The challenge of TB and malaria control

A DFID practice paper

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Executive summary

This paper will guide DFID’s response to the challenges of tuberculosis (TB) and malaria control.

The Millennium Development Goal (MDG) on combating AIDS, malaria and other diseases will not be met at current rates of progress. TB and malaria are increasing and together kill over 3 million people each year.

Both diseases disproportionately affect the poor, and the greatest impact of malaria is among women and children. TB and HIV exacerbate each other’s burden. The control of TB is an integral part of the response to AIDS.

Both diseases create an economic burden on the poorest countries and scaling up action to control them will contribute to poverty reduction.

TB and malaria place an immense strain on health services. TB and malaria cannot be controlled without increasing investment in health and ensuring universal access to effective interventions.

Stigma and discrimination, gender inequality, population displacement and mobility all constrain access to services by the most vulnerable people.

Low-cost effective interventions to prevent and treat both TB and malaria exist, but remain underused.

Commitment to take action to control both TB and malaria is increasing. In 2005, G8 leaders at the Gleneagles Summit and the UN World Summit reconfirmed commitments to step up action.

Resources are also increasing, through both domestic and external funding – particularly through the Global Fund to fight AIDS, TB and Malaria (GFATM) – yet still fall far short of need.

Important challenges to accelerating control of TB and malaria include:

- to adequately reflect TB and malaria in national and regional development frameworks and budgets;
- to ensure effective partnerships and increased and better use of funding;
- to strengthen the systems that deliver health services;
- to ensure a reliable supply of effective health commodities; and
- to promote social mobilisation and effective communications.
DFID provides substantial support to TB and malaria control through a broad portfolio of approaches at global, regional and national levels.

The UK will continue to maintain a balanced portfolio of its work on TB and malaria control within its broader work on health. This will include:

i. pushing for greater coherence between poverty reduction strategies, policies, plans and budgets, and their translation into results;

ii. support to strengthen health systems;

iii. improving health in post conflict countries and in non post conflict fragile states;

iv. accelerating delivery of underused interventions – through increased funding, as well as commitment and coordination at global and country levels;

v. providing predictable finance to GFATM, and to work to improve the effectiveness of GFATM as a financing instrument;

vi. supporting the global Stop TB and Roll Back Malaria partnerships to provide a platform for better coordination of action on TB and malaria;

vii. further strengthening our engagement with the World Health Organisation (WHO);

viii. enhancing work across UK government;

ix. ensuring supplies of key commodities;

x. scaling up use of insecticide treated nets;

xi. promoting coordinated programme delivery, particularly between TB and AIDS services;

xii. investing in research and development (R&D) of new drugs, diagnostic tools and vaccines to ensure effective technologies; and

xiii. maintaining high level political commitment to TB and malaria control.
The purpose of this paper

This paper will guide DFID’s response to the challenges of TB and malaria control, as part of our work to scale up services for human development in poor countries. The DFID paper *From Commitment to Action: Health* (which is available online at [http://www.dfid.gov.uk/pubs/](http://www.dfid.gov.uk/pubs/)) sets out this broader perspective.

The paper will also provide a basis for reviewing our work on TB and malaria – as part of global action to implement the Global Strategic Plan to Roll Back Malaria and the Global Plan to Stop TB.

In 2005 DFID held a consultation process to hear the views of others on whether its current portfolio of activities on TB and malaria is effective, and where it should place its efforts in future.

Written responses to a consultation document were received, and two consultation meetings were held, with participants drawn from NGOs, academic institutions, product development organisations, the private sector, and technical agencies.

This paper has benefited from the analysis and perspectives of both written submissions and meetings.
Tuberculosis and malaria – major barriers to development

TB and malaria together kill more than 3 million people each year. The incidence of both diseases is increasing. Their burden is particularly great in Africa.

Reductions in prevalence and death rates from TB since the 1990s would have been faster, were it not for strongly adverse trends in sub-Saharan Africa and high rates in the former Soviet Union.¹

HIV and TB form a deadly combination, each increasing the other’s impact. In Africa, HIV is the most important factor behind the dramatic increase in TB in the last 10 years. TB is the most common opportunistic infection among people with HIV and is a leading cause of AIDS-related death – in some countries in sub-Saharan Africa, up to 70% of TB patients are co-infected with HIV.² In Africa, the proportion of women with TB is increasing because of HIV infection.

Malaria is returning to areas where it had previously been controlled. Some 350-500 million episodes of malaria occur every year. About 60% of all malaria cases, and more than 80% of malaria deaths occur in Africa south of the Sahara.³ Increasing drug resistance is a major contributor to increased ill health and deaths. Children under five and pregnant women are most at risk from malaria. There is increasing evidence of interactions between HIV and malaria. Malnutrition and malaria exacerbate each other, and there is evidence of a link between worm infections and the severity of fever.

TB and malaria are diseases that disproportionately affect the poor, who are more exposed to infection, have least access to services, and suffer more from the consequences of the diseases. Controlling TB and malaria contributes to reducing poverty. According to the World Bank costs of dealing with malaria have been estimated to account for 7% of household income in Malawi, 9-18% of annual income for small farmers in Kenya, and 7-13% of farmer’s income in Nigeria.⁴

Both diseases place an immense burden on health systems. Effective TB treatment requires daily, supervised treatment for 6 months. Malaria is responsible for about 25-35% of all outpatient visits, and 20-45% of hospital admissions in endemic countries in Africa.⁵

Drug resistance is an increasing problem for both diseases. Drug-resistant TB, including multidrug-resistant TB (MDR-TB), is found worldwide but particularly in Eastern Europe and countries of the former Soviet Union. Resistance to long-established low cost anti-malarials has now spread to most of sub Saharan Africa. Treatment of resistant cases of both TB and malaria requires a shift to more expensive drugs. Insecticide resistance is likely to emerge as a major problem in malaria control.

