World Health Organization

Stop TB Partnership

THE STOP TB STRATEGY

Building on and enhancing DOTS to meet the TB-related Millennium Development Goals

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PREFACE

The major progress in global tuberculosis (TB) control seen in the past decade has been due in large part to the development and widespread implementation of the DOTS strategy, especially in countries with a high burden of TB. Building on current achievements, and in accordance with the 2005 World Health Assembly resolution on sustainable financing for TB control, the major task for the next decade is to achieve the Millennium Development Goal (MDG) and related Stop TB Partnership targets for TB control, which have been set for 2015. As with the DOTS strategy, some of the targets relate to TB diagnosis and cure; others are concerned with epidemiological impact, including reversing incidence and halving the 1990 level of TB prevalence and death rates. Meeting these targets requires a coherent strategy that is capable of sustaining existing achievements and addressing remaining constraints and challenges more effectively. This document defines such a strategy – the Stop TB Strategy.

The Stop TB Strategy sets out the steps that national TB control programmes and their partners need to take, assisted actively by all stakeholders. It is based both on experience gained over the past decade and on continuing consultations with stakeholders at the global, regional, national and local levels. Implementation of the strategy should ensure equitable access to care of international standards for *all* TB patients – infectious and non-infectious, adults and children, with and without HIV, with and without drug-resistant TB – regardless of whether they receive care from a public or a private provider.

Stopping TB must be seen within the framework of country-owned strategies to reduce poverty and advance development. The Stop TB Strategy must be aligned with other strategies and partnerships to meet all major public health challenges. Tackling TB effectively requires addressing all the risk factors that make individuals vulnerable to infection with *Mycobacterium tuberculosis* and to developing the disease. It also means reducing the adverse effects of the disease, including its social and economic consequences. Clearly, the main focus of the Stop TB Strategy is on making the best use of currently available tools for diagnosis, treatment and prevention of TB and of the improved tools that are likely to become available through research and development.

The strength of global efforts to control TB lies in the coordinated and collaborative efforts of the Stop TB Partnership, which now has more than 400 partners worldwide. The Stop TB Strategy presented here underpins the Global Plan to Stop TB (2006–2015), developed by the Stop TB Partnership.

With a clear global strategy and related global plan, the framework is in place for unprecedented efforts in TB control over the next 10 years. Full implementation will require substantial resources – while funding is rising, more is needed. I am confident that WHO and its partners will continue to work closely with countries to help achieve the MDG and Stop TB Partnership targets for TB control, and set us on the path to elimination of this ancient scourge of humanity.

Mario Raviglione
Director, Stop TB Department

I. BACKGROUND

Achievements in the past 15 years

Global efforts to control TB were reinvigorated in 1991, when a World Health Assembly (WHA) resolution recognized TB as a major global public health problem (*1*). Two targets for TB control were established as part of this resolution – detection of 70% of new smear-positive cases, and cure of 85% of such cases, by the year 2000. In 1994, the internationally recommended control strategy, later named DOTS, was launched (*2*). Its key components included: government commitment; case detection by predominantly passive case-finding; standardized short-course chemotherapy to, at least, all confirmed sputum smear-positive cases, provided under proper case management conditions; a system of regular drug supply; and a monitoring system for programme supervision and evaluation. The DOTS framework has subsequently been expanded (*3*), further clarified, and implemented in 182 countries. DOTS implementation has helped countries to improve national TB control programmes (NTPs) and make major progress in TB control. By 2004, more than 20 million patients had been treated in DOTS programmes worldwide and more than 16 million of them had been cured. Mortality due to TB has been declining and incidence diminishing or stabilizing in all world regions except sub-Saharan Africa and, to some extent, eastern Europe. The global treatment success rate among new smear-positive TB cases had reached 83% by 2003 (just short of the WHA target of 85% by 2005), and in 2004 the case detection rate, which has accelerated globally since 2001 (*4*), was 53% (against the target of 70% by 2005).

The first Global Plan to Stop TB set out the actions that were needed in TB control over the period 2001–2005 (*5*) and helped to steer global TB control efforts during that time. Global TB control has also been boosted by increased political commitment from high-burden countries and partners in the Amsterdam Declaration (2000), the Washington Commitment to Stop TB (2001), and the Stop TB Partners' Forum in Delhi (2004). In 2005, the WHA passed a resolution advocating "sustainable financing for TB control and prevention", with Member States making a commitment to strengthen efforts to achieve the TB-related targets included in the MDGs (*6*) – see section III for details. This resolution built on the report of the Commission on Macroeconomics and Health (2001), the High-Level Forum on the Health Millennium Development Goals (MDGs) in 2004, and the Second Ad Hoc Committee on the TB Epidemic (2005) (*7*).

