anti-TB drug grants, including pediatric formulations for some countries.

11. Notwithstanding, latest available information indicates that only 69% of 42 countries that submitted reports had uninterrupted supply of first line anti-TB drugs at both the central and peripheral levels during 2006, while 92.8% had uninterrupted supply at peripheral level. Since implementation is mostly at peripheral level, approximately 7.2% of countries ran out of drugs at some point, thereby limiting access to these. This is a significant short fall with regard to Universal Access to essential TB treatment.

12. For the treatment of drug resistant TB, of the 26 countries that reported at least a case of MDR or XDR-TB during 2007, only 17 countries (65.4%) have an organized treatment programme. Even then, except for those supported through the GLC, not all patients have access to second line anti-TB drugs. As of January 2008, only 9 countries had applied and been approved to access concessionary priced second line drugs from the Green Light Committee (GLC) of the Stop TB Partnership. This facility is available to all DOTS based TB Control programmes and should be utilized more widely than is currently the case considering the wide spread existence especially of MDR-TB cases.

Resource Mobilization

National financing of TB services

13. There is insufficient information to determine national funding for TB Control as most activities are implemented within primary health care services without clear ear

marking for TB control. The WHO has developed a planning and budgeting tool that is designed to help countries align their strategic plans and budgets with all the elements of the new Stop TB Strategy. During 2007, 35 countries in the African Region were introduced to the tool and used it to elaborate programme budgets. This is expected to improve the process of budget estimation and expenditure accountability in the coming years. Most countries provide some funding for their TB programmes. However, it is essential that there be a national commitment for mobilizing domestic resources and targeting TB as an intervention against the occurrences of MDR-TB and XDR-TB.

External financing of TB services

14. During the past five years, external funding for TB control activities has increased significantly. The Global Fund to Fight AIDS, TB and Malaria (GFATM) has been the single most important source. During rounds 1-7 from 2002-2007, approximately 953 million USD (37% of total available grants global) was approved for TB Control activities in the African Region. This is the largest proportion, followed only by the West Pacific Region at 430 Million USD. There are a number of other sources for TB financing. However, the increase in funding has not been marched with spending and translating into increased case detection and treatment success rates. This may be partly due to weak laboratory infrastructure and lack of social mobilization for increased awareness of prevention of TB.

Drug Resistant TB

15. "*Drug resistant TB is essentially a man made problem arising from causes related to the practice of health care workers or the patient. In the former, inadequate dosage, improper drug combinations, or incorrect duration of treatment are the main causes. In the latter, patient intolerance to some drugs, failures to adhere to treatment or defaulting are the commonest causes".* Additionally, periodic hunger, famine and malnutrition in vulnerable groups may contribute to TB becoming dug resistance.

16. Available data shows that drug resistant TB has emerged as a silent element of the TB epidemic. Regular case notification initiated in 2007 yielded 8,624 MDR-TB cases from 28 countries and 541 XDR-TB cases from four countries.

17. By the end of 2007, there were still 10 Member States without facilities to identify drug resistant TB cases, translating into 78.3% coverage with culture and drug susceptibility testing coverage by country.

18. Of the 26 countries that reported at least a case of MDR or XDR-TB during 2007, only 17 countries (65.4%) have an organized treatment programme. As of January 2008, only 9 countries had applied and been approved to access concessionary priced second line drugs from the Green Light Committee (GLC) of the Stop TB Partnership. This facility is available to all DOTS based TB Control programmes.

Status of implementation of TB/HIV Interventions

19. While the increase in notified TB cases in the region is widespread, it is most noticeable where HIV prevalence is high. HIV promotes the progression of TB infection to disease while TB is responsible for over 40% of AIDS related deaths in the region

and is an AIDS defining condition. Several randomised trials have demonstrated the effectiveness of joint tuberculosis and HIV/AIDS interventions in reducing morbidity and mortality among dually infected persons and such interventions are now recommended as standard minimum package of care for dually infected persons.

20. During 2006, only 22% of notified cases were tested for HIV, compared to the 100% set by the Abuja Summit. However, this represents a 1005 increase in coverage compares to 11.2% for 2005. Of those who tested positive, 37.1% were started on Anti-Retroviral Therapy (ART), increasing from 27.3% in 2005. Again this is far less than the 100% target. At this rate, the region is unlikely to reach the 100% target by 2010. However, 11 countries recorded ART coverage of 30% and above, ranging from 30.8% in Rwanda to 56.9% in Malawi. Furthermore, 89.1% were started on Co-trimoxazole preventive therapy (CPT), a 23.4% increase compared to 72.2% in 2005. At this rate, Universal access to CPT is likely to be achieved by 2010.

Access to essential anti-TB medicines

21. Overall, availability of first line anti-TB drugs has improved tremendously. By the end of December 2007, all 36 eligible countries from the region that applied to the GDF secured 3 year first line anti-TB drug grants, including pediatric formulations for some countries.