While the impact of both diseases is devastating, there are many differences between them. The causes of vulnerability differ, and the poor people that the diseases affect may be distinct. Malaria is an acute illness, whereas TB is a chronic condition. Malaria kills predominantly children, whereas TB affects mainly adults. Malaria kills many children without prior contact with a health centre, whereas many TB patients have passed through a government health facility that has failed them. Malaria is more common in rural communities whereas TB rates are higher in urban settings. Effective responses to malaria and TB will need to recognise these differences.
Effective and affordable interventions are available for both diseases but remain massively underused

Malaria

The Global Strategic Plan to Roll Back Malaria (2005-2015)\(^6\) developed by the Roll Back Malaria partnership describes the package of interventions for malaria control around which there is a consensus globally.

- **Prevention of malaria with insecticide-treated mosquito nets (ITNs):** ITNs can reduce under-five deaths by about 20% and clinical episodes of malaria by about half. Long lasting insecticide treated nets (LLINs) remove the need to retreat with insecticide and maintain protection for longer.

- **In certain well-defined settings: Indoor Residual Spraying (IRS) of insecticides (including DDT\(^7\)) and environmental measures to reduce mosquito breeding.**

- **Prompt and effective treatment.** Where malaria parasites have developed resistance to current first line drugs (typically chloroquine or sulphadoxine-pyrimethamine) WHO recommends artemisinin-based combination therapy (ACT), which is more efficacious and can delay the emergence of resistance. Use is constrained by higher cost, limited availability and the cost and complexity of changing practice.

- **Provision of intermittent presumptive treatment (IPT) for pregnant women** within antenatal services. Research is ongoing as to whether IPT is also an effective approach for infants. If the effectiveness and safety of IPT in infants is demonstrated, rapid introduction should be supported.

Tuberculosis

The World Health Organisation recommended strategy for detection and cure of TB is DOTS. The DOTS strategy is evolving – in 2005, the WHO consulted with partners about expanding it, and an updated framework will underpin the forthcoming Global Plan. The expanded strategy responds to a number of concerns, including new challenges such as TB and HIV co-infection, the need to be more patient-centred and the important role of working with communities. It includes the following elements:

- **Pursue quality DOTS expansion and enhancement.**

- **Address TB and HIV co-infection, drug resistant TB,** and other special challenges – such as provision of TB services to the poorest populations.

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\(^6\) Roll Back Malaria Partnership, Global Strategic Plan to Roll back Malaria 2005-2015, is available online at http://www.rollbackmalaria.org/forumV/docs/gsp_en.pdf

\(^7\) dichlorodiphenyltrichloroethane
• **Contribute to health system strengthening** by building capacity and mobilizing additional human and financial resources for implementation and evaluation.

• **Engage all care providers**, public, non-governmental and private, to provide the international standard of TB care.

• **Empower patients and communities** to demand, and contribute to, effective care.

• **Enable and promote research and development** for new drugs, diagnostics and vaccines.

**The need for further operations research**

While there is some consensus over the packages of interventions described, there is a need for further operations research to improve strategies – for example on appropriate responses to TB and HIV co-infection and the best way to deliver ITNs.
Slow progress towards the MDGs but increasing commitment

MDG Goal 6 is to combat HIV/AIDS, malaria and other diseases. Target 8 is: by 2015 to have halted and begun to reverse the incidence of malaria and other major diseases. Indicators of progress are specified for TB and malaria.

Their control will contribute directly to achievement of other MDGs, in particular; eradication of extreme poverty and hunger; reduction in child mortality; and improved maternal health. While much progress has been made it is clear that, at current rates of progress, international targets will not be met.

Tuberculosis

The global targets for TB control set for the year 2005 in the Amsterdam Declaration to Stop Tuberculosis (2000) were to detect 70% of new infectious cases and to treat successfully 85% of detected sputum-positive patients. Countries will need to reach these targets and sustain or improve on these levels of control in order to achieve the reduction in prevalence and death rates indicated in the MDGs.

Many countries have made considerable progress: the latest global figures for new sputum smear-positive cases indicate a 45% case detection rate (at the end of 2003) and an 82% treatment success rate (for patients registered in 2002). According to the World Health Organisation, continuation of the upward trend will result in a case detection rate of 60% by 2005 and achievement of the 70% global target by 2007. To find the ‘missing cases’, we need to reach poor and underserved populations with TB diagnosis and treatment. Particular efforts are also needed in areas with large HIV epidemics, to find people who are co-infected, and to offer those living with HIV preventive treatment for TB.

Although the treatment success rate is substantially below average in Africa and in Europe, the global target of an 85% rate should be attained by 2005.

While TB incidence rate is decreasing or stable in all regions apart from the African Region, the global incidence rate in 2003 was increasing by 1% per year on account of the increasing rate in Africa (fuelled by the HIV epidemic).

The second Global Plan to Stop TB will be launched in January 2006, and will set out the actions necessary to meet the MDG targets – in line with other global commitments (for example to scale up towards universal access for AIDS treatment).

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8 WHO Stop TB Department, Report to World Health Assembly, May 2005.
**Malaria**

The 2000 Abuja Declaration to Roll Back Malaria set targets of 60% coverage for the key interventions against malaria. While overall use of insecticide treated nets (ITNs) remains low at 2% of under fives in Africa, a number of low-income countries have demonstrated impressive progress. In Malawi use of nets in under-fives increased from 8% to 36% between 2000 and 2003, and in some districts is now 60%. Thirty countries have now adopted ACT (16 in sub-Saharan Africa) as first line treatment policy although there are substantial challenges in translating policy to practice and in coordinating supply and demand for artemesinin.

The Global Strategic Plan to Roll Back Malaria (2005-2015) updates targets for malaria control – with a view to achieving 80% coverage of core interventions by 2010. The plan sets out the actions needed to reach these goals – to achieve a 75% reduction in malaria morbidity and mortality by 2015.

**Global and regional commitment**

The progress towards targets on TB and malaria indicates growing commitment by country governments to expand programmes. African governments and regional organisations have demonstrated commitment to tackling both diseases. For example, in August 2005 African Health Ministers gathering at the WHO Africa Regional Committee declared TB an emergency in the region.

