END TB BY 2030

FRAMEWORK FOR IMPLEMENTING THE "END TB STRATEGY" IN THE AFRICAN REGION 2016 - 2020

World Health Organization
REGIONAL OFFICE FOR Africa

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Suggested citation. Framework for implementing the "End TB Strategy" in the African Region 2016-2020. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

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Printed in South Africa

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Abbreviations

AU	African Union
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
BCG	Bacillus Calmette-Guérin
CPT	Cotrimoxazole preventative therapy
DR-TB	Drug-resistant tuberculosis
DST	Drug susceptibility testing
HIV	Human immunodeficiency virus
LTBI	Latent tuberculosis infection
MDG	Millennium Development Goals
MDR-TB	Multidrug-resistant tuberculosis
MOU	Memorandum of understanding
SDG	Sustainable Development Goals
TB	Tuberculosis
UHC	Universal health coverage
UN	United Nations
WHO	World Health Organization
XDR-TB	Extensively drug-resistant tuberculosis

Executive Summary

Tuberculosis (TB) control in the African Region has evolved since the disease was declared a global emergency by the World Health Organization (WHO) in 1993. Member States have adopted and implemented successive global and regional strategies and resolutions, with demonstrable positive impacts on incidence, prevalence and mortality, albeit with variations across countries. By the end of 2015, the Region as a whole met the key Millennium Development Goal (MDG) target of halting and beginning to reverse TB incidence. However only 35 of the 47 Member States met the MDG target.

Despite current achievements, TB still remains a major public health problem due to continued high incidence, prevalence and mortality. A multisectoral, health-in-all-policies approach and a paradigm shift from focusing on controlling the disease to ending the epidemic is now required. Strong government stewardship, universal access, reaching vulnerable populations, engagement of civil society and communities as well as adoption of new technologies have also been recognised as critical factors for ending the TB epidemic.

The Global End TB Strategy aims to end the global TB epidemic. This means reducing the TB burden in the whole world to levels achieved in high-income countries. The End TB Strategy builds on and significantly expands the scope of efforts in the context of the United Nations Sustainable Development Goal 3.3. The Global Strategy comprises three pillars, namely: (1) Integrated, people-centred care and prevention – aimed at early and universal access to diagnosis and treatment of all forms of tuberculosis; (2) Bold policies and supportive systems – aimed at strengthened government leadership, civil society and private sector engagement, as well as universal health coverage, social protection, poverty alleviation and action on the social determinants of TB; (3) Intensified research and innovation – aimed at accelerating discovery, development and rapid uptake of new tools, interventions and strategies. The strategy has specific indicators, milestones and targets for 2020, 2025, 2030 and 2035.

This framework supports the adaptation and implementation of the Global Strategy in countries of the Region based on their contextual circumstances.

The Regional Committee reviewed and adopted this Framework for Implementing the End TB Strategy in the African Region 2016 – 2020.

Introduction

The previously declining incidence of TB increased steadily after 1986 due to the emergence of HIV. This prompted the declaration of TB as a global emergency in 1993 by the World Health Organization (WHO).[1] Member States adopted the recommended DOTS[2] Strategy for TB control in 1995. In 2003, the Expanded Framework for DOTS Strategy that incorporated response to TB/HIV coinfection and multidrug-resistant TB was launched. This was followed by the launch of the Stop TB Strategy in 2006.[3]

In May 2014, the Sixty-seventh World Health Assembly adopted a post-2015 TB prevention, care and control strategy known as the End TB Strategy,[4] (Annex 1). It aims to end the global TB epidemic by 2035. In 2015, the United Nations (UN) Sustainable Development Goals (SDGs),[5] which are fully aligned with the WHO End TB Strategy, were adopted. The SDGs have set the target of ending the TB epidemic by 2030. Implementation of the End TB Strategy will be instrumental in supporting countries to achieve the indicated goal and targets. In November 2015, the AU adopted a road map, followed by the Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030.

The End TB Strategy provides a holistic, multisectoral response to overcome issues and challenges, and to end the epidemic in the context of the UN SDGs for 2030. The purpose of this framework is to provide the necessary policy and technical guidance to Member States on the adaptation and implementation of the End TB Strategy during the period 2016 – 2020.

