Bending the Curve

TB in the WHO South–East Asia Region

World Health Organization
Regional Office for South-East Asia

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ABBREVIATIONS

AIDS	:	Acquired immune deficiency syndrome
ART	:	Antiretroviral therapy
ARV	:	Antiretrovirals
DOT	:	Directly observed therapy
DOTS	:	The internationally recommended strategy for TB control and the foundation of the Stop TB Strategy introduced in 2006 and the End TB strategy in 2016
DRS	:	Drug resistance surveillance
DR-TB	:	Drug-resistant tuberculosis
DST	:	Drug susceptibility testing
GF	:	The Global Fund to fight AIDS, Tuberculosis and Malaria
rGLC	:	regional Green Light Committee
HBC	:	High-burden (TB) country
HRD	:	Human resource development
HSS	:	Health system strengthening
IC	:	Infection control
IPT	:	Isoniazid preventive therapy
ISTC	:	International Standards for TB Care
IC	:	Infection control
LBC	:	Low-burden (TB) country
LTBI	:	Latent TB infection
MDG	:	Millennium Development Goals
MDR-TB	:	Multidrug-resistant tuberculosis
NGO	:	Nongovernmental organization
PMDT	:	Programmatic management of drug-resistant tuberculosis

PPM	:	Public-private mix
PTB	:	Pulmonary TB
RR-TB	:	Rifampicin-resistant TB
SEA	:	South-East Asia
SEAR	:	South-East Asia Region (of WHO)
SLD	:	Second-line anti-TB drugs
TA	:	Technical assistance
TB	:	Tuberculosis
WHA	:	World Health Assembly
WHO	:	World Health Organization
XDR-TB	:	extensively drug-resistant TB

FOREWORD

The WHO South-East Asia Region is home to 26% of the world's population and yet accounts for 41% of the global burden of tuberculosis (TB) incidence. In 2014, there was an estimated TB prevalence of 5.4 million and an incidence of 4 million. About 460 000 people died of the disease that year in the Region. The Region is also home to around 30% of the estimated global cases of multidrug-resistant (MDR) TB.

Given the Region's outsized TB disease burden, not doing enough and not doing it fast enough is simply unacceptable. Delays in addressing the disease mean not only perpetuating the disease but also the associated suffering and resultant deaths.

WHO's Global End TB Strategy was endorsed by the World Health Assembly in Geneva in May 2014. The Strategy calls for an 80% reduction in TB incidence by 2030 and a reduction of 90% by 2035. The Strategy is based on principles of government stewardship and accountability; strong coalition with civil society organizations and communities; protection and promotion of human rights, ethics, and equity. All Member States need to adopt this bold and comprehensive Strategy to end TB.

The SEA Region has achieved the 2015 Millennium Development Goal of halting and reversing TB incidence. Access to TB care has expanded substantially. However, these gains are inadequate and the current trends clearly show that without bold policies and fast-tracked approaches, the SEA Region will fail to meet the End TB Strategy targets.

The Side-event at the Sixty-ninth Session of the WHO Regional Committee for South-East Asia provides an opportunity for participants to discuss various high-impact interventions that can be contextualized for each country and fast-tracked. While the focus of high-TB burden countries would be mainly to improve access to reach out to cases which are not yet on quality treatment, the low-burden countries in the Region should aim towards reaching the pre-elimination stage and serve as models for other countries.

I am sure the forum will come up with concrete ideas in this short period of time that can be taken back to their respective countries for implementation to be bolstered. Partnerships with communities and various stakeholders will be essential for this implementation and they should be part of the process, starting from the planning stages. I also call upon the technical partners and funding agencies to continue their support to the Member States. We need to support innovations because going on with the "usual" will not lead to the "unusual" results that we envisage for TB control in the Region.

Dr. Poonam Khetrapal Singh
Regional Director

GLOBAL AND REGIONAL PROGRESS IN TUBERCULOSIS CARE & MANAGEMENT

TB care and control

Worldwide

6 million newly diagnosed cases in 2014

86% treatment success rate for people newly diagnosed with TB

SEA Region

2.6 million newly diagnosed cases in 2014

13% increase over 2013

88% treatment success rate for people newly diagnosed with TB

Drug-resistant TB

Worldwide
300 000
MDR-TB cases among notified pulmonary TB cases

In SEA Region
99 000

Worldwide

123 000 people diagnosed with MDR-TB

111 000 people started MDR-TB treatment

50% MDR-TB patients were successfully treated

SEA Region

33 264 people diagnosed with MDR-TB

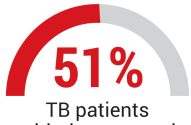
28 536 patients initiated on second-line treatment