In 2005 there was also unprecedented global attention to development, coupled with recognition that both TB and malaria were an important part of this agenda (see Annex 1).

The report of the UN Millennium Project identified malaria prevention and control, and TB treatment as ‘quick wins’ for development.

The Commission for Africa Report identified the control of malaria and TB as priorities for human development.

At the Gleneagles Summit in July 2005, G8 leaders reconfirmed the importance of health to Africa’s development. They called for progress on TB, to meet the needs identified by the Stop TB partnership, and for working with African countries to scale up action against malaria.

The UN World Summit stressed the need to urgently address malaria and tuberculosis and welcomed the scaling up of bilateral and multilateral initiatives.

The European Union has reconfirmed the importance of TB and malaria control to development the November European Consensus on Development.
Key challenges in scaling up responses to TB and malaria

There is a large degree of consensus around effective interventions. There is recognition of the importance of strong international leadership, well established and broad-based, inclusive partnerships such as Roll Back Malaria and Stop TB, and greater commitment from donors and affected countries.

The commitments of 2005 and the increased profile of TB and malaria are leading to greater resources notably through the GFATM but also through large new programmes such as the World Bank Booster Programme on malaria, and the US President’s Malaria Initiative.

This has created an opportunity to address a number of key challenges and obstacles to scaling up access to, and demand for, services. We have selected five key challenges for further discussion below. The challenges are common to all the major health problems of developing countries. They require the strengthening of general health systems as well as delivery of targeted malaria and TB programmes. These five challenges are not exhaustive. There are others, including the need for sustained political commitment.

A. Adequately reflect TB and malaria in national and regional development frameworks and budgets

Strategic planning and coordination on health generally, and on TB and malaria control specifically, remains weak in many countries. Governments need to better reflect the impact of health, and TB, HIV and malaria in poverty reduction strategies (PRS), sector plans and budgets – including regional plans and budgets where countries move towards more decentralised arrangements.

Going to scale is mainly about providing services for the poor and marginalised. This requires strengthening existing services and ensuring that TB and malaria are core elements of essential packages of health care.

Funding shortfalls remain and a serious effort to realise the MDGs will require increased and better investment in health, particularly targeted at those who at present do not access health services. The Commission for Macroeconomics and Health calculated a requirement of US $35 per capita to provide a basic package of essential services in all countries. This compares with existing spend in low-income settings of US $5-10.
The Stop TB partnership will launch a revised Global Plan to Stop TB in January 2006 and set out resource needs. Stop TB estimates that in 2006 US $3.2 billion is required for implementation of control programmes alone, with a further US $800 million required for research and development. The funding gap will be close to US $2 billion in 2006.9

The WHO Roll Back Malaria Department has estimated a global need for country level implementation of malaria control along with international technical support of US $3.4 billion per year. The global resource gap for malaria is estimated at US $2.4 billion on average per year.10

### Current issues:

There is often little coherence between poverty reduction strategies (PRSs), health sector plans, budgets and actual spend. Inclusion of a health issue in a PRS does not guarantee prioritisation of resources. International calls for greater action often clash with calls for public expenditure limits, sector ceilings and other demands on national budgets. Predictable and longer-term aid is needed to provide confidence to governments to scale up services.

### B. Effective partnerships and increased and better use of funding

Effective support for countries’ scaling up efforts requires the use of a range of aid instruments that have global reach, provide predictable financing and sound technical and policy advice. New sources of financing such as the GFATM are providing increased resources.

Recent studies on the impact of global health funds and partnerships have confirmed that global health partnerships (GHPs) have contributed many benefits. The major GHPs have advocated for, or directly provided, large-scale new financing. They have raised the profile of the diseases they address at the highest political levels. Other key areas of success have been to accelerate progress; attract new partners and increase the profile of non-governmental stakeholders, including NGOs and the private sector; provide a means of supporting global public goods; secure substantial economies of scale (for example in drug procurement); and in some cases lead innovation.

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9 Stop TB Partnership, Global Plan to Stop TB (draft, to be launched January 2006).
10 WHO, Roll Back Malaria Department, 2005.
At the same time, the proliferation of global health partnerships and funds over the last few years – alongside traditional donor activity – has raised new issues. Overall the collective impact of GHPs has created or exacerbated a series of problems at country level including: poor coordination and duplication among GHPs; high transaction costs to government and donors from having to deal with multiple initiatives; variable degrees of country ownership; and lack of alignment with country systems. The cumulative effect of these problems is to risk undermining the sustainability of national development plans, distorting national priorities, diverting scarce human resources and/or establishing uncoordinated service delivery structures.

As resources for TB and malaria control increase it will be important for all efforts to align in support of nationally led plans. In November 2005 at the Roll Back Malaria Partners Forum in Cameroon, African countries made a strong call for increased harmonisation in malaria.

**Current issues:**

There is increasing evidence on the effectiveness and impacts of global health partnerships at country level – both positive and negative. The High Level Forum on the Health MDGs has supported the development of a series of best practice principles, based on accepted principles of effective delivery of aid. Partnerships themselves will need to understand how best to implement these principles, while also championing innovation in health. Stakeholders in the partnerships should clarify what actions they need to take to support countries to make best use of the resources that GHPs can bring.

C. **Strengthening the systems that deliver health services**

A number of low-income countries have demonstrated that with commitment to expanding access to services and a focus on equity and accountability, it is possible to deliver improved health outcomes.

Governments need a strategic overview of trends in health and health services in order to reconcile competing demands for resources, protect vulnerable people and ensure accountability.

This is a particular challenge since in many settings, most malaria treatment and much TB care is provided through the largely unregulated and often low quality, private sector (in some countries up to 80% of health care is delivered through the private sector). There is need to develop capacity in the public sector to provide an overview (‘stewardship’) of services, to regulate non-state providers, and to stimulate demand at community level. Private providers need incentives to provide clients with high quality and affordable services, and a functioning interface with the public sector.
The increased profile and resources for TB and malaria are an opportunity for investing in equitable health systems that will deliver better malaria and TB control for the long term, as well as produce shorter term results. They must address common constraints: the lack of trained staff; inadequate infrastructure including laboratory services; lack of coordination and the failure to engage other stakeholders; and weak information systems.

