

Tuberculosis in the WHO South-East Asia Region

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One-third of the world's burden of tuberculosis (TB), or about 4.9 million prevalent cases, is found in the World Health Organization (WHO) South-East Asia Region (<http://www.who.int/about/regions/searo>). The disease, which is most common among people in their productive years,¹ has a huge economic impact. For instance, in 2006, TB caused India to lose an estimated 23.7 billion United States dollars.² In a region where one-fourth of the world's poorest live,³ TB can lead to catastrophic out-of-pocket expenditure⁴ and cause patients to lose an average of 3 to 4 months' wages due to illness-related absence from work.⁵

TB associated with human immunodeficiency virus (HIV) infection is also an important concern. The age groups most affected by these diseases overlap, and over 50% of those dually affected die.⁶ Thus, interventions targeting these individuals must be urgently scaled up.⁶ Fortunately, multidrug-resistant TB (MDR-TB) still occurs in fewer than 3% of new cases and 18% of re-treatment cases in the region.⁷ However, the high TB incidence makes even these low percentages translate into a large number of patients. Extensively drug-resistant TB has also been reported in Bangladesh, India, Indonesia, Myanmar and Thailand.⁸

The region is rising to these enormous challenges. Thanks to the expansion of high-quality TB services, case detection in the region had exceeded 69% by 2008 while treatment success rates have consistently surpassed 85% since 2003.⁸ WHO's Stop TB Strategy, adopted by all countries of the region in 2006, has broadened the scope of services. A comprehensive intervention package for patients with HIV-associated TB is now available to more than 600 million inhabitants. All national TB programmes are establishing MDR-TB case management services. These were first expanded nationwide in Nepal.⁸ Thousands of private providers, hundreds of medical schools, corporate

institutions, health facilities in non-health sectors and prisons are collaborating with national TB programmes through public-private partnerships.

More than 2 million patients are diagnosed annually by national TB programmes in the region, which thereby contribute greatly to global case detection. India alone notifies nearly 25% of all cases in the world.² According to WHO estimates, TB prevalence, incidence and mortality in the region have declined steadily since 1990. However, these efforts will not suffice to achieve the TB targets set under Millennium Development Goal 6, which are to halve TB prevalence and mortality and reverse TB incidence by 2015.

National TB programmes must focus on immediate challenges. It is estimated that at least one-third of TB patients go undetected or get treated outside national programmes, mostly with poor outcomes. These patients contribute to disease transmission and are at greater risk of developing drug resistance and dying from TB. It is to address these concerns, while recognizing that 60–70% of patients in the region use private health care,^{9,10} that national programmes are working with thousands of public and private health-care providers. This initiative needs to be scaled up to ensure that TB services throughout the region comply with international standards for TB care. Preventing further drug resistance also calls for measures to reduce the widespread availability of over-the-counter drugs of uncertain quality and the irrational prescription of anti-TB drugs. At the same time, strategies to improve communication and social mobilization are needed to overcome the socioeconomic and cultural barriers, such as poverty, stigma, gender inequality and discrimination against migrants, that limit access to TB services despite good geographical access in most parts of the region.^{11–14} National TB programmes must also focus more on research to develop cost-effective interventions,

replicate successful approaches and explore the use of newer modalities for diagnosis and treatment that are now becoming available.

Further challenges arise from health systems constraints caused by chronic staff shortages, inadequate laboratory facilities, and weak procurement, supply chains and surveillance systems. These challenges need to be effectively addressed. Doing so would help national TB programmes to depend less on the semi-vertical systems that they established to overcome these constraints, while expanding DOTS programmes, over a decade ago.

Since the Stop TB strategy was launched, the scope of TB control activities has expanded beyond the capacity of national TB programmes to ensure quality services. Capacity needs to be urgently enhanced to support the rapid expansion of services for patients with MDR-TB and HIV-associated TB. Financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and assistance through bilateral donors have served to strengthen capacity within both national programmes and health systems. However, a more sustainable solution calls for prioritizing ways to resolve the health systems constraints faced by all major health programmes through a stronger commitment to using domestic and external funding more effectively to improve health infrastructure, procurement, logistics, and information systems and to increase human resources for health. Weaknesses in oversight and financial management systems that undermine the effectiveness of external aid must be resolved under the stewardship of national governments. WHO, other technical partners and development agencies must support these efforts in the true spirit of the Paris Declaration on Aid Effectiveness.¹⁵ ■

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