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1. WHO, Stop TB Programme 1993: TB emergency declaration, Geneva, World Health Organization.
2. The core package of the WHO-recommended TB strategies of 1995 and 2006.
3. WHO, Stop TB Programme 2006: The Stop TB Strategy, Geneva, World Health Organization.
4. WHA Resolution A67/11: May 2014, Geneva Switzerland.
5. Resolution A/RES/70/1 adopted by the Seventieth session of the General Assembly on 25 September 2015. Agenda items 15 and 116: Transforming our world: the 2030 Agenda for Sustainable Development.

Current Situation

The African Region continues to bear a significant proportion of the global burden of tuberculosis and accounts for 28% of the estimated 9.6 million incident tuberculosis cases that occurred worldwide in 2014. Between 2000 and 2014, the implementation of the DOTS and Stop TB Strategy by Member States resulted in an estimated 10.1 million lives saved in the African Region. The Region also achieved a 37% decline in the TB mortality rate from 2000 to 2014 and 47% among people living with HIV. The Stop TB Strategy target of 85% treatment success rate by 2015 was achieved by 21 Member States,[6] while the regional average stands at 79%.

The Region accounts for 74% of the estimated 1.2 million HIV-infected TB patients notified globally in 2014. This is despite the massive scale up of collaborative TB/HIV interventions to over 90% of TB patients with known HIV status in 24 countries; the attainment of 77% ART coverage among co-infected patients; 89% enrolment on Cotrimoxazole preventative therapy (CPT); and a 47% decline in mortality among HIV positive TB patients from 2000 to 2014.

WHO estimates that between 32 000 and 49 000 multidrug-resistant tuberculosis cases occurred in the Region in 2014.[7] Programmatic management of drug-resistant TB has been scaled up in countries, resulting in the detection of 26 531 of the 32 000 (83%) estimated MDR-TB cases among notified TB patients in 2014. Sixty-eight percent of diagnosed cases have been enrolled on treatment but with a less than satisfactory average treatment success rate of 55% in 2012 (latest year for which information is available). Therefore, MDR-TB remains a public health crisis due to gaps in access to diagnosis and treatment.

TB microscopy centres increased from 10 469 in 2009 to 15 200 at the end of 2014. Twenty-eight Member States[8] have achieved the WHO benchmark for microscopy laboratory coverage of one to 100 000 population, while 15 achieved the benchmark of one culture laboratory to five million population,[9] and only 10 achieved the standard for one Drug Susceptibility Testing (DST) laboratory to five million population.[10] WHO recommends moving from microscopy to rapid diagnostic methods. Attaining optimal coverage with rapid diagnostics is even more challenging.

6. Comoros, Algeria, Burundi, Tanzania, Benin, Eritrea, Ethiopia, Cabo Verde, Mauritius, Mozambique, Togo, Democratic Republic of Congo, Senegal, Sierra Leone, Gambia, Kenya, Namibia, Nigeria, Ghana, Rwanda and Zambia.
7. WHO, Global Tuberculosis Report 2015: Geneva, World Health Organization, 2015.
8. Botswana, Burundi, Cabo Verde, Cameroon, Central African Republic, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Malawi, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Sierra Leone, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
9. Algeria, Botswana, Central African Republic, Eritrea, Gabon, Gambia, Guinea-Bissau, Lesotho, Liberia, Mauritania, Namibia, Niger, Rwanda, South Africa and Zambia.
10. Botswana, Central African Republic, Eritrea, Gambia, Lesotho, Liberia, Mauritania, Namibia, Niger and South Africa.

Issues and Challenges

Africa achieved MDG target 6.C; "to halt and begin to reverse TB incidence by 2015". However, the global 2015 TB mortality and prevalence targets of a 50% reduction were not achieved in the African Region. This is partly due to inadequate implementation of WHO recommended strategies and weak health systems among others.

Despite remarkable achievements in the Region, further advancement towards ending the epidemic and ultimately achieving TB elimination is slow. Only 36[11] of the 47 countries attained the MDG target of halting and beginning to reverse TB incidence. Achievement of targets has been hampered by limited access to health services, inadequate health infrastructure, insufficient quality of care, inadequate human and financial resources for health and inadequate social protection. The underlying social determinants of TB have also not been adequately addressed.