49% MDR-TB patients were successfully treated

6 countries in SEA Region
reported extensively drug-resistant TB

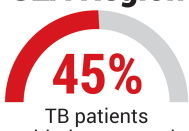
Co-epidemic of TB and HIV

Worldwide



TB patients with documented HIV test result

SEA Region



TB patients with documented HIV test result

- SEA Region maintained **85%** CPT enrolment of all notified HIV-positive TB patients from 2003
- IPT uptake is still low with only **3049** cases reported in 2014

Roll out of new drugs

WHO issued interim guidance on the use of **bedaquiline & delamanid** for treatment for MDR-TB.

Indonesia is among the first countries in the Region to systematically pilot bedaquiline

BACKGROUND

Globally, 9.6 million people fell ill with tuberculosis (TB) in 2014, including 1.2 million people living with HIV. In the same year 1.5 million people died from TB, including 0.4 million people who were HIV-positive. TB is one of the top five killers of adult women aged 20–59 years. An estimated 480 000 women died from TB in 2014, including 140 000 deaths among women who were HIV-positive. About 890 000 men died from TB and 5.4 million fell ill with the disease in the same year. An estimated 1 million children became ill with TB and 140 000 children died of the disease in 2014. An estimated 480 000 people developed multidrug-resistant TB (MDR-TB) and approximately 190 000 deaths from MDR-TB occurred globally in 2014. If all TB cases notified in 2014 had been tested for drug resistance, an estimated 300 000 would have been found to have MDR-TB. In 2014, an estimated 1.2 million (12%) of the 9.6 million people who developed TB worldwide were HIV-positive. Globally, the number of people dying from HIV-associated TB peaked at 570 000 in 2004, and then fell to 390 000 in 2014 (32% decrease).[1] Out of all estimated TB cases, 6 million newly diagnosed cases were notified to national TB programmes in 2014. This is about 63% of the 9.6 million people estimated to have fallen sick with the disease. Globally, the treatment success rate for people newly diagnosed with TB was 86% for the 2013 cohort.

The South–East Asia region is home to

- 41% of the global TB burden
- 4 million new TB cases each year
- 99 000 MDR-TB cases among notified TB cases
- 210 000 TB cases HIV positive
- 460 000 TB deaths -more than 1200 each day

The SEA Region of WHO is home to 26% of the world's population; however, the Region accounts for 41% of the global burden of TB in terms of disease incidence. In 2014, an estimated 4 million new (incident) cases of TB emerged. About 460 000 people died due to TB – more than 1200 each day. India and Indonesia bear 23% and 10% of the total global burden respectively. There are also 99 000 estimated MDR-TB cases among notified pulmonary TB cases – approximately 30% of the world's MDR-TB cases in the Region. Six of the 30 high-MDR-TB-burden countries are in the SEA Region: Bangladesh, Democratic People's Republic of Korea, India, Indonesia, Myanmar and Thailand. Extensively drug-resistant TB has been reported by six countries in the SEA Region. An estimated 210 000 cases (5.2%) of the 4 million incident TB cases are HIV-positive. This corresponds to 11 per 100 000 and 5% of all estimated TB incident cases.

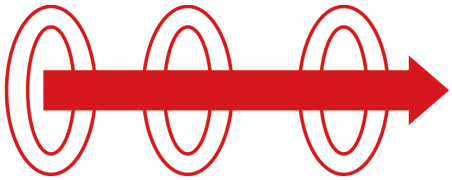
The SEA Region has achieved the Millennium Development Goals of halving the TB mortality rate; halving the 1990 level of TB prevalence; and halting and reversing TB incidence. TB notifications were about 2.6 million (65% of incidence) in 2014 an increase from 2.3 million in 2013. The TB treatment success rate in the Region has continued to be more than 88% since 2009.

Out of the estimated 99 000 drug-resistant TB cases among notified pulmonary TB cases, 33 264 cases were confirmed as Rifampicin-resistant or multidrug-resistant TB and 28 536 cases were started on MDR-TB treatment. Only 49% of MDR-TB patients (initiated on treatment in 2012) were successfully treated. About 45% of notified TB patients had a documented HIV test result.

