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Global "END TB strategy" and targets for tuberculosis control – I

WHO declared tuberculosis as a global public health emergency in 1993. This declaration lead to end a period of prolonged global neglect. The Millennium Development Goal target "to halt and begin to reverse the incidence of tuberculosis by 2015" has already been achieved.

The vision for the post-2015 global tuberculosis strategy is "a world free of tuberculosis" .It has also expressed as "zero deaths, disease and suffering due to tuberculosis" and the percentage of affected families facing catastrophic costs due to tuberculosis is zero. The goal is to "end the global tuberculosis epidemic".

To end tuberculosis epidemic a 95% decline in deaths due to tuberculosis compared with 2015 is needed. This also includes 90% reduction in tuberculosis incidence rate from a projected 110 cases/100 000 in 2015 to 10 cases/100 000 or less by 2035.

To achieve the above targets a key milestone is a 75% reduction in tuberculosis deaths by 2025, compared with 2015. To achieve this target two requirements are needed:

- First, the annual decline in global tuberculosis incidence rates must accelerate from an average of 2% per year in 2015 to 10% per year by 2025. A 10% per year decline in tuberculosis incidence is ambitious yet feasible.

- Secondly, the proportion of incident caes dying from tuberculosis (the case-fatality ratio) needs to reduce from a projected 15% in 2015 to 6.5% by 2025. It has been identified that rapid progress towards universal access to existing tools together with socioeconomic development can lead to a 75% reduction in tuberculosis deaths.

A 50 % reduction in tuberculosis incidence rate by 2025 compared with 2015 is another key milestone and this is equivalent to reduction up to 55/100 000 or less by 2025 .

Principles of the strategy
1. Government stewardship and accountability, with monitoring and evaluation
2. Strong coalition with civil society organizations and communities
3. Protection and promotion of human rights, ethics and equity
4. Adaptation of the strategy and targets at country level, with global collaboration

1. Government stewardship and accountability, with monitoring and evaluation
Governments need close collaboration with all stakeholders. They should have effective execution of key stewardship responsibilities and influence the success of the post-2015 global tuberculosis strategy . Stewardship responsibilities should be shared by all levels of the government – local, provincial, and central.

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countries include a treatment success rate of at least 85%, and testing of 100% of tuberculosis patients for drug susceptibility and HIV.

2. Strong coalition with civil society organizations and communities

Community representatives and civil society must be enabled as coalition of partners to assist people to access high-quality care and in demanding high quality services. These organizations can engage more actively in programme planning and design, service delivery, and monitoring, as well as in information, education, support to patients and their families, research, and advocacy.

3. Protection and promotion of human rights, ethics and equity

Access to high-quality tuberculosis care is an important element of the right to health . Delivery of tuberculosis care and prevention, have to explicitly address human rights, ethics and equity.

National tuberculosis programmes should acknowledge and address these with due respect to relevant ethical values. These may include, for example, the conflict between the public interest in preventing disease transmission and patients' rights to demand a supportive care environment ; the response to the stigmatization attached to the disease and the discrimination against those affected; the lengthy treatment and the challenges of adherence to treatment; ensuring patient-centered service provision and balancing the risk of infection to health care workers. Ways to address these dilemmas should be guided by globally recognized principles and values, should be sensitive to local values and traditions, and should be informed by debates among all stakeholders.

The process through which to meet the targets, and achieve the goals, of the strategy will be better served by applying a rights-based approach, developing and maintaining the highest ethical standards in every action taken, and ensuring that inequities are reduced and eliminated .

4. Adaptation of the strategy and targets at country level, with global collaboration

Prioritization of interventions should be undertaken based on local contexts, needs and capacities. A sound knowledge of country-specific disease epidemiology will be essential, including mapping of people at a greater risk and understanding of socioeconomic contexts of vulnerable populations.

In a globalized world, diseases like tuberculosis can spread far

and wide via international travel and trade. Tackling tuberculosis effectively requires close collaboration among countries.

The success of the "END TB Strategy" in driving down TB deaths and illness will depend on countries respecting the key principles as they implement the interventions outlined in the three pillars and the components of each pillar.

