

SESSION 1

IMPROVING



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Session one confirmed the links between TB and development, ill-health and poverty, and stressed how improved health is a catalyst for development.

TB affects the poorest people in the world—95% of new TB cases every year are in developing countries—and their illness tumbles them further into poverty. They are unable to work when sick and families often have to sell what little they own to pay for health care. Research by the World Bank among 60 000 poor people in 60 countries confirms that one critical missing link between poverty and a life worth living is personal security, especially freedom from disease. Illnesses such as TB—and the deadly combination of TB and HIV/AIDS—prevent people from helping themselves out of poverty, compounding the poverty cycle. Improved health through effective TB control contributes to a country's development.

TB control makes development sense

Delegates were urged to remember the lessons of TB control in the Netherlands and New York City. In both places, as TB was brought under control, the facilities and resources for treating the disease were scaled down. It was assumed TB could be consigned to the history books. Instead, TB persisted. In the Netherlands, the disease manifested itself again among poor communities such as the homeless and among those with reduced resistance such as people with HIV. Today, TB control is an integral part of the health care system in the Netherlands.

In New York City between 1979 and 1992, the number of patients with TB tripled and the percentage of patients with MDR-TB more than doubled. By allocating the necessary financial and human resources and designing a comprehensive, integrated TB control plan, the City is winning the battle against TB. A crucial part of the programme is the use of “Directly Observed Therapy”, where outreach workers visit patients in their homes and workplaces, in the streets, homeless shelters and subway stations. Today in New York City, TB continues its downward trend.

The global response to TB has suffered from a legacy of complacency and neglect. There has been no new TB drug for 30 years. There is no vaccine that truly protects against infectious pulmonary disease. Investment is urgently needed in developing better tools—diagnostics, drugs, vaccines—to guarantee the elimination of TB for good. Speakers stressed the urgency of the problem and the need to take action NOW to apply on a large scale what is known about tackling the disease. Otherwise, the world faces the growing threat of drug-resistant TB and a potentially incurable epidemic.



Credit: ©WHO/UNEP/Camp



HEALTH: A CATALYST FOR DEVELOPMENT



6 Action Points

Dr Donna E. Shalala, Secretary of Health and Human Services, Department of Health and Human Services, USA

1. Act now to avoid a more serious and dangerous epidemic in the future.
2. Make TB control programmes comprehensive and accountable: piecemeal approaches make the problem worse.
3. Commit adequate resources, including the necessary political and social will.
4. Pledge commitment to research into new diagnostics, including a more rapid test for MDR-TB, new drugs to reduce the length of treatment and a TB vaccine.
5. Eliminate the poor social and economic conditions that allow TB to survive and thrive.
6. Work together through global partnerships.

Conference speakers stress need for urgency: "We Must Act Now!"

The Honourable Clare Short, Secretary of State for International Development, UK



"We can ensure this conference will be a turning point, by developing strategies for sustainable

financing, resource mobilization and partnership building. And when we've all gone home, translating them into action. Action to tackle TB, action to tackle poverty. We have the potential to consign TB to the dustbin of history. Let's just do it."

"TB attacks the body and assaults the spirit. It hinders economic development. It holds the poor in the grip of poverty and disease. And none of our nations—north or south, east or west—are immune from its threat."



Dr Donna E. Shalala, Secretary of Health and Human Services, USA

"The fight against tuberculosis is a dynamic process that needs to be adjusted continuously. The moment you think you can sit back and relax, TB will rear its ugly head again."

Dr Els Borst-Eilers, Minister of Health, Welfare and Sport, The Netherlands



"Health expenditure to fight such epidemics will force very hard trade-offs in public finance. Every time I look at such financial projections, I shudder. Economists like me are not good at making impossible, unethical, trade-offs. I do not wish such nightmares on anyone, especially political leaders of developing nations. But they will be the reality one day if we do not act now."

Ms Mieke Nishimizu, Vice-President, The World Bank, USA

II. WE RECOGNIZE THAT:

The global tuberculosis emergency is much more than a health concern;

It is a complex socioeconomic problem that impedes human development, & cannot be defeated by the health sector acting alone; Confronting tuberculosis requires collaboration across government sectors & action across society;

Expanded actions must be underpinned by rigorously tested technical strategies; New opportunities exist to enlist modern communications, media & technology in health education aimed at improving health-seeking behaviour;

There exists a cost-effective cure; However, accessibility of safe & efficacious first-line drugs is still an important concern in many countries;

Moreover, the affordability of & access to second- & third-line drugs requires urgent attention;

In addition, the need for accelerated development of diagnostics, new drugs & vaccines is noted;

An accelerated response to tuberculosis founded on increased political commitment is now required to avert a worldwide drug-resistant epidemic with colossal social and economic costs.