Increased supply of health services needs to be matched by investments in demand by poor people and in strengthening the ways that institutions and services providers can be held to account. Giving communities a greater voice in service planning, management, monitoring budgets and ensuring service quality and responsiveness increases accountability.

Opportunities exist to invest more in sound methods of collecting health information, building capacity among health service staff to understand this information, and showing how good analysis leads to action to improve the performance of health services.

The delivery of important TB and malaria services must be context-specific. For example, for some interventions in some settings (notably ITNs), private sector delivery systems can be much more effective, equitable and sustainable.

For many years efforts to tackle TB and HIV have been largely separate, despite the overlapping epidemiology. Coordinated planning and implementation of TB and HIV/AIDS programmes will lead to more effective prevention and treatment of TB among HIV-infected people, increased enrolment to HIV treatment programmes and to significant public health gains. While access to anti-retroviral drugs is essential for longer term survival, TB treatment is essential to prolong life in extremely ill co-infected people. Therefore attention to strengthening TB services is important alongside expansion of treatment for AIDS.

User fees remain a major deterrent to seeking or continuing care in many settings. There is a strong public health and development argument for removing them for primary services (at the district level and below) and for diseases such as TB that have major public health implications.
**Current issues:**

There is a need to resolve the tension between short and long-term goals. A targeted disease-specific approach can deliver politically important returns faster than longer-term, broader, system-strengthening interventions. There is often an assumption that support for targeted disease programmes will contribute to broader system strengthening. However, experience to date suggests that problems may arise when several vertical, parallel subsystems are created within the broader health-care system. We need to develop a synthesis whereby broader health systems focus on delivering TB and malaria outcomes while disease-specific programmes are designed to maximise potential for strengthening health systems.

Demand for skilled providers exceeds supply almost everywhere but new funding mechanisms place further burden on scarce staff, or displace staff from one programme to another. Many externally driven programmes fail to fund the additional human resource requirements that they create.

Ensuring service delivery reaches the poorest. Policy makers often assume that investment in TB and malaria control — tackling the ‘diseases of poverty’ — automatically assists the poor. This is not always the case. Specific attention needs to be paid to how the poorest can access services.

There is often a disconnect between public policy and the organisation of health services (public provision) and the reality on the ground where the unregulated private sector plays an important role.

User fees remain a strong deterrent to accessing care in many low-income countries.

**D. Ensuring a reliable supply of effective health commodities.**

Scaling up access to effective interventions is often limited by failures in the supply of drugs and other health commodities, inconsistent drug quality, inadequate drug policies, the slow pace of translating policy to practice, and the spread of drug resistance. WHO provides technical assistance to countries to decide appropriate drug policy, and to build capacity in health systems for procurement and distribution. Both Stop TB and Roll Back Malaria have developed mechanisms (Global TB Drug Facility and Malaria Medicines and Supply Service (MMSS) to support country efforts.

Effective relations between sources of financing (including the Global Fund), drug supply services, and research and development efforts into new drugs and diagnostics are critical. Such linkages will support effective use of new financing and can also serve to roll out new technologies more effectively.
Alongside existing commodities it is important to sustain and expand research and development for new tools. Recent evidence on resistance of malaria to artemisinin underscores the need for a continued pipeline of new drugs. Public private partnerships to develop new tools have demonstrated their effectiveness, but long term financing for development of drugs, diagnostics, vaccines and insecticides is a fraction of overall need. The Advance Market Commitment model may create incentives for the pharmaceutical industry to invest in R&D of vaccines but needs to be balanced with push mechanisms for investment.

Finally, there exist a number of weaknesses in the management of supply chains within health systems in developing countries. In the private sector in developing countries a number of innovative solutions to supply chain management have been developed, but very few of these are being adapted for use in the public sector. Programmes should work to strengthen country capacity. There are risks of undue centralization of supply, which could undermine efforts to build partner governments’ own management capacities, and which might lead to unintended supply bottlenecks.

### Current issues:

1. **Introducing new drugs**
   
   New products such as artemisinin-containing antimalarial combinations (ACTs) need to be incorporated into policy and practice. Scaling up of ACTs is threatened by the greater cost of these drugs, mismatches between supply and demand and safety concerns about use in women of reproductive age. The development of synthetic artemisinin is a priority but is likely to take several years. In addition, drug resistance to artemisinin has been induced in the laboratory for the first time – reinforcing the need for a continued pipeline of new drugs. Current TB treatments are over 40 years old, take six months to administer and cannot be taken at the same time as antiretrovirals. The Global Alliance for TB Drug Development (a public-private partnership) will begin clinical trials of new drugs over the next few years. They aim to develop regimens that can shorten treatment times, simplify dosages and reduce the burden on health care systems.
b) **DOTS for TB**

Various agencies have argued that improving DOTS, not simply expanding it, is critical. They recommend a more inclusive programme (DOTS is currently focused on people with smear-positive respiratory TB), innovative and community based approaches to improving treatment adherence (reducing the need for direct observation) and more resources to develop new diagnostics and drugs. The WHO has evolved the DOTS strategy in line with these concerns – but has yet to turn the new strategy into practice.

c) **Delivery of insecticide-treated nets (ITNs) to prevent malaria**

There has been considerable controversy over the best way to get nets to poor people in a sustainable way, whether through free distribution or through a range of approaches including varying levels of subsidy. We need to build upon local approaches that ensure rapid scale up of access to vulnerable groups while developing a sustainable market in the longer term. Most now recognise that the solution should be context specific and a range of approaches is often needed. Long lasting nets (LLNs), a new technology, are the future. While they cost more than ordinary nets, they do not require re-treatment.

d) **Indoor residual spraying (IRS) with DDT to prevent malaria**

WHO and RBM recommend that IRS should be used only in well defined, high or special risk situations. DDT may be used provided that it is used only for IRS, the material is manufactured according to WHO specifications, and the necessary safety precautions are taken in use and disposal.

e) **Vaccines and diagnostics**

Malaria vaccines are at various stages of development. Recent results on the effectiveness of GSK’s RTS,S/AS02A vaccine indicate that at 18 months efficacy was 29%, and a reduction in severe malaria equivalent to 49% was shown. This indicates that development of a vaccine with wide public health utility is feasible – but we will need to combine with other interventions, and may need combinations of vaccine targets and types. While BCG provides protection in young children, no vaccine exists that is fully effective against adult pulmonary tuberculosis. The Global TB Vaccine Forum and the Malaria Vaccine Initiative provide mechanisms for more and better coordinated action on vaccine development. There is need for new tests for TB. More sensitive diagnostics are particularly needed for people with smear negative TB – which includes many adults and children also infected with HIV. Better use of diagnostics is essential as more expensive malaria drugs are increasingly used – to ensure the rational use of these medicines.