The association between poverty, undernutrition, HIV, diabetes and TB, and the concentration of the disease among vulnerable populations constituted major challenges to control efforts. These key affected population groups which may include miners, migrants, prisoners, smokers, drug abusers, children and the elderly, contribute to the 1.26 million missing TB cases in Africa. Furthermore, despite a policy of free TB services in most countries of the Region, TB patients and their families continue to suffer catastrophic financial burden in seeking TB care. The magnitude of this however needs to be further documented.

Only 35 (83%) of the 42 Member States that have dedicated National TB Reference Laboratories are linked to a Supranational Reference Laboratory and only 60% have quality management systems in place. Eleven countries lack laboratory capacity to diagnose MDR-TB,[12] while only 15 countries have in-country laboratory capacity to confirm XDR-TB diagnosis.[13]

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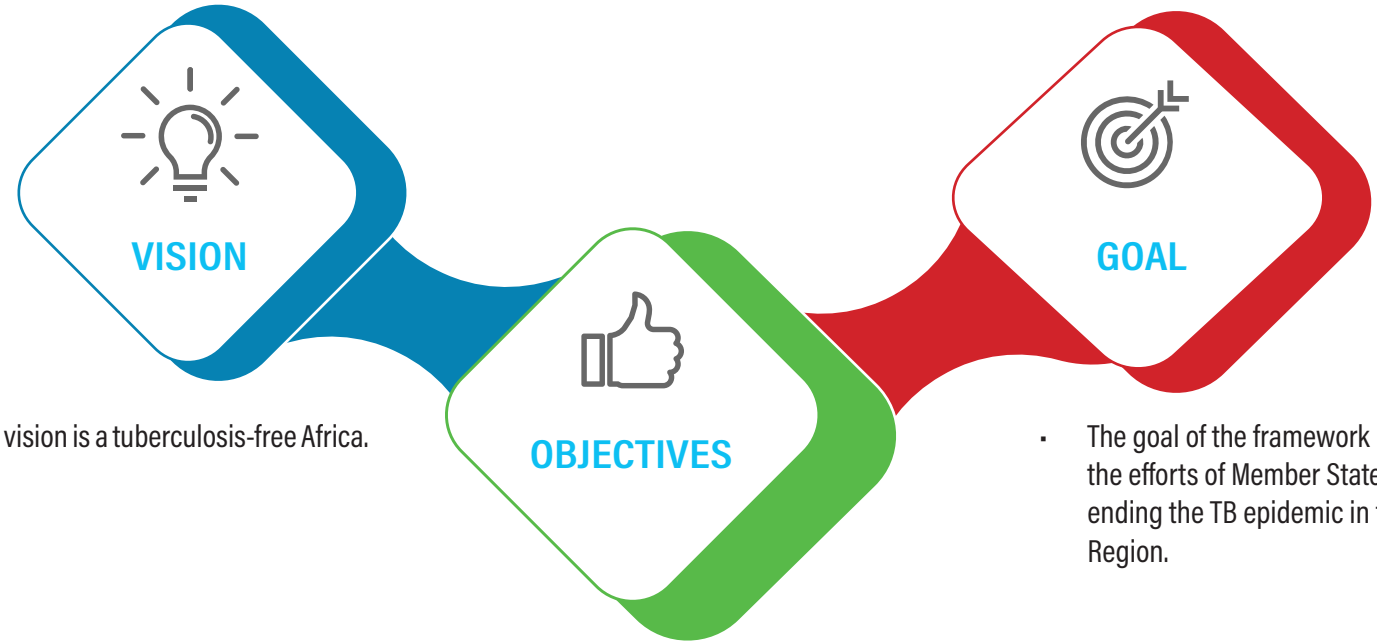
11. Algeria, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, CAR, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Guinea, Kenya, Lesotho, Madagascar, Mali, Mauritania, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
12. Cabo Verde, Chad, Comoros, Congo, Equatorial Guinea, Gabon, Guinea-Bissau, Sao Tome and Principe, Seychelles, Sierra Leone and South Sudan.
13. Algeria, Benin, Botswana, Democratic Republic of Congo, Ethiopia, Madagascar, Nigeria, Rwanda, Senegal, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