SESSION 2

CONF



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Session two examined TB in the context of other infectious diseases—and learned how Bangladesh, Kenya, the United Republic of Tanzania, and Viet Nam have successfully confronted the epidemic and are overcoming particular challenges. All four countries have committed considerable financial and human resources to TB control. Success is attributed to political commitment and partnerships with NGOs, the private sector and international agencies.

The importance of community education around TB and DOTS was stressed in discussion. In South Africa, health officials go on community “focus weeks”, materials on TB are translated into local languages and there is a programme of campaigning and community education.

Pakistan recognizes that community education needs in the country must be linked to one phrase—social stigma. Stigma is strongest in countries with the highest burden of TB and is a major barrier to people seeking diagnosis.

TB in perspective

There are 54 million deaths in the world each year. In low-income nations, 45% of deaths are due to infectious diseases, including TB. Worldwide, premature death from infectious diseases is 48%, of which 90% is attributable to just six infectious diseases: acute respiratory infections, TB, AIDS, diarrhoeal diseases, malaria, and measles. This figure varies greatly from region to region. In the United States it is about 10%, whereas in Sub-Saharan Africa it is as high as 60%. Partnerships between high- and low-prevalence countries are crucial to addressing the TB epidemic.

TB and HIV/AIDS

HIV/AIDS has fuelled the rise in TB cases at an alarming rate, spawning a lethal dual epidemic. Of the 2.3 million deaths from AIDS each year, one half million is due to TB. AIDS is ravaging parts of Africa, leaving children orphaned and communities destitute. The epidemic is rapidly becoming more devastating than war: it is now an international issue of human security.

MDR-TB

A major challenge confronting TB control is the emergence of multidrug-resistant TB. MDR-TB trends are alarming, and the cost of treating MDR-TB is 100 times more expensive than standard TB treatment. Speakers recognized MDR-TB as a public health emergency requiring a prompt international response, including research. It was noted that MDR-TB is generated by poorly managed TB programmes. Several delegates spoke of the problem of drug-resistant TB in their countries. In Tomsk in the Russian Federation, for example, 30% of TB patients have MDR-TB. Globalization, particularly through international travel and migration, contributes to the spread of TB and MDR-TB.



Credit: ©Capital. Photos/WHO

“In countries where strong political leadership, openness about the issues, strong community involvement and broad, crosscutting responses come together, the tide is turning and clear success is being demonstrated.”

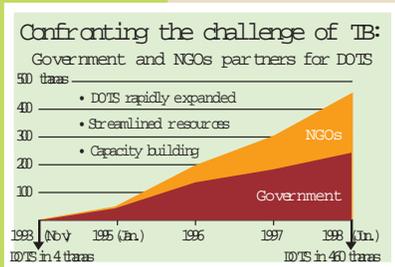
Dr Peter Piot, Executive Director, UNAIDS, Geneva



FRONTING AND OVERCOMING CHALLENGES



Ministerial Panel



3

Messages

Peter Piot, Executive Director, UNAIDS, Geneva

1. Any action that stops the HIV epidemic will also stop TB.
2. To stop TB we need to go beyond DOTS.
3. HIV and TB must not be competing priorities—partnership is essential.

III. WE AFFIRM THAT:

The effective management of tuberculosis in adults & children is an integral part of primary health care; if mainstreamed as a high priority it can be a major contributor to the overall development of national health systems;

The WHO-recommended strategy to combat tuberculosis (DOTS) is the internationally-accepted set of core practices required to confront the disease & prevent the emergence of drug resistance;

Tuberculosis control is a highly effective strategy for poverty alleviation; Access to life-saving tuberculosis control programmes providing safe, high quality drugs opens doors to life's opportunities by getting people back to work & school;

TB control represents a global public good as the epidemic will get worse if we fail to effectively treat infectious cases, track the epidemic, & share best practices & tools within & across borders;

Effective treatment & cure of tuberculosis is one of the most tangible interventions available to extend the life of persons with HIV/AIDS;

Poorly devised actions lead to the emergence of drug-resistant epidemics.