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11 IRS involves spraying indoor walls with insecticide that leaves a residue that lasts up to 6 months. IRS is better suited for small areas of focal endemcity and epidemic prone areas, and some urban settings, where a house-to-house, publicly funded and managed approach can achieve very high coverage and thus major impact. IRS programmes are resource intensive and require a strong, well-organised delivery mechanism.
E. Social mobilisation through effective communications

In many poor countries poor people face barriers to accessing services due to stigma and discrimination, gender inequality, population displacement and mobility, and changing communication environments.

Responses to overcome barriers to services include advocacy to raise political and financial commitments, communication to stimulate dialogue about behaviour and social change and social mobilisation to build a multi-sectoral response. Advocacy and social mobilisation have been particularly effective when carried through community groups, especially groups of people living with HIV and AIDS.

Current issues

Health promotion and behaviour change communication activities are a cornerstone in TB case-finding and treatment. No matter how good diagnostic services, unless people come forward to use them TB detection rates will remain low.
UK support for TB and malaria control: current portfolio of activities

Currently DFID provides support to action against malaria and TB through a variety of channels.

A. Rebuilding the systems that deliver health services in developing countries

DFID places a high priority on ensuring that TB and malaria services are accessible through well functioning health systems.

DFID is working to support countries to scale up health and education services. Increasingly DFID funds the broader health sector plans of developing country governments through sector wide programming and poverty reduction budget support. Such sector programmes will build capacity in health systems to improve the way health services diagnose and treat all major causes of illness – including TB and malaria. For example in Pakistan the National TB programme is one of the beneficiaries specified within a DFID £60 million National Health Facility sectoral support programme which will run from 2003 to 2007.

Such sectoral support means that it is not always possible – or appropriate – to disaggregate the amount of DFID finance which goes to specific TB or malaria control activities. However, DFID estimates that in 2004-05, £363 million of its bilateral assistance was spent on the broad health sector.

DFID provides expertise to countries on malaria, TB, and health systems through its health advisers, health resource centres and research programmes. This includes support to governments to ensure TB and malaria are reflected appropriately in national and regional plans.

DFID supports country-led human resource strategies and international best practice frameworks, and encourages global health partnerships, and UN and donor agencies, to give adequate attention to human resource aspects of programmes (and adapt their funding mechanisms/rules to enable this).

DFID also provides funding to the World Bank and European Commission, which also support health sector programmes.

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12 DFID, September 2005, From Commitment to Action: Health.
13 DFID, 2005, Statistics on International Development. In addition, most poverty reduction budget support or emergency relief – which would not be covered in this figure – is likely to have significant health related inputs.
B. Support to international technical organisations and global health partnerships

DFID provides core funding to the World Health Organisation – in 2004-05 DFID provided £12.5 million to WHO in support of the objectives set out in its Institutional Strategy for WHO: a unified WHO to address health and poverty; a strengthened country focus for the organisation; UN coordination on health and development; and reform of WHO to support results based planning and management. Technical agencies such as WHO have an important role in providing technical support so that countries can make best use of new resources available, such as from the GFATM.

DFID also provides support to key global health partnerships. The UK is a board member of the global Roll Back Malaria partnership, and is its largest donor to date, having provided £48.5 million from 1998-2005. DFID supports the Stop TB Partnership, and in March 2005 pledged £5 million over three years to the partnership.

The UK is a key donor to the GFATM, and has pledged £359 million to the fund through to 2008 – including £100 million for both 2006 and 2007. The first replenishment of the Global Fund to Fight AIDS, tuberculosis and malaria concluded with the UK-hosted Replenishment Conference on 5-6 September 2005. Donors pledged US $ 3.7 billion for 2006 and 2007. This represents more than half of the US $ 7.0 billion that the Global Fund estimated it needed for these two years. The money pledged will enable all existing Global Fund grants to be renewed and provide a modest launch pad for new programmes. The EU (Member States and the EC) is the largest contributor to the Global Fund.

A mid-term review of the replenishment is planned for June 2006. This will be an opportunity for donors to review further the Global Fund’s performance and get new and existing donors to put in more money.

DFID has supported the development of evidence and proposals for improving the effectiveness of global health partnerships, including a set of good practice principles for GHPs.

15 Source GFATM: Chair’s Report 16 Sept 2005.
C. Specific country support for tuberculosis and malaria

While the UK increasingly funds broader health sector programmes, in some countries DFID does provide support for specific TB and malaria programmes. Some examples are included in the box below.

Examples of DFID funded projects on TB and malaria

**China** – DFID has allocated £28 million over seven years in partnership with the World Bank towards reducing tuberculosis morbidity and mortality through an effective and sustainable National TB control programme focused on the poor. This has involved raising case detection and treatment through DOTS based services and it is likely that due to China’s strong political commitment to fighting TB, that the detection rate will reach 70% by the end of 2005. The cure rate is already over 85% and the increasing establishment of effective institutions to control TB at all government levels should help to maintain a high cure rate as detection rates improve.

**India** – £20 million has been allocated by DFID to India to achieve sustainable improvements in the quality, effectiveness and accessibility of the TB services in Andhra Pradesh, especially for the poor, women and other under-served groups. Through effective collaboration with the Indian government and the WHO, effective DOTS regimens have been implemented in many districts and the supply and delivery of essential drugs has been improved. DFID India is currently exploring possible future support on TB.

