

Report on the Second Technical Advisory Group Meeting to Stop TB in the Western Pacific Region, Beijing, China 4–6 June 2001

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"A world free of poverty will remain a mere dream, unless we join hands to overcome major global threats to the poor and marginalized people around the world. Without question, tuberculosis is one such threat, and its control must be on the global development agenda. TB and poverty are closely linked. Poor living and working conditions stimulate transmission and disease, and disease exacerbates economic and social distress... The public health strategy known as DOTS (Directly-observed Treatment, Short course) provides the cornerstone for action in fighting TB. But for such a strategy to stop TB, it must be an integral part of poverty reduction strategies of developing countries, strategies that are of these nations' own conviction and political will, and strategies that are owned by these countries and supported by the international community."

Source: World Bank Vice President for the South Asia region, Mieko Nishimizu at the *Tuberculosis and Sustainable Development Ministerial Conference*, 22–24 March 2000, Amsterdam. World Bank Group News Release No: 2000/254/HD.

Australia is fortunate to have one of the lowest rates of tuberculosis (TB) in the world. Rates have remained consistently around 6 cases per 100,000 population or lower since the 1986, with a rate in the Australian born population of less than 2 cases per 100,000 population.¹ Australia's *National Strategic Plan for TB Control in Australia Beyond 2000*² was launched this year on World TB Day (24 March) as a statement of directions and priorities for TB control. The Plan was developed by the National Tuberculosis Advisory Committee (NTAC) of the Communicable Diseases Network Australia and includes a number of verifiable performance indicators against which to monitor the next phase of the TB control program.

The most important issues that currently affect the control of TB in Australia are increased migration from countries with very high rates of TB and socioeconomic inequalities within Australia reflected in higher rates of TB in indigenous Australians. In 1999, the rate of pulmonary tuberculosis in non-Indigenous Australian-born persons was 0.9 cases per 100,000 population compared to 13.6 cases per 100,000 population in the overseas-born and 6.6 cases per 100,000 population in Indigenous Australians.¹ While the proportion of overseas born cases represented in annual TB notifications has increased over the last decade, the rates of TB have not, a testament to the success of our TB control program which provides for free diagnosis and treatment, contact tracing and preventive treatment for eligible Mantoux positive contacts among other strategies.

In 1986, 60 per cent of TB notifications were overseas-born, compared to 70 per cent in 1990, 75 per cent in 1996, 77 per cent in 1998 and 83 per cent in 1999.¹ Australia is also fortunate that despite the impact on global TB control of the HIV/AIDS epidemic and the emergence of multi-drug resistant TB (MDR-TB), these factors have had a limited effect on TB control in Australia. Appropriately, one of the recommendations of the National Strategic Plan is to "liaise with regional partners to assist TB control programs in neighbouring countries."²

Annually, over 2 million deaths worldwide were attributable to TB, with 95 per cent of these occurring in developing countries. It is estimated that there were over 8 million new cases of TB in 1998 worldwide with over 3.6 million reported to the World Health Organization (WHO) Global Surveillance Program by 189 countries.³ Of these TB notifications, 39 per cent were managed under the WHO Directly Observed Treatment-Short course (DOTS) strategy for TB control and 1.4 million of these notifications (40%) were new sputum-positive pulmonary cases.³ There are an estimated 2 million cases of TB in the World Health Organization's Western Pacific Region (WPR), of which some 850,000 are infectious sputum smear-positive cases.⁴

The Region's countries can be grouped according to the burden of tuberculosis and DOTS coverage. There are four groups in the Western Pacific Region (Box),⁵ with countries representing some of the

highest and lowest burden countries globally. Nearly one third of the global burden of TB is found in the WPR which has a population of approximately 1.7 billion people and includes seven high burden countries – Cambodia, China, Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines and Viet Nam. China accounts for over half of the regional TB cases followed by the Philippines and Viet Nam. The 1999 estimated average rate of all types of TB in the high burden countries was 50.7 cases per 100,000 population and 25 cases per 100,000 population for new smear positive TB compared to 49.2 and 23.5 respectively for the WPR as a whole. The WHO reported that the case detection rate in the Region in 1999 was 44 per cent and 47 per cent for all types of TB and new smear positive TB respectively, with an estimated 792,914 new smear positive cases in that year. Although overall TB/HIV co-infection rates are still low in the WPR, some countries, notably Cambodia and PNG, have reported an increase in co-infected cases with an expected rise over the next few years.

In 1999 a 'tuberculosis crisis' was declared in the WPR which led to the establishment of a WHO sponsored Special Project to Stop TB.⁶ The STOP TB Initiative was presented as a global partnership being mobilised to serve the needs of countries, particularly high burden countries. Participants expressed their interest and expectations that such an initiative would provide them needed support to advocate the case for TB control. As a result, participants developed outline action plans to lobby their governments about pushing TB control higher in the domestic political agenda and participating in building the foundation of the STOP TB Initiative.