Successes and Lessons Learned

- Achieved national DOTS coverage
- Quality services build users confidence
- Coalition with AIDS programme to re-enforce control and prevention of HIV and TB
- International support effectively used
- Pro-active role in health sector reform
- Partnerships developed since 20 years

in TB case finding between 1987 and 1998. The highest increase is among the most productive age group (15–49 years). Challenges include the development of a joint HIV/AIDS-TB control strategy and further involvement of community care providers.

Kenya

Bangladesh

Bangladesh has achieved 90% DOTS coverage. Government is committed to addressing TB through partnerships with the private sector, NGOs and international organizations such as the World Bank. Challenges include expanding DOTS coverage to the main cities and to remote populations, women and the poor.

The United Republic of Tanzania introduced DOTS as early as 1977. Cure rates of more than 80% have been achieved, with low drug resistance. **Strong Government commitment, close collaboration with donors and integration of TB services have been key to its success.** Since 1982, the number of TB cases has increased four-fold due to HIV. This has led to an overburdening of the health sector and has affected access to TB services. The challenge is to scale up and sustain DOTS despite the severe impacts of the HIV/AIDS epidemic.

United Republic of Tanzania

The Key to Success

- Strong Government commitment
- Collaboration with donors
- Integration of NIP at service delivery point
- Reliable drug-supply since 1983
- Well-trained staff at all levels
- Transport availability at all levels
- Good recording, reporting and surveillance system
- Strong technical support – national and regional

Reasons for Success

- Strong political commitment
- A vast and well-functioning health network
- TB control fully integrated
- Nationwide implementation of DOTS
- Effective and strong international support

Viet Nam was the first Asian country to introduce a DOTS pilot programme in 1989. By 1997, DOTS was expanded nationwide (96%) and global targets of >70% detection rate and >85% cure rate achieved. **Strong political commitment, full integration of TB services and strong international support has guaranteed success.** Major challenges include the growing threat of HIV/AIDS and the expansion of DOTS to remote and mountainous areas and to vulnerable groups.

Viet Nam

Kenya established a National TB and Leprosy Control Programme in 1980. **TB services in public institutions are free of charge. Government recognizes TB control as a public good.** These services are at risk, however, because of the rising TB epidemic in the last decade due to HIV/AIDS: a 500% increase

SESSION 3



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Session three focused on opportunities for global action to Stop TB. Dr Arata Kochi, the Director of Stop TB, proposed three initiatives to accelerate action to eliminate TB: the Global Investment Plan, Global Drug Fund and Global Partnership Agreement. The draft Amsterdam Declaration to Stop TB was presented for discussion and consideration by His Excellency Korn Dabbaransi, Deputy Prime Minister and Minister of Public Health, Thailand.

A personal testimony

Ram Khadka, a teacher from Kathmandu, Nepal, gave a personal testimony to the misery of TB. TB killed both his parents. His mother developed MDR-TB after six years of ineffective TB treatment. Mr Khadka became sick with TB whilst his mother was alive and started DOTS treatment a month before her death. Mr Khadka reminded delegates that "although it is not a recently emerging problem, we are still not able to eradicate this grand problem of the world. History shows us that it took the lives of too many and it is growing even more serious day to day because of HIV and MDR-TB." Mr Khadka called on governments around the world to work together to eliminate TB or "soon the whole world will be a place like hell and won't be a living place."

The key issues raised in the discussion of the draft Declaration included the reluctance of pharmaceutical companies to develop new TB drugs; a call for access to low-cost drugs; the problem of poor countries having to pay for high cost MDR-TB treatment; the inability of some countries to finance TB control due to indebtedness; and the urgent need for vaccine development.

The role of effective TB control in strengthening health systems and contributing to sustainable development was also highlighted, and the consequences of poor TB control were addressed, particularly the risk of increasing drug resistance where TB programmes are ineffective.

Expanding coverage of DOTS must involve changing the focus from a purely technical, health intervention to a multisectoral response engaging the commitment of political leaders and civil society.

Credit: ©WHO/TB/Champ



"The organizers, governments, NGOs and WHO who are working together to eradicate TB have to involve people like us who had the bitter and hard experience of TB. The involvement of technical manpower will not be the entire solution to the problem. There needs to be a change in the attitude of people. They must know that TB can be cured. We know it because we have had TB."