**Nepal** – DFID has committed £5.4 million to provide effective diagnostic and treatment facilities for all patients with TB, within existing primary health care services. The National TB Programme has expanded DOTS regimens across Nepal, and by July 2003 there were 1254 DOTS subcentres covering 94% of the population. Case detection rates are 71% and increasing, and the treatment success rate in new smear positive patients (2001-02) was 88% (exceeding national and international targets).

**Kenya** – DFID has committed £47.4 million to social marketing of insecticide treated nets (ITNs). The goal of the project is to increase the use of nets among pregnant women and children under 5. The project aims to increase the number of households using a net by selling 6.7 million ITNs and 4.4 million net retreatments. It is estimated that the resources provided will result in 167,000 child lives saved, and an 18% reduction in overall mortality.
D. Providing cheaper commodities

DFID is working with others, including G8 colleagues, to secure greater international commitment to affordable pricing for medicine, including drugs to treat TB and malaria. We support the Stop TB and RBM Partnerships to coordinate global support to meet drug supply gaps. In keeping with the RBM ITN framework we also support context-specific delivery of ITNs, for example targeted distribution of free or highly subsidised ITNs to children under five and pregnant women, extensive social marketing efforts, providing an enabling environment for net manufacturers and distributors and supporting research into equitable delivery mechanisms.

E. Development of new research evidence

This year, DFID has commissioned a number of new programmes of health research, including two on communicable diseases both with a focus on malaria and TB, worth £5 million each over five years. These programmes will be implemented by consortia of research partners, including a number of developing country research organisations. The two programmes on communicable disease will be led by the London School of Hygiene and Tropical Medicine and the University of Leeds.
F. Supporting product development public-private partnerships (PDPs)

DFID will continue to support the Medicines for Malaria Venture (MMV), which aims to discover, develop and deliver new affordable anti-malarial drugs through public private partnerships and has recently announced a further £2 million a year over the next five years. This is a joint commitment with the Wellcome Trust, who will match our support. By furthering our funding to help combat malaria through MMV, we are showing our commitment to the MDGs and to fulfilling a G8 commitment to encourage the development of new drugs for malaria through the mechanism of public private partnerships.

DFID does not currently provide financial support to PDPs working on TB drugs, diagnostics and vaccines. However, this is currently under review, in line with the aims of our published Research Funding Framework.
What will the UK do to step up action against TB and malaria?

2005 saw a dramatic increase in global commitment for development. The control of TB and malaria has been recognised as a critical element of poverty reduction. The UK will work to push forward the commitments made in 2005, and accelerate action to achieve the targets set out in the Global Plan to Stop TB and the Global Strategic Plan to Roll Back Malaria. We will maintain a comprehensive approach which continues to maintain a high profile for TB and malaria, in addition to AIDS. This is in line with responses received to the DFID consultation.

i. In countries where DFID has a bilateral presence, the UK will continue to support greater coherence between poverty reduction strategies, policies, plans and budgets, and their translation into outcomes – including on TB and malaria. Where appropriate DFID funds broad health sector programming and poverty reduction budget support, and these processes offer opportunities for enhanced working between Ministries of Health and Finance in developing countries. Strategies for TB and malaria will not be implemented without attention to improving capacity and resources for broader health sector planning. Effective scaling up of the underused interventions will require partnerships with governments and non-state providers of goods and services in ways that allow access for the most vulnerable – including women – and that support long-term capacity development and integration.

ii. The core intervention should remain support to strengthen health systems – to ensure that health services have the resources (finance, staff, drugs and vaccines, information systems) to deal with the main causes of ill health and death and progress towards all the health MDGs. The series of meetings held by the High Level Forum on the Health MDGs (the final meeting was held in Paris in November 2005) has helped move forward evidence for action in a number of critical areas: testing approaches to address the crisis of human resources in health; improving the predictability of aid over the long term; and ensuring that Global Health Initiatives complement country development efforts. DFID is piloting new and innovative country approaches to address the human resources crisis in health, initially in Malawi.

iii. There are particular challenges to improving health in post conflict countries and in other fragile states to ensure attention to communicable diseases in the immediate response, and to find ways to respond to the needs of countries where DFID does not have a strong country-level presence. Recent analytical work, including that done for the
High Level Forum, has improved the evidence base on how donors can work more effectively in such environments. This work will feed into the development of Development Assistance Committee (DAC) guidelines on service delivery in fragile states. Different coverage targets may be needed for TB and malaria in such environments.

iv. There is a real opportunity to accelerate delivery of underused interventions – including ITNs and new drug combination therapies for malaria, and treatment under the DOTS strategy for TB. To do so will require increased levels of funding, as well as commitment and coordination at global, and country levels.

v. The UK is committed to providing predictable finance to GFATM, and to work to improve the effectiveness of GFATM as a financing instrument. Over the longer term, GFATM should be provided with the finance to maintain its part of an increased response to the three diseases. At country level DFID could engage with other Country Coordinating Mechanism (CCM) partners to ensure appropriate technical assistance is available to proposal development and programme implementation.

vi. At its final meeting (Paris, November 2005) the High Level Forum on Health supported a set of good practice principles for global health partnerships based on established principles for effective delivery of aid. The UK will continue to engage in the GFATM Board and working group mechanisms to promote these principles, improve effectiveness of operations at country level, enhance the speed of disbursement and promote harmonisation with sector processes where requested by countries.

