The new Stop TB Strategy and the Global Plan to Stop TB, 2006–2015

Mario C Raviglione[a]

Even though they were not reached everywhere, the international tuberculosis (TB) control targets set in 1991 for 2005 led to stronger government programmes based on sound approaches[1] and impressive improvements in many countries.[2] The new Stop TB Strategy and the Global Plan to Stop TB, 2006–2015 have been developed in light of this experience.

But if the previous strategies and plans were so successful, why do we need new ones? What has changed since the TB control targets were set? What changes in TB control are needed? How will the new strategies and plans achieve the TB-related Millennium Development Goals (MDGs)?

In recent years there have been significant changes in the social context in which TB control is carried out and in the resources required. Disease control efforts have become increasingly patient-centred and directed towards universal access to care. Recognition that TB is intimately associated with poverty and related socioeconomic determinants led to inclusion of TB control among the highest health priorities for development. Policies are needed to ensure that services reach disadvantaged populations, meaning all economically deprived, vulnerable and marginalized groups who have disproportionately high TB burdens and poor access to health care.

New public health challenges have also emerged, straining resources. The epidemic of HIV infection has become a strong force behind the increasing incidence of TB, especially in sub-Saharan Africa, and has required TB programmes to work jointly with HIV services.[3] These programmes have had to face the emergence of multidrug-resistant TB (MDR-TB) in many countries, and most recently the epidemic of extensively drug-resistant TB (XDR-TB). Addressing drug-resistant TB requires a massive increase of resources to treat patients with second-line drugs and to improve programme performance to prevent further development of resistance.

The new public health paradigm, focused on building health systems and primary services to provide access to health care for all, also brings new challenges. National TB programme managers will have to contribute to general system development, while demanding from systems and services the necessary contributions specific for TB.

Health service provision increasingly involves the non-state sector in patient care, ensuring that adequate standards of TB care are applied by all providers. The new International Standards for TB Care represent a promising step in this direction.[4]

Civil society and communities are key elements in the fight against TB, but their engagement and empowerment need to be promoted. The recent Patients' Charter for TB Care, based on input from affected communities worldwide, has not yet been widely adopted by national programmes.

Research on TB, neglected for decades, must be fostered to meet the increasingly pressing needs for new drugs, diagnostics and vaccines. Addressing TB/HIV and MDR-TB requires improved and rapid diagnostics and new classes of drugs; and engaging non-state practitioners and communities requires operational research to fine-tune interventions. Above all, eliminating TB requires effective preventive measures as well as optimal case management.

Taking account of these novel and changing situations, the new Stop TB Strategy defines specific objectives and components directed towards the overall target in MDG 6, target 8: to halt and begin to reverse the incidence of TB by 2015.[5] The Global Plan to Stop TB sets out the most effective approaches based on best estimates and projections of the TB epidemic, as well as the resources needed to support comprehensive TB control and priority research.[6]

The Global Plan addresses each major challenge, providing the rationale for interventions, estimation of their potential impact and costs and financial gaps. It also describes what needs to be done to reach the MDGs in different epidemiological regions. Full implementation of the Global Plan will result in major gains worldwide and the MDG 6 may be achieved globally and in most regions. By 2015, global TB incidence could be reversed and its prevalence and mortality reduced by half compared to 1990.

The way forward entails an urgent need to mobilize increased resources. Country governments have not significantly increased their contributions to TB control, and too few donors have supplemented local budgets or increased research funding. We now have a global strategy supported by a budgeted plan with feasible targets and specific directions towards ending the burden of human suffering due to TB. Failing to put them into action will be a legacy of failure for future generations. ■

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[a] Stop TB Department, World Health Organization, 20 avenue Appia, 1211 Geneva 27, Switzerland. Correspondence to Mario C Raviglione (e-mail: raviglionem@who.int).
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