Since the development of the DOTS strategy, WHO and partners have worked on complementary policies and strategies to address the remaining major constraints to achievement of global TB control targets. These include expanding access to diagnosis and treatment through community TB care, and public–private mix (PPM) approaches aimed at engaging all care providers – state and non-state – in DOTS implementation. Innovative mechanisms such as the Global Drug Facility and the Green Light Committee have been developed to improve access to quality-assured and affordable drugs in resource-poor settings. The collaborative activities that need to be implemented by TB and HIV/AIDS control programmes have been defined, and strategies for managing multidrug-resistant TB (MDR-TB) have been developed and tested. Impact assessment is being pursued as a means of evaluating progress towards the MDGs. New partnerships and academic research initiatives for development of new tools are beginning to produce results, and several new diagnostics, drugs and candidate vaccines are in the pipeline.

Challenges for 2006–2015

Current rates of progress are insufficient to allow the targets of halving TB mortality and prevalence by 2015 to be achieved (*8*). Particularly urgent action is needed where the epidemic is worsening, notably in Africa but also in eastern Europe. While there has been substantial progress in extending and improving NTPs in sub-Saharan Africa, this region has to face the challenge of the rapid rise in TB cases produced by the HIV epidemic, often in places where human resources in the health care sector are already overburdened. In eastern Europe, the socioeconomic crisis that followed the dismantling of the Soviet Union in the early 1990s and impoverished public health systems have contributed to a major increase in the incidence and prevalence of TB, including MDR-TB.

Increased and sustained efforts are also needed in Asia, which continues to bear two-thirds

of the global burden of TB, with India and China ranking first and second in terms of total number of TB cases. An emerging HIV epidemic in Asia also threatens recent progress in TB control, and in some parts of China MDR-TB is a major problem.

In all regions, identifying and reaching all those in need of care, especially the poorest of the poor, poses a major challenge. Efforts to control TB must progress hand-in-hand with efforts to strengthen health systems as a whole. The ultimate goal of eliminating TB depends on new diagnostics, drugs and vaccines. New approaches to overcoming the obstacles to TB control have been developed, but greater resources are needed to allow these approaches to be widely implemented.

Opportunities for 2006–2015

New resources are becoming available, from increased domestic funding in some high-burden countries and rising international funding, including that from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), development banks and bilateral development agencies. Partnerships to respond to health system and disease control challenges are being developed across and within countries and among a wide array of stakeholders. As noted above, a variety of new policies and strategies have been developed which, if implemented more widely, would make a major contribution to improving TB control.

The need for a new strategy

The past decade has seen major progress in global TB control – in large part as a result of the development and widespread implementation of the DOTS strategy. Building on current achievements, the major task for the next decade is to achieve the MDG and related Stop TB Partnership targets for TB control. Meeting these targets requires a coherent strategy to provide the context for the second Global Plan to Stop TB (2006–2015) (*9*) – a strategy that enables existing achievements to be sustained, effectively addresses the remaining constraints and challenges, and underpins efforts to strengthen health systems, alleviate poverty and advance human rights.

This document defines such a strategy – the Stop TB Strategy – and is divided into four major sections:

- **The Stop TB Strategy at a glance.** Provides an overview of the strategy.
- **Vision, goal, objectives, targets and indicators.** Explains the goal and related objectives, targets and indicators of the Stop TB Strategy, as well as the overall vision to which the Strategy will contribute.
- **The six principal components of the Stop TB Strategy.** Explains the major components of the strategy in more detail: pursuing high-quality DOTS expansion and enhancement; addressing TB/HIV, MDR-TB and other challenges; contributing to health system strengthening; engaging all care providers; empowering patients and communities; and enabling and promoting research.
- **Measuring global progress and impact.** Explains how progress towards TB control targets will need to be measured and evaluated.

II. THE STOP TB STRATEGY AT A GLANCE

VISION	**A WORLD FREE OF TB**
GOAL	• To reduce dramatically the global burden of TB by 2015 in line with the Millennium Development Goals and the Stop TB Partnership targets
OBJECTIVES	• To achieve universal access to high-quality diagnosis and patient-centred treatment • To reduce the suffering and socioeconomic burden associated with TB • To protect poor and vulnerable populations from TB, TB/HIV and MDR-TB • To support development of new tools and enable their timely and effective use
TARGETS	• MDG 6, Target 8 – ...halted by 2015 and begun to reverse the incidence... • Targets linked to the MDGs and endorsed by the Stop TB Partnership: – by 2005, detect at least 70% of new sputum smear-positive TB cases and cure at least 85% of these cases – by 2015, reduce TB prevalence and death rates by 50% relative to 1990 – by 2050, eliminate TB as a public health problem (<1 case per million population)

COMPONENTS OF THE STRATEGY AND IMPLEMENTATION APPROACHES

1. **Pursue high-quality DOTS expansion and enhancement**
   a. Political commitment with increased and sustained financing
   b. Case detection through quality-assured bacteriology
   c. Standardized treatment, with supervision and patient support
   d. An effective drug supply and management system
   e. Monitoring and evaluation system, and impact measurement
2. **Address TB/HIV, MDR-TB and other challenges**
   a. Implement collaborative TB/HIV activities
   b. Prevent and control MDR-TB
   c. Address prisoners, refugees and other high-risk groups and situations