A Technical Advisory Group (TAG)⁴ comprising of tuberculosis experts from around the world met for the first time in February 2000. The meeting endorsed the Regional Strategic Plan, including the regional objectives to reduce tuberculosis prevalence and mortality by half by 2010. The TAG and Member Countries committed to reach regional targets for the Stop TB Special Project. The Second TAG Meeting, reported here, was held in Beijing in June 2001. In recognition of the increasing incidence of TB/HIV co-infection in the Region, the development of a regional strategy for TB/HIV co-infection control was initiated and the WHO Western Pacific Regional Office (WPRO) participated in the first meeting of the Global TB/HIV Working Group meeting in April 2001.

There is an increasing recognition of the relationship between chronic diseases, such as TB, and a spiralling descent into abject poverty among the infected poor unable to work because of their disease. This has serious implications not only for the affected individual, but also their family, community, and at a population level, to national economic growth and development. Approximately 23 per cent of the world's poor live in the WPR. Globally, over 60 per cent of TB deaths occur among the poorest 20 per cent of the population. At the Second TB TAG Meeting,⁴ a presentation by Ms Christy Hanson from the World Bank presented on behalf of the World Bank's East Asia group on 'Poverty and TB Control' raised concerns that although the WHO's DOTS program was a 'pro-poor' initiative in principle, there was a need for further investigation to determine how well DOTS programs were actually reaching the poor and whether health systems and financing policies in some countries were further restricting access to health care by the poor.

The Stop TB Special Project aims to treat all diagnosed patients with TB within the DOTS program. Currently DOTS uptake in the Region is 60 per cent with a wide range between countries. Dr Mario Raviglione, Coordinator of Tuberculosis Strategy and Operations in WHO, Geneva, reported that the WPR notified 25 per cent of sputum smear positive TB cases globally while having the highest treatment success rates of all WHO regions.⁴ The cure rate and treatment success rate of new smear-positive cases under DOTS were 93.3 per cent and 94.8 per cent, respectively, in the Region. For China, data strongly influence the regional figures, particularly the high regional treatment success rate (96.6% success rate in DOTS areas in China).⁷ However, in order to reach the Region's 2005 target of 70 per cent case detection rate an acceleration of DOTS uptake was required; the target would otherwise be delayed until around 2007.⁴ All participants acknowledged the need for even greater political commitment to reaching these targets.

In addition to the ongoing challenge of sustained political and financial support for the Stop TB Program, the current challenges to TB control in the Region were summarised at the Second TAG Meeting as the need to:

- secure additional funding to reduce financial shortfall;
- strengthen DOTS management in-country and secure adequate human resources to run programs effectively;

- strengthen laboratory networks in high burden countries and the Pacific Islands and develop a Regional Laboratory Quality Control Strategy;
- secure a regular uninterrupted supply of TB drugs to treat all diagnosed patients;
- improve TB burden estimates by conducting national TB prevalence surveys;
- improve cure rates to block the emergence of MDR-TB; and
- liaise more effectively with HIV/AIDS control programs at a national and regional level to minimise the risk of TB/HIV co-infection.

Australia's international aid program in health for 2001 to 2002 is estimated at around \$205 million of direct health assistance to developing countries, approximately 12 per cent of overall aid expenditure, and is disbursed through the Australian Agency for International Development (AusAID).⁸

Approximately 12 per cent of the health budget will be directed to programs aimed at reducing the burden of communicable and vectorborne diseases, including tuberculosis and malaria. A further 19 per cent is earmarked for the control of sexually transmitted infections, including HIV. In addition, Australia's aid program assists developing countries in reducing their burden of communicable diseases by providing training to professionals in the government and non-government sectors and community-based organisations in health services management, strategic planning, monitoring and evaluation, and in technical aspects of their work, supporting health sector reform and promoting gender and poverty awareness. Australia works bilaterally with partner governments and also funds multilateral organisations such as WHO to achieve health gain in developing countries.

The Third TAG Meeting was held in February 2002 in Osaka, Japan. We await the proceedings of the meeting with interest.

Box. Grouping of countries in the Western Pacific Region according to TB burden

Group 1: *Countries with high tuberculosis burden:*

Cambodia, China, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines, Viet Nam.

Group 2: *Countries with intermediate tuberculosis burden and good health infrastructure:*

Brunei Darussalam, Hong Kong, China, Japan, the Republic of Korea, Macao, Malaysia, Singapore.

Group 3: *Pacific Island Countries (PICs) with populations of less than 1 million and initial stage of DOTS implementation:*

All small PICs: American Samoa, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, the Commonwealth of the Northern Mariana Islands, the Marshall Islands, the Federated States of Micronesia, Nauru, New Caledonia, Niue, Palau, the Pitcairn Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Wallis and Futuna.

Group 4: *Industrialized countries with low tuberculosis burden and low incidence:*

Australia, New Zealand.

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