SYMPTOMS

DIAGNOSIS

TREATMENT

Vision, Goal & Objectives

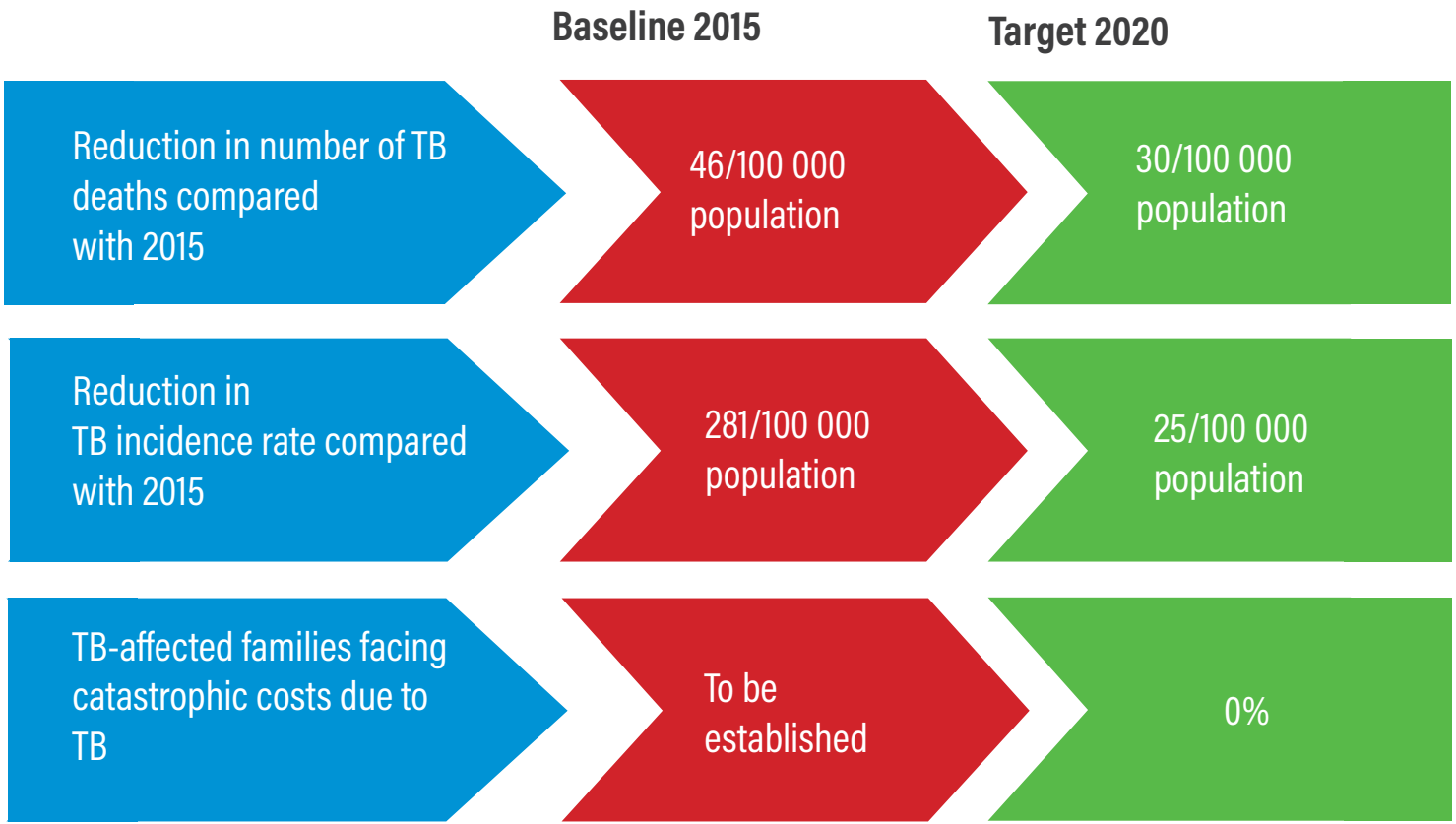


- The vision is a tuberculosis-free Africa.

- The goal of the framework is to support the efforts of Member States towards ending the TB epidemic in the African Region.

- To reduce the number of TB deaths by 35% compared with the 2015 rate
- To reduce TB incidence rate by 20% compared with the 2015 rate
- To attain 0% TB-affected families facing catastrophic costs due to TB.