Pillar –01

Integrated, patient centered TB care and prevention

This pillar puts patients at the heart of service delivery .

Component 1.1 Early diagnosis of TB including universal drug susceptibility testing, and systematic screening of contacts and high-risk groups

This component is described under several areas.

1.1.1 Ensure early detection of tuberculosis

i. Ensuring universal access to early and accurate diagnosis of tuberculosis will require the strengthening and expansion of a network of diagnostic facilities with easy access to new molecular tests

ii. Information and education to prompt people with symptoms of tuberculosis to seek care

iii. Engagement of all care providers in service delivery

iv. Abolition of barriers that people encounter in seeking care

v. Systematic screening in selected high-risk groups

1.1.2 Detect all cases of drug-resistant tuberculosis

Adequate capacity to diagnose all cases of drug resistant tuberculosis is essential to make further progress in global tuberculosis care and control.

1.1.3 Scale up introduction of new diagnostics.

New molecular diagnostic testing platforms will allow early and accurate diagnosis of tuberculosis and drug resistance. It could help to diagnose less advanced forms of tuberculosis and facilitate early treatment.

Source: WHO. The End TB Strategy. Available at : http://www.who.int

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Table 1: Selected notifiable diseases reported by Medical Officers of Health   31ˢᵗ ⁻ 06ᵗʰ Apr 2018 (14ᵗʰ Week)

RDHS Division	Dengue Fever		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Chickenpox		Meningitis		Leishmania-sis		WRCD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**
Colombo	98	2372	2	21	1	4	1	17	0	5	4	54	0	3	1	3	0	0	31	253	0	18	0	1	63	100
Gampaha	53	1407	2	15	1	4	3	11	0	9	10	85	0	2	0	4	0	0	17	257	1	12	1	4	74	100
Kalutara	29	1079	4	23	0	2	0	1	0	32	26	140	0	2	1	5	0	0	19	194	2	26	0	1	54	100
Kandy	37	970	0	19	0	4	0	1	0	5	0	12	2	33	2	9	0	0	3	109	0	7	0	6	60	100
Matale	12	288	0	5	0	1	0	0	0	10	0	14	0	1	0	3	0	0	2	13	0	3	7	37	60	100
NuwaraEliya	4	53	2	6	1	2	0	5	0	2	0	8	4	51	0	8	0	0	1	86	0	11	0	0	25	100
Galle	13	381	1	14	0	5	0	0	0	2	20	142	1	12	0	1	0	1	8	89	0	15	0	4	14	100
Hambantota	19	390	2	6	0	0	1	2	0	4	1	16	1	21	0	0	0	0	7	93	0	2	33	195	73	100
Matara	21	372	2	13	1	4	0	3	1	21	8	60	3	15	0	2	0	0	7	109	0	3	15	126	55	100
Jaffna	28	1185	2	43	0	0	2	20	16	193	0	4	1	192	0	0	0	0	7	111	0	5	1	1	32	93
Kilinochchi	4	101	1	8	0	1	0	8	0	0	0	1	1	4	0	0	0	1	2	22	0	0	0	0	43	100
Mannar	3	23	0	10	0	0	0	2	0	2	0	1	0	0	0	0	0	0	1	14	0	1	0	0	36	100
Vavuniya	10	177	0	2	0	3	2	21	0	7	0	13	0	6	0	0	0	0	2	16	0	1	1	3	54	100
Mullaitivu	2	27	0	2	0	0	0	5	0	9	1	6	0	2	0	0	0	0	2	4	0	0	0	1	11	100
Batticaloa	116	1758	1	57	1	5	0	2	0	9	2	13	0	1	0	1	0	1	2	45	0	7	0	0	63	100
Ampara	1	53	2	14	0	0	1	1	0	1	0	18	0	0	0	3	0	0	5	70	0	4	0	1	69	100
Trincomalee	12	266	3	21	0	0	2	2	0	7	2	17	2	11	0	1	0	0	6	81	0	1	2	9	30	100
Kurunegala	30	1020	4	42	0	5	2	6	0	2	0	36	0	6	1	7	0	1	10	171	6	33	5	70	69	100
Puttalam	12	943	1	15	0	4	0	3	0	4	2	12	0	6	0	1	0	0	7	50	2	28	0	1	75	100
Anuradhapura	10	299	1	16	0	2	0	1	0	6	2	47	0	12	1	3	0	0	7	129	3	9	4	111	42	100
Polonnaruwa	8	94	1	10	0	1	0	0	0	6	2	50	0	0	0	1	0	0	5	69	2	6	2	60	65	100
Badulla	9	153	1	38	0	1	0	5	1	6	2	47	0	21	1	9	0	0	13	209	4	31	0	2	50	100
Monaragala	15	401	0	31	0	2	0	1	0	2	8	102	7	52	0	5	0	0	3	55	2	8	4	16	58	100
Ratnapura	40	571	6	55	1	20	7	7	0	2	17	115	1	14	0	5	0	1	12	109	3	39	2	96	39	100
Kegalle	17	423	0	18	0	5	0	2	3	57	1	32	2	30	1	7	0	0	11	119	2	15	1	3	66	100
Kalmune	38	981	1	16	0	0	0	1	0	13	1	2	0	0	0	1	0	0	4	60	0	3	0	1	46	100
SRILANKA	**641**	**15787**	**39**	**520**	**6**	**75**	**11**	**127**	**21**	**416**	**10**	**1047**	**25**	**497**	**8**	**79**	**0**	**6**	**194**	**2537**	**27**	**288**	**78**	**749**	**53**	**99**