vii. The UK supports the global Stop TB and Roll Back Malaria partnerships to provide a platform for better coordination of action on TB and malaria and a forum for engagement with the private, sector, NGOs, academia, affected countries and other stakeholders. In March 2005 DFID announced an additional £5 million over three years to Stop TB. As a Board member of the RBM partnership we will work to improve its effectiveness. DFID will develop strategies for working with the partnerships, to support the implementation of the good practice principles for GHPs. The relation between these partnerships and the World Health Organisation as their host is important – over time there will be scope for rationalisation and consolidation of these different players.
viii. Technical agencies – particularly the World Health Organisation – have an important role in providing support to countries in planning and implementation. DFID’s current Institutional Strategy for WHO finishes mid 2006, and we will be looking at options for **furthering our engagement with WHO**. Africa, as the most affected continent for malaria, and where the joint epidemics of HIV and TB are most evident, needs special consideration. WHO AFRO is an obvious interlocutor and opportunities should be explored with the WHO Regional Director. An extended programme for support for TB and malaria control could open the door for broader support for institutional reform and the potential for greater impact across the MDGs.

ix. DFID will work to improve **working across UK government**, particularly on TB. The UK Chief Medical Officer’s plan for TB control in England specifies international partnership as a focus – and DFID will continue to liaise closely with the Department of Health on international activity related to TB control.

x. DFID looks to technical agencies and global partnerships to provide the information, technical support and, where appropriate, procurement services needed by countries to ensure **supplies of key commodities**. Streamlining of prequalification processes for drugs and insecticides will help increase the number of suppliers, for example companies pre-qualified to supply ACT. Within the RBM Partnership, the Malaria Medicines and Supplies Service has an important role in providing accurate information on supply and demand for newer commodities in order to support the management of the supply chain and to provide confidence to industry of a viable market.

xi. In January 2005 the Prime Minister called for the G8 to do more to **scale up use of insecticide treated nets**. The UK supports recommendations (for example in the Commission for Africa and the Millennium Project Reports) that in all malarious countries, all pregnant women and children under five years should have an insecticide-treated net to sleep under by the end of 2007. DFID will work with other donors and international agencies to support developing countries in their plans to rapidly expand ownership and use of insecticide treated nets. The UK has recently announced increased funding for ITN programmes in Kenya and Tanzania.
xii. Efforts should be made to coordinate programme delivery, particularly in relation to AIDS and TB where there are high levels of co-infection. DFID supports WHO to provide technical leadership on coordinated TB and HIV responses – through the principle of ‘one patient, two diseases’, including development of research plans for both basic and operations research. The UK is committed to achieving international agreements on scaling up towards universal access to comprehensive AIDS services of prevention, treatment, care and support by 2010 – which will include treatment of major opportunistic infections such as TB.

xiii. There is continued need to invest in R&D of new drugs, diagnostic tools and vaccines to ensure effective technologies in the long term. At the Gleneagles summit G8 leaders committed to support both direct investment in research and to explore incentive mechanisms such as advanced market commitments. A number of targeted public-private partnerships (PDPs) are already showing results in expanding the number of new products being researched. DFID’s central research department has recently developed criteria for support to PDPs, and will assess PDPs active in the fields of TB and malaria to identify which of them warrant support. In addition, the UK will be part of G8 efforts to work up advanced market commitments to increase the incentives for industry to invest in new products, particularly vaccines.

xiv. Finally, high level political commitment to TB and malaria control is essential. We will work to ensure that commitments made by the European Union and G8 are met. It is important that the G8 takes forward momentum on development and health, on scaling up TB and malaria interventions and on investing in and creating incentives for the development of new tools and technologies.
How will we know if we are on track?

DFID’s continued action on TB and malaria control will be in support of its role in the achievement of the vision and targets of the Global Strategic Plan to Roll Back Malaria and the Second Global Plan to Stop TB.

We therefore look to the monitoring of those plans, and in particular the strengthening of monitoring and evaluation systems in developing countries, to provide information on progress. We will not collect data specifically to measure DFID’s impact.

This paper will be updated over time, and when significant events occur.
Annex 1: Key international statements and commitments that include TB and malaria

Commission for Africa

The Commission for Africa Report can be found online at http://213.225.140.43/english/home/newsstories.html

Under ‘Leaving No-one Out: Investing in People’ includes the following recommendations:

**Tuberculosis**

60 Some 70 per cent of the 14 million people worldwide who have both HIV and TB (which are often linked) are in Africa, where the TB epidemic is rising by four per cent a year and is now the most common opportunistic infection of people living with HIV. The integration of care for HIV and AIDS and TB would reduce the impact of TB among people living with HIV and AIDS and reduce the impact of HIV among TB patients. African governments must ensure collaborative TB and HIV programmes. Recommendation: the World Health Organization’s ‘Two diseases, one patient’ strategy should be supported to provide integrated TB and HIV care. The allocation of US $0.25 billion each year for collaborative TB and HIV programmes would ensure that all patients with TB are offered VCT and all HIV patients are tested and treated for TB.

**Malaria**

61 Despite some progress, malaria continues to pose a major challenge, with 400-500 million episodes in children each year in Africa. Malaria is the biggest fatal parasitic disease among African children despite being largely preventable and almost entirely treatable. Malaria-related costs and lost GDP deprive Africa of US $12 billion each year. New technologies, such as artemisinin-based drugs, have a proven and powerful impact. A big push to control the carriers of diseases such as malaria is both cost-effective and sustainable, particularly if provision of bednets could be integrated with the delivery of other public health programmes such as de-worming, vaccinations and improving water drainage. Supporting Africa’s ability to develop and produce its own long-lasting insecticide treated bed-nets would both increase supply and strengthen local economies. The Global Fund’s guarantee of purchase of bed nets in Tanzania encouraged external investment in bed net manufacturing. Roll Back Malaria estimates that US $1.8 billion each year is needed for treatment and prevention amongst pregnant women and children and these costs are included in the overall financing figure above. Recommendation: African governments and donors should work together to ensure that every pregnant mother and every child has a long lasting insecticide treated net and is provided with effective malaria drugs.
GB Africa Communiqué

Can be found online at http://www.g8.gov.uk

In the Africa communiqué, under Investing in People, includes the following:

Life expectancy is increasing in every continent except Africa, where it has been falling for the last 20 years. We will continue to support African strategies to improve health, education and food security.

To unlock the vast human potential of Africa, we will work with Africa to create an environment where its most capable citizens, including teachers and healthcare workers, see a long-term future on the continent. We will work with committed national governments to assist in creating that environment.