Regional Targets: 2016 - 2020



Guiding Principles

The guiding principles of the Regional Framework are:

1. Government stewardship and accountability with monitoring and evaluation: Successful implementation of the End TB strategy will depend on effective execution of key stewardship responsibilities by governments in close collaboration with all stakeholders. This entails setting the vision and providing direction for the national response; collection and use of data for improved decision making; setting norms and standards; providing guidelines and tools as well as necessary regulatory frameworks.

2. Strong coalition with civil society organizations and communities: Effective coordination of tuberculosis care and prevention, working across sectors and with engagement of civil society and communities is critical to achieving the goal of ending tuberculosis. This should be guided by integrated patient-centred care and prevention. The strategy envisages the engagement of affected communities as a means of ensuring ownership and being part of proposed solutions and supporting the implementation in a sustainable manner. Communities should be empowered to engage more actively in programme planning and design; service delivery and monitoring; patient and family support as well as advocacy. It will include the establishment of a national coalition to galvanize a greater national response.

3. Protection and promotion of human rights, ethics and equity: This entails Member States ensuring that their respective national policies and strategies for tuberculosis response, and the delivery of tuberculosis care and prevention explicitly incorporate issues relating to gender, human rights, ethics and equity. Implementation should also be enforced by ensuring that appropriate legislation is enacted and disseminated among all stakeholders.

Guiding principles

4. Adaptation of the strategy and targets at country level, with global collaboration: This is in recognition of the diversity and peculiarities of countries that need to be considered in the design and roll-out of the End TB Strategy. It includes the prioritization of interventions based on local contexts, needs and capacities. This principle underscores the importance of a sound knowledge of country-specific disease epidemiology. It also underscores understanding of socioeconomic contexts of vulnerable populations, and a thorough assessment of the health systems to inform national adaptation of the strategy. Collaboration of partners across the region and globally in support of progress in Africa to End TB will further enable adaptation and implementation.

Priority Interventions and Actions

Ending the tuberculosis epidemic in the context of the End TB Strategy requires further expansion of the scope and reach of interventions for tuberculosis care and prevention. Systems and policies should be strengthened to create an enabling environment and coordination. Aggressive pursuit of research and innovation is needed to promote development and use of new tools for tuberculosis care and prevention. This undertaking requires combined efforts and close coordination and collaboration between the national ministries of health and multiple stakeholders within and outside the government. Appropriate monitoring indicators are shown in annex 2.

The priority interventions and activities to reach the overall goal, vision, objectives and targets to End TB are presented under the three pillars as follows:

Pillar 1: Integrated Patient-Centred Care and Prevention

1. Expand access to integrated patient-centred TB diagnosis, treatment and care: Abolishing barriers that people encounter in seeking care and providing timely and effective treatment constitute the core strategic approach. It includes enabling access to quality-assured new medicines for tuberculosis care and expanding services to underserved and vulnerable populations. It also includes promoting use of innovative information and communication technologies for health (eHealth and mHealth). Programmatic management of latent tuberculosis infection among high-risk groups will also be promoted. Furthermore, contacts of index TB patients will be targeted for timely and systematic screening for early diagnosis.

2. Addressing the challenges of quality-assured diagnostics will require innovative, multi-sectoral, and integrated approaches. The Stop TB Strategy, built on DOTS, laid the basis for addressing drug-resistant tuberculosis and HIV-associated tuberculosis while promoting research to develop new tools. MDR-TB should be addressed by prevention through quality TB treatment to prevent emergence of resistant strains, expanding rapid diagnosis and resistance testing as well as universal access to quality-assured DST and infection control.

Priority Interventions and Actions

3. Scale up joint tuberculosis/HIV interventions, and management of comorbidities: Strengthening joint TB and HIV programming remains critical to optimize the use of resources for greater impact. The "one-stop shop" integrated TB/HIV service model is to be promoted for universal access to TB/HIV interventions. These include HIV testing and counselling to all presumptive and diagnosed TB patients; systematic screening for people living with HIV; ART and preventative therapies. In addition, prophylactic TB treatment for people living with HIV and effective management of comorbidities such as diabetes, hepatitis, silicosis and others should be strengthened. The implementation of measures for TB infection control in health-care facilities providing services to people living with HIV should be scaled up.