22. Notwithstanding, latest available information indicates that only 69% of 42 countries that submitted reports had uninterrupted supply of first line anti-TB drugs at both the central and peripheral levels during 2006. This is a significant short fall with regard to Universal Access to essential TB treatment.

23. For the treatment of drug resistant TB, only 65.4% of countries that reported some drug resistant TB cases had organized treatment programmes. Furthermore, as of January 2008, only 9 countries had applied and been approved to access concessionary priced second line drugs from the Green Light Committee (GLC) of the Stop TB Partnership. This facility is available to all DOTS based TB Control programmes and should be utilized more widely than is currently the case.

24. Despite the progress in tuberculosis control, AFRICA has failed to achieve the global targets for tuberculosis control. While DOTS has expanded, covering 94% of the regional population and treatment success is high (82%), the case detection rate is only 44%. To improve case detection, the regional plan to Stop TB was developed as part of the global plan 2006–2015. The budgetary need for the period of 2006 to 2015 indicated in the Plan is US$ 3.1 billion in the Region. Support to countries was enhanced and partnership development promoted.

CONCLUSIONS

25. Tuberculosis control in Africa has generally progressed in the last decade but the continent still lags behind on major TB Control targets. Financial resources, traditionally a bottleneck for NTPs till the 2000's, is no longer a major factor as GFATM grants, GDF grants (for standard TB treatment), GLC support (for drug resistant TB), bilateral donors support and several Partnership mechanisms provide technical and financial assistance to cover most needs. In order to achieve Universal Access by 2010 and the MDG targets by 2015, much remains to be done, especially to:

- **Increase treatment success rate for smear positive TB cases:** through implementation of initiatives to reduce preventable unfavourable treatment outcomes such as patient default, transfer out and HIV/AIDS related TB deaths
- **Increase case detection rates:** through development and strengthening of laboratory infrastructure, public private partnerships in the delivery of TB services and expanded institutional and community DOTS services.
- **Detect, treat and prevent Drug resistant TB:** through surveillance, development of culture and DST capability for first line anti-TB drugs, and programmatic management of drug resistant TB cases as part of routine NTP activities

- **Scale up TB/HIV collaborative activities:** especially HIV testing among TB patients, Co-trimoxazole and other preventive therapy, and ART for eligible dually infected persons

- **Address Health Systems Components** that affect TB Control (laboratory networks, personnel, surveillance, supply systems and monitoring and evaluation.

Key Recommendations

26. The following recommendations are, therefore finally made:

i. Member states should review their TB Control performance with regard to the WHA, MDG and Abuja targets and develop strategies to accelerate their attainment;

ii. Member states should decentralize and strengthen TB laboratory services in the public and private sectors to improve case detection and ensure quality assured laboratory services in pursuit of Universal Access to such services;

iii. National TB Control Programmes to prioritize implementation of strategies to expand DOTS diagnosis and treatment services with a view to rapidly move towards the WHA, MDG, Abuja and Regional Committee targets for treatment success and case detection. This includes strengthening the capacity of the Health Systems to suspect and diagnose Tuberculosis, and to reduce treatment failures, treatment defaulters and transfer outs.

iv. Member States with generalized HIV epidemic (5% or higher) in the general population to programme and implement in full the Regional Strategy for controlling TB-HIV with particular emphasis on universal access to HIV testing for TB patients, ART for eligible HIV positive patients and other interventions to reduce the burden of TB on People Living with HIV & AIDS, and reduce the burden of HIV &AIDS on dually infected TB patients.

v. Member states to allocate sufficient resources to ensure uninterrupted supply of first line anti-TB drugs at central and peripheral levels, including adequate buffer stocks at the various levels.

vi. For drug resistant TB cases, national programmes should determine the burden of MDR-TB as soon as possible, and initiate treatment programmes for all confirmed cases. National programmes should also mobilize sufficient quality assured second line drugs including concessionary priced drugs through the Stop TB Partnership Green Light Committee;

vii. Member states should respect the pledge to allocate at least 15% of the national budget to health development and allocate a sufficient amount of that for delivery for TB control interventions. Further, Member States to timely expend approved GFATM grants and submit proposals for more funding to meet funding gaps for scale up of activities towards universal access;

viii. Development partners should scale up efforts to provide technical support to Member States, and to sustain funding, and to support Member States conduct the 5-year review, and subsequently prepare implementation reports on the Abuja commitments in 2010;

ix. The AU, RECs, and Regional Health Organisations should advocate with national governments in the 10 countries without local capability for TB culture and drug susceptibility testing for first line anti-TB drugs to establish this capacity in order to facilitate diagnosis and treatment of MDR-TB cases. They should also collaborate in mobilizing national 5-year review reports, and also compile regional reports and then the continental report for heads of State and Government in 2010.