The core aims for education and health are stated in the UN Millennium Declaration. We support our African partners’ commitment to ensure that by 2015 all children have access to and complete free and compulsory primary education of good quality, and have access to basic health care (free wherever countries choose to provide this) to reduce mortality among those most at risk from dying from preventable causes, particularly women and children; and so that the spread of HIV, malaria and other killer diseases is halted and reversed and people have access to safe water and sanitation.

We will work to achieve these aims by:

(g) Working with African countries to scale up action against malaria to reach 85% of the vulnerable populations with the key interventions that will save 600,000 children’s lives a year by 2015 and reduce the drag on African economies from this preventable and treatable disease. By contributing to the additional US $1.5bn a year needed annually to help ensure access to antimalaria insecticide-treated mosquito nets, adequate and sustainable supplies of Combination Therapies including Artemisinin, presumptive treatment for pregnant women and babies, household residual spraying and the capacity in African health services to effectively use them, we can reduce the burden of malaria as a major killer of children in sub-Saharan Africa.

(h) Helping to meet the needs identified by the Stop TB Partnership. We also support the call for a high-level conference of Health Ministers for TB in 2006.
UN World Summit Outcome Document

Can be found online at http://www.un.org/summit2005/documents.html

Under ‘Quick-impact initiatives’ includes the following:

34. Given the need to accelerate progress immediately in countries where current trends make the achievement of the internationally agreed development goals unlikely, we resolve to urgently identify and implement country-led initiatives with adequate international support, consistent with long-term national development strategies, that promise immediate and durable improvements in the lives of people and renewed hope for the achievement of the development goals. In this regard, we will take such actions as the distribution of malaria bed nets, including free distribution, where appropriate, and effective anti-malarial treatments, the expansion of local school meal programmes, using home-grown foods where possible, and the elimination of user fees for primary education and, where appropriate, health-care services.

Under ‘HIV/AIDS, malaria, tuberculosis and other health issues’, includes the following:

57. We recognize that HIV/AIDS, malaria, tuberculosis and other infectious diseases pose severe risks for the entire world and serious challenges to the achievement of development goals. We acknowledge the substantial efforts and financial contributions made by the international community, while recognizing that these diseases and other emerging health challenges require a sustained international response. To this end, we commit ourselves to:

(i) Stressing the need to urgently address malaria and tuberculosis, in particular in the most affected countries, and welcoming the scaling up, in this regard, of bilateral and multilateral initiatives.

The European Consensus on Development

Can be found online at http://europa.eu.int/comm/development/

The statement includes the following:

94. The MDGs cannot be attained without progress in achieving the goal of universal sexual and reproductive health and rights as set out in the ICPD Cairo Agenda. To confront the devastating impact of HIV/AIDS, TB and malaria in developing countries, a roadmap for joint EU actions on the European Programme for Action will be developed. The Community will support the full implementation of strategies to promote sexual and reproductive health and rights and will link the fight against HIV/AIDS with support for reproductive and sexual health and rights. The Community will also address the exceptional human resource crisis of health providers, fair financing for health and strengthening health systems in order to promote better health outcomes, making medicines more affordable for the poor.
Annex 2: Abuja targets for malaria control for 2005

1. At least 60% of those suffering from malaria/fever will have access to and are able to use correct and appropriate treatment within 24 hours.

2. At least 50% of households in targeted districts will have at least one Insecticide Treated Mosquito Net/Material.

3. At least 60% of those at risk of malaria, particularly children under five years of age and pregnant women will sleep under Insecticide Treated Mosquito Nets/ Materials.

4. At least 60% of all pregnant women who are at risk of malaria, especially those in their first pregnancy will have access to chemoprophylaxis or intermittent antimalarial treatment.

5. At least 60% of the epidemic-prone countries will have capacity to detect early and respond appropriately to malaria epidemics.


By 2005, a significant increase in the number of vulnerable groups receiving recommended treatment and prevention measures, in accordance with the Abuja targets.

By 2010, particularly in the lowest two economic quintiles:

- 80% of people at risk from malaria are protected, thanks to locally appropriate vector control methods such as insecticide-treated nets (ITNs), and, where appropriate, indoor residual spraying (IRS) and, in some settings, other environmental and biological measures;

- 80% of malaria patients are diagnosed and treated with effective antimalarial medicines, e.g. artemisinin-based combination therapy (ACT) within one day of the onset of illness;

- in areas where transmission is stable, 80% of pregnant women receive intermittent preventive treatment (IPT); and

- malaria burden is reduced by 50% compared with 2000.

By 2015:

- malaria morbidity and mortality are reduced by 75% in comparison with 2005, not only by national aggregate but particularly among the poorest groups across all affected countries;

- malaria-related MDGs are achieved, not only by national aggregate but also among the poorest groups, across all affected countries; and

- universal and equitable coverage with effective interventions.
Department for International Development

DFID, the Department for International Development: leading the British government’s fight against world poverty.

One in five people in the world today, over 1 billion people, live in poverty on less than one dollar a day. In an increasingly interdependent world, many problems – like conflict, crime, pollution, and diseases such as HIV and AIDS – are caused or made worse by poverty.

DFID supports long-term programmes to help tackle the underlying causes of poverty. DFID also responds to emergencies, both natural and man-made.

DFID’s work forms part of a global promise to

- halve the number of people living in extreme poverty and hunger
- ensure that all children receive primary education
- promote sexual equality and give women a stronger voice
- reduce child death rates
- improve the health of mothers
- combat HIV & AIDS, malaria and other diseases
- make sure the environment is protected
- build a global partnership for those working in development.

Together, these form the United Nations’ eight ‘Millennium Development Goals’, with a 2015 deadline. Each of these Goals has its own, measurable, targets.

DFID works in partnership with governments, civil society, the private sector and others. It also works with multilateral institutions, including the World Bank, United Nations agencies, and the European Commission.

DFID works directly in over 150 countries worldwide, with a budget of nearly £4 billion in 2004. Its headquarters are in London and East Kilbride, near Glasgow.

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