[1] *World Health Organization. Global tuberculosis report 2015. Geneva, 2015.*

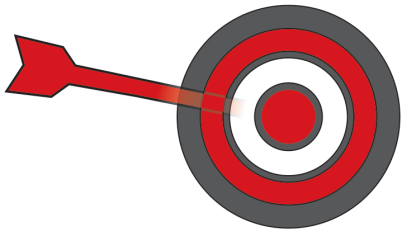
THE END TB STRATEGY 2016–2035

Vision



- **A world free of TB**
- **Zero deaths, disease and suffering due to TB**

Goal



End the Global TB epidemic

MILESTONES FOR 2025	TARGETS FOR 2035
75% reduction in TB deaths (compared with 2015)	95% reduction in TB deaths (compared with 2015)
50% reduction in TB incidence rate (less than 55 TB cases per 100 000 population)	90% reduction in TB incidence rate (less than 10 TB cases per 100 000 population)
No affected families facing catastrophic costs due to TB	No affected families facing catastrophic costs due to TB

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.

PILLARS AND COMPONENTS

Integrated, patient-centred care and prevention

1. Early diagnosis of TB including universal drug susceptibility testing; and systematic screening of contacts and high-risk groups.
2. Treatment of all people with TB including drug-resistant TB; and patient support.
3. Collaborative TB/HIV activities and management of comorbidities.
4. Preventive treatment of persons at high-risk; and vaccination against TB.

2. Bold policies and supportive systems

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

3. Intensified research and innovation

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

END TB STRATEGY

In May 2014, the World Health Assembly in its resolution WHA67.1 adopted the Global Strategy and Targets for Tuberculosis Prevention, Care and Control after 2015 based on a bold vision of a world without tuberculosis and targets for ending the global tuberculosis epidemic and elimination of associated catastrophic costs for tuberculosis-affected households. The three pillars of the strategy include: integrated, patient-centred care and prevention; bold policies and supportive systems; and intensified research and innovation.

The three pillars of End TB strategy include

- Integrated, patient-centred care and prevention
- Bold policies and supportive systems; and
- Intensified research and innovation

The strategy is based on principles of government stewardship and accountability, with monitoring and evaluation; strong coalition with civil society organizations and community; protection and promotion of human rights, ethics, and equity; and adaptation of the strategy and targets at the country level, with global collaboration.

The End TB Strategy identifies four barriers to achieving progress in the fight against TB:

a) Weak health systems, including those with large, unregulated non-State sectors.

b) Underlying determinants of TB such as poverty, undernutrition, migration and aging populations; and risk factors such as diabetes, silicosis and smoking.

c) Lack of effective tools.

d) Continuous unmet funding needs

The End TB Strategy aims to address these barriers by eliciting a strong, systemic response to end the TB epidemic drawing on the opportunities provided by the Sustainable Development Goals, especially those goals aimed at achieving universal health coverage and social protection from disease.

REGIONAL STRATEGIC PLAN: AN OVERVIEW

Vision

The vision for TB control in the SEA Region is to have a region free of TB with zero death, disease and suffering due to TB. All Member States can adopt this vision in their national strategies and plans.

Goal

The goal for TB control in the SEA Region is to End the TB epidemic in the Region by 2035, by adopting and adapting the vision, milestones and targets as outlined in the World Health Assembly resolution WHA67.1.

Objectives

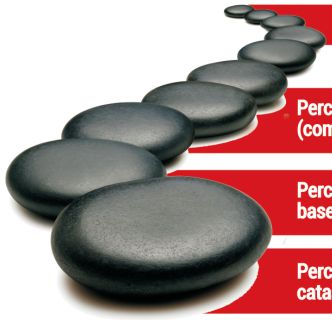
The overall objectives of the plan are to:

1. **Advance universal access to high-quality care for all people with TB as part of robust health systems.**
2. Reduce the human suffering and socioeconomic burden associated with TB.
3. Protect vulnerable populations from TB, TB/HIV, and drug-resistant TB.
4. Protect and promote human rights in TB prevention, care and control.
5. Roll out new tools and enable their timely and effective use.