4. Scale up response to drug resistant TB: This intervention seeks to ensure the existence of in-country capacity to diagnose drug-resistant tuberculosis especially through WHO-approved rapid diagnostic tests. It includes universal access to first line Drug Susceptibility Testing; and access to second line DST for excluding XDR-TB. Effective treatment of all confirmed DR-TB cases with guaranteed uninterrupted supply of quality-assured second line medicines should be ensured. Patient-friendly and context-appropriate patient care models, including decentralization and ambulatory care of DR-TB patients will be promoted. In addition, access to new, safer and more effective WHO-approved medicines and shorter course treatment regimens will be facilitated as they become available. There is also need to establish palliative care mechanisms for treatment of those M/XDR-TB patients in need.

5. Combat TB in children: The challenges of timely detection and treatment of tuberculosis in children, and reaching child contacts of adult patients will be prioritized in line with the regional childhood TB framework. An integrated family-based approach to childhood tuberculosis care will be promoted to remove access barriers, minimize diagnostic delays and improve treatment adherence. This includes enabling access to BCG vaccination, TB prevention strategies, sensitive diagnostic tools and child-friendly dosage formulations of anti-TB medicines. Latent TB infection (LTBI) in children should be treated according to WHO guidelines. Treatment of LTBI is the main intervention available to prevent development of active TB disease in those already infected with M. tuberculosis. Integrate childhood tuberculosis care within the various maternal and child health service platforms.

Priority Interventions and Actions

6. Address TB among vulnerable populations: Member States should be supported in the mapping of groups at high risk of tuberculosis such as people living with HIV, miners, migrants, refugees and prisoners to determine their health care needs. Targeted interventions including systematic screening for tuberculosis should be implemented among identified high-risk populations. Strategies should also be designed to address the social determinants of health associated with TB, including malnutrition and poverty alleviation interventions.

7. Ensure preventive treatment of people at high risk and vaccination against TB: Expand preventive treatment of people with high risk of tuberculosis, especially children below the age of 5 years in close contact with adults affected with TB. Ensure that WHO recommendations on BCG immunization are implemented through the immunization programmes.

PILLAR 2: BOLD POLICIES AND SUPPORTIVE SYSTEMS

8. Strengthen government stewardship: Strong government stewardship through the various Members States' ministries of health is critical to the successful coordination of the efforts of all stakeholders in the adaptation, implementation and monitoring of the national End TB Strategy. WHO will focus on strengthening national capacity, subregional and regional collaboration as outlined in the AU road map. In addition, WHO in collaboration with relevant partners will provide necessary guidance and tools to support Member States' efforts towards successful adaptation, implementation and monitoring of the national End TB Strategy as well as resource mobilization. WHO will also strongly advocate for sustained political commitment demonstrated by adequate domestic funding of national 'End TB' initiatives, inter-sectoral collaboration, and action on the social determinants of health including poverty alleviation.

9. Strengthen health systems for Universal Health Coverage: This entails strengthening the national health and social sector policies and systems to prevent and end TB; as well as support implementation of Universal Health Coverage (UHC) and social protection. Furthermore, development of relevant regulatory frameworks for quality-assured TB services, vital registration and disease surveillance will be supported. This includes supporting the implementation of effective TB infection control policies and interventions.

Priority Interventions and Actions

10. Mobilize resources: Supporting Member States in the development of well-costed national TB strategic plans to facilitate resource mobilization from domestic and international sources for implementation of the End TB Strategy.

11. Support strengthening of national regulatory frameworks: This relates to supporting Member States in developing appropriate strategies for ensuring mandatory notification of tuberculosis cases, legal frameworks for cross-border TB prevention, care and control through inter-ministerial and intersectoral collaboration. In addition, regulation around the production, quality assurance and use of tuberculosis diagnostics and anti-TB medicines will be supported.

12. Build strong coalition with civil society and communities: Establishment of lasting partnerships across the health services and social sector and between the health sector and communities including mapping and engagement of un-engaged organizations is to be promoted. This entails strengthening civil society's competencies to create demand for care and addressing determinants of the TB epidemic; enabling greater involvement of civil society and communities in policy development, planning, and implementation; as well as periodic monitoring of programme implementation.

13. Engage the private sector: This entails providing support to Member States towards the establishment of lasting partnerships with non-State health providers. WHO will support by providing the enabling guidance and tools to empower the private providers to engage more actively in programme planning and design; service delivery and monitoring; patient and family support as well as advocacy. It will include support in the establishment of working agreements and MOUs to galvanize a greater national response.