*Mr Ram Khadka, Kathmandu,
personal testimony*



TAKING ACTION

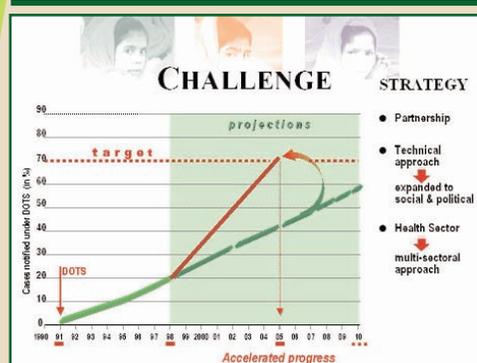


Opportunity for Action

The Mission of Stop TB

The mission of Stop TB is to ensure that every person with TB has all the necessary information and access to treatment and cure; to protect vulnerable populations from TB and multi-drug-resistant TB; and to prevent the unnecessary social and economic tolls of TB.

Arata Kochi, Director, the Stop TB Initiative: "Why TB?"



- Massive burden of illness
- Devastating social and economic impacts
- Cost-effective strategy exists
- Valuable catalyst for health development
- TB control as international public good
- Urgency due to HIV/AIDS and MDR-TB
- Feasible even in resource-poor settings

IV. WE COMMIT OURSELVES TO ACCELERATE ACTION AGAINST TUBERCULOSIS THROUGH:

- Expanded coverage of our populations with the WHO-recommended strategy to combat tuberculosis (DOTS) providing for at least 70% detection of infectious cases by the year 2005;
- Ensuring that sufficient human & financial resources are available on a sustainable basis & expanded to meet the challenges of stopping tuberculosis;
- Ensuring that the implementation capacity is developed to utilize these resources efficiently & effectively;
- Implementing, monitoring & evaluating our national tuberculosis programmes in line with internationally-accepted WHO standards;
- Improving systems of procurement & distribution of tuberculosis drugs to ensure quality, access, transparency & timely supply;
- Incorporating basic outcome measures for tuberculosis as performance indicators for overall health sector performance;
- Promoting the development of national & international partnerships to stop tuberculosis with all stakeholders in society, including government departments & organizations, private health sector, industry, nongovernmental organizations & the community;
- Actively participating in the development & subsequent implementation of a global partnership agreement to Stop Tuberculosis designed to foster ownership & accountability.

Initiatives for Action

Global Investment Plan

An investment guide to mobilize significant new resources and partners.

Global Drug Facility

A mechanism to ensure equitable and reliable access to TB drugs for all who need them.

Global Partnership Agreement

A means to operationalize the Amsterdam Declaration to Stop TB through expanded global and national partnerships for action.



Credit: ©WHO/IFER/UNICEF

SESSION FINANCE

4 First round



Credit: ©Capital Photos/World Health Organization

Finance round tables in Session four debated the socioeconomic impacts of TB and TB/HIV, and options for finance and sustainability—supported by country presentations.

Credit: ©WHO/TDR/Chang



Indonesia

Indonesia continues to suffer the economic legacy of poverty from the financial crisis in Asia in 1997. In 1996, the World Bank estimated that TB caused 7.7% of the total disease burden in the country. **Approximately 75% of cases are in the economically active age group of 15–54 years.** Some 60% of TB cases occur among the poor and poorly educated. Indonesia introduced DOTS in 1990. The strategy aims for 70% coverage within five years; currently, only about 51% of health clinics implement DOTS. Despite the economic challenges, TB control is recognized as critical to avoid even more difficult and expensive problems in the future.



Credit: ©WHO/TDR/Chang

Socioeconomic Impacts of TB and TB/HIV

India

India carries one-third of the global tuberculosis burden, which affects the most productive age group (15–49 years). **TB causes more deaths among women than all other causes of maternal mortality in India.** The social stigma associated with the disease makes the situation worse. India recognizes that any TB control initiative has to be implemented in tandem with poverty elimination programmes. In 1993, the Revised National TB Programme based on the DOTS Strategy was started on a pilot basis and scaled up in 1997. Resources were committed and free treatment is now available for a population of 130 million people.

Uganda

Uganda has experienced the dramatic socioeconomic impacts of the dual TB/HIV epidemic for the past fifteen years. **Half of TB patients are also infected with HIV.** Life expectancy has steadily declined since the onset of the HIV/AIDS epidemic. The socioeconomic impacts of the dual epidemic on households and communities include:

- Decreased labour supply;
- Loss of skilled labour;
- Increased number of orphans;
- Loss of school time;
- Loss of worktime leading to lower incomes and lower food production;
- High financial costs to the family due to illness and burials;
- Family livelihood disrupted and distress following death of the principal wage-earner.