Source: **Weekly Returns of Communicable Diseases (WRCD).**

*T=Timeliness refers to returns received on or before 06ᵗʰ April , 2018 Total number of reporting units 351 Number of reporting units data provided for the current week: 330 **C****-Completeness

A = Cases reported during the current week. **B** = Cumulative cases for the year.

Table 2: Vaccine-Preventable Diseases & AFP　　31st – 06th Apr 2018 (14th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2018	Number of cases during same week in 2017	Total number of cases to date in 2018	Total number of cases to date in 2017	Difference between the number of cases to date in 2018 & 2017
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	01	00	00	00	01	00	00	00	02	00	15	26	- 42.3 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps	07	01	00	01	00	00	01	00	01	11	01	115	84	36.9 %
Measles	02	01	00	00	00	00	00	00	00	03	01	37	95	- 61%
Rubella	00	00	00	00	00	00	00	00	00	00	00	04	05	- 20 %
CRS**	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Tetanus	00	00	00	00	01	00	00	00	00	01	00	08	06	33.33 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis	00	00	00	00	00	00	00	00	00	00	00	13	21	- 38.1%
Whooping Cough	01	00	00	00	00	00	00	00	00	01	00	10	04	150 %
Tuberculosis	98	25	34	21	09	16	00	00	16	219	191	2035	2388	- 14.7 %

Key to Table 1 & 2

Provinces:　　**W**: Western, **C**: Central, **S**: Southern, **N**: North, **E**: East, **NC**: North Central, **NW**: North Western, **U**: Uva, **Sab**: Sabaragamuwa.
RDHS Divisions:　**CB**: Colombo, **GM**: Gampaha, **KL**: Kalutara, **KD**: Kandy, **ML**: Matale, **NE**: Nuwara Eliya, **GL**: Galle, **HB**: Hambantota, **MT**: Matara, **JF**: Jaffna,
　　　　　　　　KN: Killinochchi, **MN**: Mannar, **VA**: Vavuniya, **MU**: Mullaitivu, **BT**: Batticaloa, **AM**: Ampara, **TR**: Trincomalee, **KM**: Kalmunai, **KR**: Kurunegala, **PU**: Puttalam,
　　　　　　　　AP: Anuradhapura, **PO**: Polonnaruwa, **BD**: Badulla, **MO**: Moneragala, **RP**: Ratnapura, **KG**: Kegalle.

Data Sources:
Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Neonatal Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps., Rubella, CRS,
Special Surveillance: AFP* (Acute Flaccid Paralysis), Japanese Encephalitis
CRS** =Congenital Rubella Syndrome
NA = Not Available

Dengue Prevention and Control Health Messages
Look for plants such as bamboo, bohemia, rampe and banana in your surroundings and maintain them free of water collection.

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ON STATE SERVICE

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