14. Promote a human rights-based approach: This entails supporting Member States in ensuring articulation of relevant policies and guidelines or legislation that incorporates protection of human rights and dignity for presumed TB patients, their families and contacts. Similarly, protection of people with tuberculosis against stigma and discrimination will be advocated as well as TB prevention, care and control in prison services and other holding facilities.

Priority Interventions and Actions

15. Enable social protection and action on poverty alleviation and the social determinants of tuberculosis: Expand coverage of social protection schemes to cover needs associated with tuberculosis beyond free diagnosis and treatment. Address poverty and related risk factors through "health–in–all policies" approaches.

16. Provide effective patient support: Ensure patient-centred mechanisms and systems for social and psychological support to patients in need to ensure effective ambulatory treatment adherence including follow-up after treatment, and reduction of the economic and social burden of illness and care-seeking.

PILLAR 3: INTENSIFIED RESEARCH AND INNOVATION

17. Promote research: Strengthening national stewardship in developing a national TB research agenda linked to country-specific priorities, sustainable TB research funding, as well as translation of research findings into policy will be promoted. There should be increased pursuit of research and innovation to promote development and use of new tools for tuberculosis diagnosis and prevention. Furthermore, national capacity to conduct relevant research for rapid uptake of new tools, interventions and strategies as well as research to optimize implementation and promote innovations will be strengthened. Also important is development of a coherent national network or coalition of all those involved in research to develop priorities and improve efficiency of actions to design and implement research and ensure impact of results.

18. Monitor progress towards the targets: WHO recommends that countries use the following priority operational indicators; uptake of new diagnostics and new drugs, treatment coverage, TB treatment success rate, preventive treatment coverage, and TB affected households facing catastrophic costs. A full set of indicators is presented in annex 2.

19. This framework proposes strategic interventions to guide countries to implement the 'End TB Strategy'. The Regional Committee examined the framework for implementing the End TB Strategy and adopted the actions proposed.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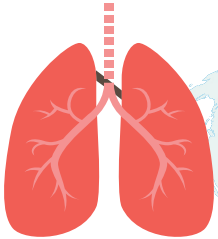
Annex 1 The global "End TB strategy" at a glance [14]

VISION



A WORLD FREE OF TUBERCULOSIS

– zero deaths, disease and suffering due to tuberculosis

GOAL

END THE GLOBAL TUBERCULOSIS EPIDEMIC

INDICATORS	MILESTONES 2020	MILESTONES 2025	TARGETS 2030	TARGETS 2035
Reduction in number of TB deaths compared with 2015 (%)	35%	75%	90%	95%
Reduction in TB incidence rate compared with 2015 (%)	20% (<85/100 000)	50% (<55/100 000)	80% (<20/100 000)	90% (<10/100 000)
TB-affected families facing catastrophic costs due to TB (%)	0	0	0	0

PILLARS AND COMPONENTS

INTEGRATED PATIENT-CENTRED CARE & PREVENTION

Early diagnosis of tuberculosis including universal drug-susceptibility testing, and systematic screening of contacts and high-risk groups	Treatment of all people with tuberculosis including drug-resistant tuberculosis, and patient support	Collaborative tuberculosis/HIV activities, and management of comorbidities	Preventive treatment of persons at high risk, and vaccination against tuberculosis

[14] WHO_HTM_2015, End TB strategy

Annex 1 The global "End TB strategy" at a glance [14]

PILLARS AND COMPONENTS

BOLD POLICIES & SUPPORTIVE SYSTEMS

Political commitment with adequate resources for tuberculosis care and prevention	Engagement of communities, civil society organizations, and public and private care providers Universal health coverage policy, and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control	Social protection, poverty alleviation and action on other determinants of tuberculosis

INTENSIFIED RESEARCH & INNOVATION

Discovery, development and rapid uptake of new tools, interventions and strategies	Research to optimize implementation and impact, and promote innovations

14. WHO_HTM_2015, End TB strategy

Annex 1 The global "End TB strategy" at a glance [14]

PRINCIPLES

GOVERNMENT STEWARDSHIP AND ACCOUNTABILITY WITH MONITORING AND EVALUATION

STRONG COALITION WITH CIVIL SOCIETY ORGANIZATIONS AND COMMUNITIES

PROTECTION AND PROMOTION OF HUMAN RIGHTS, ETHICS AND EQUITY

ADAPTATION OF THE STRATEGY AND TARGETS AT COUNTRY LEVEL, WITH GLOBAL COLLABORATION

14. WHO_HTM_2015, End TB strategy

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Annex 2 Operational indicators and targets for 2020 for monitoring implementation of the "End TB strategy"