Zimbabwe

Zimbabwe has among the highest rates of HIV infection in the world. The TB and HIV epidemics have together contributed to the decline in the average growth rate and the GDP per capita. Debt servicing accounts for more than four times the expenditure on health and education. Some 41% of the population lives on less than US\$1 per day. Extended family systems that used to care for orphans can no longer absorb the costs. Resources otherwise available for investment are now used for health care and social welfare, especially care for orphans. **Where support for orphans is failing, the phenomenon of street children in the major cities is rising.** Life expectancy has declined by 17 years, principally among the most socioeconomically active.

Additional country-specific information and indicators can be found in the *Country Profiles* document (reference: WHO/CDS/STB/2000.3) prepared for the Conference or at: www.stoptb.org



Second round

Options for Financing and Sustainability

Credit: GHI, Jagan



Democratic Republic of the Congo

Despite war, Congo DR has achieved 70% DOTS coverage. TB control is based in 306 health centres around the country. Health centre personnel receive ongoing education. Partners in this work include the Catholic Church. **Major obstacles to TB control are debt servicing, epidemics and war.** Some 70% of financing comes from donors. The country recognizes the need to mobilize partnerships across sectors and to obtain a constant and regular increase of state budget earmarked for TB.



Credit: WHO/IDR/Chandran

Pakistan has the fifth highest burden of TB in the world, causing approximately 26% of all avoidable adult deaths. DOTS covers only 8% of TB patients. Pakistan is planning a massive poverty alleviation programme. Improved literacy, especially among women, will greatly contribute to the efficacy of the TB programme. The programme is based on two guiding principles: self-reliance through regular budget sources and sustainability through integration of programmes with general health services. **Government is committed to effective TB control and plans have been made for DOTS to expand nation-wide. All provinces have allocated funds for TB in this financial year.**

Pakistan

The Philippines needs at least US\$ 60 million over the next four years to reduce TB. Anti-TB drugs are a major cost item. Although the NTP calls for free drugs for all infectious cases, there have been insufficient resources to support this policy until 2000. **A multi-year budget has now been proposed for TB until the year 2003. A planned expansion of social health insurance is also under way.** Currently, social health insurance pays only for hospitalization of TB patients; however, the inclusion of outpatient TB diagnostic and treatment services for poor people is being piloted. Efforts are being made to lower drug costs and to reform the procurement system. Two major gaps in financing are recognized: measures to address childhood TB and adequate provision for MDR-TB.

Philippines

Russian Federation

Government has supported the fight against TB since 1910 by providing considerable resources. Since 1992, however, there has been a significant rise in the incidence of TB, with a major epidemic in the prisons. The increase is due mainly to the rapid deterioration in social and economic conditions, including the flow of refugees. The overall health system has severely deteriorated. Additional financial resources are needed for the education of physicians and the general population, for monitoring TB incidence, for the upgrading of diagnostic facilities and for anti-TB drugs.



Credit: WHO/IDR/Crupp



SESSION HEALTH

4 First round TB and Health Systems Development



Credit: ©Capital Photos/World Health Organization

Health round tables in Session four considered TB and health systems development, and strategies to cope with the dual TB and TB/HIV epidemics—supported by country presentations.

Viet Nam

Viet Nam has met WHO global targets for national DOTS coverage and TB cure rates. A major contributing factor is the existing and well-functioning network of health services. There is a health centre in every commune with dedicated and well-trained staff. The active support of communities, mass organizations of women and peasants and peoples' committees have been important factors in promoting DOTS. **A World Bank loan as part of the "Health Sector Support Project" has made possible the strengthening of commune and district health centres including TB programmes in 19 provinces.** Government is committed to social equity in health care and provides basic services to the poor. Challenges ahead include how to reach the minorities and underprivileged. Pilot projects to develop community-based DOTS in mountainous and remote areas, and close collaboration with the private sector and NGOs, will contribute to further improving health service delivery and the country's health system at large.

Additional country-specific information and indicators can be found in the *Country Profiles* document (reference: WHO/CDS/STB/2000.3) prepared for the Conference or at: www.stoptb.org

Cambodia

Despite years of isolation and conflict, Cambodia introduced DOTS in 1994 and has achieved 92% treatment success rates. Because of years of isolation and the resulting lack of a health care infrastructure, TB services were implemented in a vertical manner. **A reform of the health sector aims at providing a network of health centres run by multi-purpose health workers. A pilot programme "DOTS in health centers" begun in September 1999 integrates the already existing TB services.** Health sector reform and the integration of TB services have become even more important in the light of increasing HIV rates which, in 1999, has led to a 14% increase of TB cases.

Ethiopia

Ethiopia's Health Sector Development Programme was launched five years ago and aims at a comprehensive sector wide and integrated health system, focused on family health and communicable disease prevention. **The TB programme aims specifically at providing management training for information systems to assure a continuous drug supply and increased quality services such as microscopy, which Ethiopia recognizes are prerequisites for a sustainable health system and effective TB control.** The importance of Government commitment and effective coordination within the Government as well as with donors and partners is acknowledged. Challenges are maintaining the decentralization process while coordinating and integrating activities.

China

TB is the main communicable disease in China causing poverty in rural areas, and hampering local economic development. There are at least 1.5 million new cases every year and the total number of TB patients is 6 million. Government has used a World Bank loan and domestic resources to introduce TB control

through DOTS. In DOTS project areas, cure rates are above 90%. Successful implementation relies heavily on the development of the health system. **DOTS implementation has significantly improved the functioning of the health system and the technical skill and working capability of TB control workers.**

Philippines

The present Philippines administration was elected on the basis of a pro-poor agenda, which included an ambitious health sector reform agenda. A presidential memorandum signed in 1998 made TB control a national priority. Public health reforms support the national TB programme by improving the drug procurement system and ensuring prompt delivery of anti-TB drugs to health centres. In 1991, legal autonomy was given to provinces, cities, and municipalities. **A devolved health delivery system makes local Government units critical to DOTS implementation.** It is expected that DOTS coverage will increase from 17% currently to about 80% at the end of 2000. A key element for achieving targets is strong collaboration with the private sector, particularly important as research shows that 80% of all TB patients first see a private practitioner.



Second round

Strategies to Cope with the Dual Epidemic



Credit: ©WHO/IFR/L. Marice

South Africa

TB and HIV are of the highest priority in South Africa. The rapid progression of the HIV epidemic has fuelled the already high numbers of TB cases. Socioeconomic diversity has translated into an imbalance in service delivery across the country. In an attempt to harmonize TB and HIV/AIDS control, key areas where both programmes could work together have been identified:

- Political commitment;
- Multisectoral approach;
- Guidance and support;
- Research;
- Monitoring and evaluation of current strategies.

Networks of community-based volunteers and lay assessors have been mobilized to provide care for people living with HIV/AIDS and to ensure that TB treatment is accessible. **To improve collaboration between TB and HIV/AIDS programmes, pilot sites are being developed in health education, voluntary counselling and testing, treatment of opportunistic infections, care and support, and collaboration between home-based care projects and community-based DOTS projects.**



Credit: ©WHO/IFR/Crumph

It is estimated that HIV has contributed to 15%–20% of the new TB cases in the country after decades of decline in TB rates. In 1998, 20% of people infected with HIV also had TB. As a result of HIV, TB affects more young people and debilitates more adults in the productive age group than ever before. The dual epidemic has gone far beyond being a health problem: it has destabilized families and impeded economic development.

Thailand's response is to improve TB services at all levels, based on the DOTS strategy, and to integrate TB care with HIV community-based care. Thailand is also drawing from its experience with HIV/AIDS to address the dual epidemic. **Government leadership, an inter-sectoral response, education and information, and building networks with patient groups and activists to prevent discrimination are among the strategies being used.**

Thailand

The dual epidemic of TB/HIV is severe in Uganda with about 50% of TB cases being HIV-positive. The national response is to mobilize all stakeholders, particularly communities. The results are very promising with cure rates rising to 87%. **Decentralization, integration of TB and HIV/AIDS care into the general health system and community involvement are key to a sustained TB programme.** In the future, the participation of communities will be extended to address malaria, immunisation, and reproductive health. Village Health Committees will be set up in every village of 2000 people to mobilize a mass movement to promote health.

Uganda

Zimbabwe

A key strategy in addressing the TB/HIV epidemics is the empowerment of communities to get involved and take responsibility. **A strategic change implemented in Zimbabwe is that now the health services go to the patient.** There is a policy of decentralization to the district and the district health executive is the driver of the health services. The Ministry of Finance now allows district communities to retain the fees collected for health care.

SESSION 5



Credit: ©Capital Photos/World Health Organization

Session five considered financing and sustainability options as a means of investing in health for the long-term.

Ms Mieko Nishimizu, the World Bank, reflected on the Conference and noted the “wonderful learning” among delegates who shared common challenges and experiences. The impressive collective strength and personal commitment of leaders was commended. It was observed that such commonality stimulates a “virtuous cycle of development partnership”—a cycle that begins through action leading to visible social and economic returns.