	INDICATOR	TARGET LEVEL	MAIN RATIONALE FOR INCLUSION IN TOP-TEN
1.	**TB treatment coverage** Number of new and relapse cases that were notified and treated, divided by the estimated number of incident TB cases in the same year, expressed as a percentage	≥ 85%	High-quality TB care is essential to prevent suffering and death from TB and to cut transmission. High coverage of appropriate treatment is a fundamental requirement for achieving the milestones and targets of the End TB Strategy. In combination, it is likely that these 2 indicators will be used as tracer indicators for monitoring progress towards universal health coverage (UHC) within the post-2015 Sustainable Development Goals (SDGs)
2.	**TB treatment success rate** Percentage of notified TB patients who were successfully treated. The target is for drug-susceptible and drug-resistant TB combined, although outcomes should also be reported separately	≥ 87%	
3.	**Percentage of TB-affected households that experience catastrophic costs due to TB** Number of people treated for TB (and their households) who incur catastrophic costs (direct and indirect combined), divided by the total number of people treated for TB	0%	One of the End TB Strategy's three high-level indicators; a key marker of financial risk protection (one of the two key elements of UHC) and social protection for TB-affected households
4.	**Percentage of newly notified TB patients tested using WHO-recommended rapid tests** Number of newly notified TB patients diagnosed with WHO-recommended rapid tests, divided by the total number of newly notified TB patients	≥70%	Accurate diagnosis is a fundamental component of TB care. Rapid tests help to ensure early detection and prompt treatment

Annex 2 Operational indicators and targets for 2020 for monitoring implementation of the "End TB strategy"

	INDICATOR	TARGET LEVEL	MAIN RATIONALE FOR INCLUSION IN TOP-TEN
5.	**Latent TB infection (LTBI) treatment coverage** Sum of the number of people living with HIV newly enrolled in HIV care and the number of children who are contacts of cases started on LTBI treatment, divided by the number eligible for treatment, expressed as a percentage	≥ 80%	Treatment of LTBI is the main intervention available to prevent development of active TB disease in those already infected with M. tuberculosis
6.	**Contact investigation coverage** Number of contacts of people with bacteriologically-confirmed TB cases who were investigated for TB divided by the number of contacts eligible for testing, expressed as a percentage	≥ 80%	Contact tracing is a key component of TB prevention, especially in children
7.	**DST coverage for TB patients** Number of TB patients with DST results divided by the number of notified cases in the same year, expressed as a percentage. DST coverage includes results from molecular (e.g. Xpert MTB/RIF) as well as conventional phenotypic DST results	80%	Testing for drug susceptibility is essential to provide the right treatment for every person diagnosed with TB
8.	**Treatment coverage, new TB drugs** Number of TB patients treated with regimens that include new (endorsed after 2010) TB drugs, divided by the number of notified patients eligible for treatment with new TB drugs, expressed as a percentage	≥ 80%	An indicator that is relevant to monitoring the adoption of innovations in all countries. NB. Indicators related to the development of new tools are needed at global level but are not appropriate for monitoring progress in all countries

Annex 2 Operational indicators and targets for 2020 for monitoring implementation of the "End TB strategy"

	INDICATOR	TARGET LEVEL	MAIN RATIONALE FOR INCLUSION IN TOP-TEN
9.	**Documentation of HIV status among TB patients** Number of new and relapse TB patients with documented HIV status divided by the number of new and relapse TB patients notified in the same year, expressed as a percentage	90%	One of the core global indicators used to monitor collaborative TB/HIV activities. Documentation of HIV status is essential to provide the best care for HIV-positive TB patients, including ART
10.	**Case fatality ratio (CFR)** Number of TB deaths (from a national VR system) divided by estimated number of incident cases in the same year, expressed as a percentage	≤6%	This is a key indicator for monitoring progress towards 2020 and 2025 milestones. A CFR of 6% is required to achieve the 2025 global milestone for reductions in TB deaths and cases

World Health Organization

REGIONAL OFFICE FOR Africa