5 Lessons

Ms Mieko Nishimizu, Vice-President, The World Bank, USA

1. In the fight against TB—as in all other development challenges—one size does not fit all.
2. The enabling conditions of health systems and policies vary greatly among the 20 countries.
3. The financial constraints and associated strategies to create “room” internally and externally in terms of resources differ.
4. Social and cultural contexts for effective health outcomes vary greatly.
5. The breadth and depth of political commitment is diverse.

10 Recommendations

Dr William Foege, Senior Health Adviser, Bill and Melinda Gates Foundation, USA

1. We need to be globalists—national boundaries must be forgotten.
2. Health and development are fused in a reciprocal relationship—no problem can be understood in isolation.
3. Organize globally.
4. There is no single best approach.
5. The “secret” of leadership is in defining shared goals.
6. Money follows a good strategic plan. We need a plan that balances DOTS expansion and MDR-TB containment.
7. Seize the moment. Every day opportunities are lost that cannot be reversed.
8. Make TB a political issue in every country. Public health decisions are ultimately grounded in political decisions.
9. TB control is expensive, but not nearly as costly as the disease.
10. Take responsibility. Then provide the best management possible.

“Equity is the bottom line.”



INVESTING IN HEALTH FOR THE LONG-TERM

Ministerial Panel— Financing and Sustainability



“The difference between a body of scientific knowledge improving health or not improving health comes down to management.”

Dr William Foege,
Bill and Melinda Gates
Foundation, USA

Brazil

Brazil is committed to sustained TB control. Government spends approximately US\$ 23 million a year on TB control—equal to a per capita spending of US\$ 0.13—30% more than the level recommended by WHO. The new National Tuberculosis Programme established in 1998 focuses on integrating TB services into other major health initiatives and on decentralization to bring decision-making and care closer to the patient. Challenges include improving management capacities at local level and further improving the laboratory network. Government has increased resources (such as for microscopes and drugs) and DOTS is being expanded and implemented in all 27 States. **To increase participation, a bonus of between US\$ 55 and US\$ 85 is being paid to communities for each cured TB patient.** Brazil has committed resources to achieve cure rates of 85% by 2002.

China

In 1991, the World Bank and the Chinese Government jointly initiated a TB control project. This, in addition to a special Government funded TB control project, reached a total of 700 million people. More than 1.2 million infectious TB patients have now been diagnosed and treated free of charge, with cure rates as high as 90%. TB is the main communicable disease causing poverty. **The Government is committed to expanding DOTS to 90% of the population by 2005; it will increase the special budget for TB control and will hold a national mobilization meeting.**

India

Nearly 15% of the population is covered by DOTS compared with only 2% one year ago. It is estimated that DOTS can prevent more than 1.5 million deaths by the year 2010—the largest number of lives saved for a single public health programme. India plans to implement DOTS nationwide by 2005. Priority research areas are to develop an effective vaccine and a new generation of drugs that require only one to two months of treatment. **The costs of TB control are currently borne disproportionately by developing countries. The global community must increase its commitment to TB control, both in technical and financial terms.**

Nigeria

The budgetary allocation to health in Nigeria is low at only 2.0% to 2.5% of the national budget. Currently, approximately 10% of TB patients are treated with support from international donors. Government plans to provide treatment services to an additional 20% in the year 2000, however, more resources are needed to address the TB problem nationwide. In order to expand services further, the option of cost-sharing between three tiers of Government—federal, state, and local—is being considered. User charges have been introduced in most health facilities, although TB treatment is free. **In order to sustain support for the TB programme, further cost-sharing with patients may be required. Other options to mobilize finances are using the National Health Insurance System, linking with the National AIDS and STI programme and reducing TB drug costs by centrally procuring them in bulk.** The establishment of a national Tuberculosis Fund with money raised from public and private sectors has been discussed. In addition, decentralizing decision-making processes as well as capacity building at a local level are envisaged in order to make services more efficient.



Credit: ©WHO/IFR/Chrump



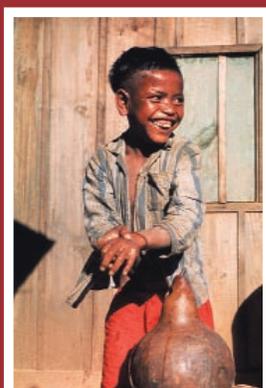
CONCLUDING SESSION



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Following unanimous adoption of the Amsterdam Declaration to Stop TB, the concluding session heard statements from two of Stop TB's partners: UNICEF and Médecins sans Frontières.

The case for UNICEF's involvement is clear. TB is a major threat to the rights of the child, adolescents, and their families. The potential negative impact on the survival, growth and development of its mandated populations is extremely grave. Women and young people (a rapidly growing affected group) face devastating stigmatization, which disenfranchises the deeply affected and adds to the grave potential risks from inadequate treatment. The impact on families is considerable. Evidence from the Asian Development Bank shows that at least half of the financial crises in poor Asian families are triggered by a catastrophic illness, especially TB.



Credit: ©AED/TDR/UNICEF

Insufficient attention has been focused on the direct and indirect impact of TB in children. The problem is underestimated because diagnosis is difficult. Children also suffer the impacts of TB in families and are often taken out of school—about 300 000 a year in India. Children are inevitably neglected when parents fall sick. The disease renders ineffective the taken-for-granted family coping mechanisms that have been the foundation of community and family care systems for generations. UNICEF called for more research on TB and HIV/AIDS that identifies the special risks to children in conflict situations and to those who are refugees, trafficked, or are in conflict with the law.

UNICEF endorsed the need to expand DOTS and urged countries to establish National Investment Plans to complement the Global Investment Plan being prepared by the Stop TB partners. These plans must be multisectoral and involve a broad partnership reaching beyond the health system. UNICEF also called for more research on TB and children.

MÉDECINS SANS FRONTIÈRES welcomed the fact that TB was now on the political agenda. For too long it has been a technical, medical disease. Dr Orbinski, International President, affirmed the need to improve, expand, and adapt DOTS. Accelerated research into new drugs, diagnostics, vaccines, and different ways of using DOTS was called for. These solutions rest on the right to health care for all, on the recognition of equity of access to health care, and on the responsibility of governments and inter-governmental organizations to ensure provision of health care.

Dr Orbinski noted that the 20 countries represented at the Conference did not have the financial resources to fight TB alone or to invest in the research needed. Their capacity was stretched to the limit. The market has clearly failed to produce new TB drugs. There needs to be international leadership on drugs research. TB is a disease of the poor, but the poor do not have consumer power. TB control is a public good and any public research and development initiative into new TB drugs must put equity of access as its first goal; access to the drug itself and to the intellectual property rights. A particular focus should be on developing a drug that shortens DOTS treatment to less than three months with minimal dosing requirements.



"FORGING NEW PARTNERSHIPS TO STOP TB"



Ministerial Panel— Partnerships for Action

5 Action Points

*Dr Gro Harlem Brundtland,
Director-General, WHO, Geneva*

Let us...

1. Make sure TB gets the priority it deserves in budget allocations.
2. Make sure that all people who need it can access treatment—regardless of whether they can pay for treatment.
3. Encourage the global community to back country partnerships to Stop TB and respond positively to requests for support that benefits human development through tackling TB.
4. Work together in partnership fighting the global epidemic, helping people all over the world to prevent TB.
5. Move urgently to tackle multidrug-resistant TB and continue to expand access to DOTS while we can.

Democratic Republic of the Congo

For the past decade Government has had strong partnerships with NGOs working on TB control. This has contributed to a very high number of cases being tracked and treated. Challenges now are to improve the expertise of health workers, strengthen the coordination capacity of the programme, prioritize advocacy and social mobilization—and end the war.



Indonesia

Partnership is a key factor in the success of the National TB Programme. Every day, 500 people die from TB—the country has the third largest number of TB cases in the world. **The Gerdunas TB Movement launched by the Minister of Health in 1999 has mobilized political commitment of the highest order.** Long-term commitment from donors is essential to ensure the continued success of the movement.

Nigeria

The National TB and Leprosy Control Programme launched in 1991 promotes the use of DOTS—implemented in 19 of the 36 states. Many activities, such as the provision and distribution of drugs, are carried out by a number of NGOs. In addition, joint action plans have been developed with the National AIDS and STI Control Programme. In order to ensure a continuous supply of drugs a key partner is the pharmaceutical industry. Other sectors that play crucial roles in improving living standards, promoting health and preventing TB are being targeted for collaboration, such as housing, education, agriculture, labour and the community. **In order to encourage more partnerships, the Nigerian Government has set aside counter-part funds to support activities by development partners who are willing to invest.**

V. WE CALL UPON PARTNERS

Recognizing that we represent the governments of countries with the highest burden of tuberculosis in the world, but that other countries not represented in this Conference face many or all of the same problems, we call on our colleagues around the world to join WHO, the World Bank & others in the Stop TB Initiative to actively participate in building new momentum against tuberculosis for better health for all in the new millennium.