Regional targets and milestones

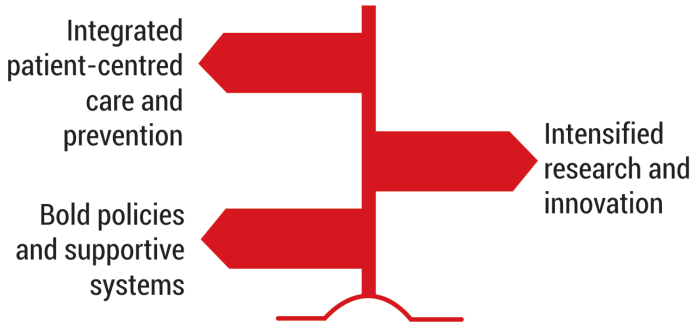
- Ending the regional TB epidemic is defined as reducing the regional burden of TB disease to ≤10 cases per 100 000 population.

Three high-level, overarching indicators, and corresponding regional targets and milestones.



Indicators	Milestones		Targets	
	2020	2025	SDG 2030	End TB 2035
Percentage reduction in the absolute number of TB deaths (compared with 2015 baseline estimated at 460 000 thousand)	35%	75%	90%	95%
Percentage reduction in the TB incidence rate (compared with 2015 baseline, estimated at around 211 cases per 100 000 population)	20%	50%	80%	95%
Percentage of TB patients and their households experiencing catastrophic costs due to TB (level in 2015 unknown)	0%	0%	0%	0%

Strategic directions



REGIONAL STRATEGIC PLAN

Vision: "zero deaths, disease and suffering due to TB" in the Region.

Achieving the milestones set out in the WHO End TB Strategy will require a paradigm shift in the scope, scale and reach of interventions to control TB within countries and national TB programmes (NTPs). With this in view, the WHO Regional Office has elaborated its *'Regional Strategic Plan towards Ending TB in the SEA Region 2016–2020'*[2]. This Plan includes three high-level, overarching indicators, and corresponding regional targets and milestones – targeting reductions in TB related mortality, TB incidence and catastrophic costs experienced by TB patients and their households.

In alignment with the End TB Strategy, the vision of the Regional Strategic Plan for TB control in the SEA Region is to have a region "free of TB with zero death, disease and suffering due to TB". All Member States can adopt this vision in national strategies and plans.

The goal for TB control in the SEA Region is to end the TB epidemic in the Region by 2035, by adopting and adapting the vision, milestones and targets as outlined in the resolution WHA67.1.

The overall objectives of the plan are to:

- Advance universal access to high-quality care for all people with TB as part of robust health systems.
- Reduce the human suffering and socioeconomic burden associated with TB.
- Protect vulnerable populations from TB, TB-HIV, and drug-resistant TB.
- Roll out new tools and enable their timely and effective use.
- Protect and promote human rights in TB prevention, care and control.

With the goal of ending TB in the SEA Region by 2035, this Regional Strategic Plan provides guidance for the first five years, 2016–2020. Ending the regional TB epidemic is defined as reducing the regional burden of TB disease to ≤10 cases per 100 000 population. For comparison, there were an estimated 183 (175–192) cases per 100 000 population reported in the Region in 2013.

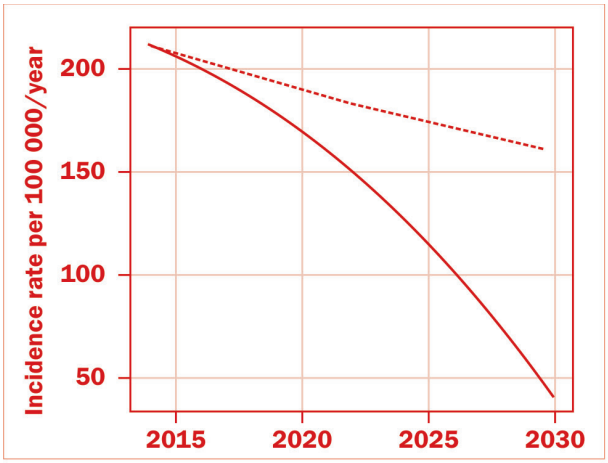
The Regional Strategic Plan to End TB 2016–2020 includes three high-level, overarching indicators, and corresponding regional targets and milestones. The long-term regional targets for reductions in TB cases and deaths by the year 2030 correspond to the end date of the United Nations' post-2015 Sustainable Development Goal framework, within which targets have been set for 2030. The SDG Framework includes the End Strategy's 2030 targets for reductions in TB cases and deaths as part of a health-related subgoal. The corresponding regional milestones are for 2020, the period covered by this Strategic Plan.

[2]*World Health Organization. Ending TB in the South-East Asia Region: regional strategic plan 2016-2020. New Delhi, 2016.*

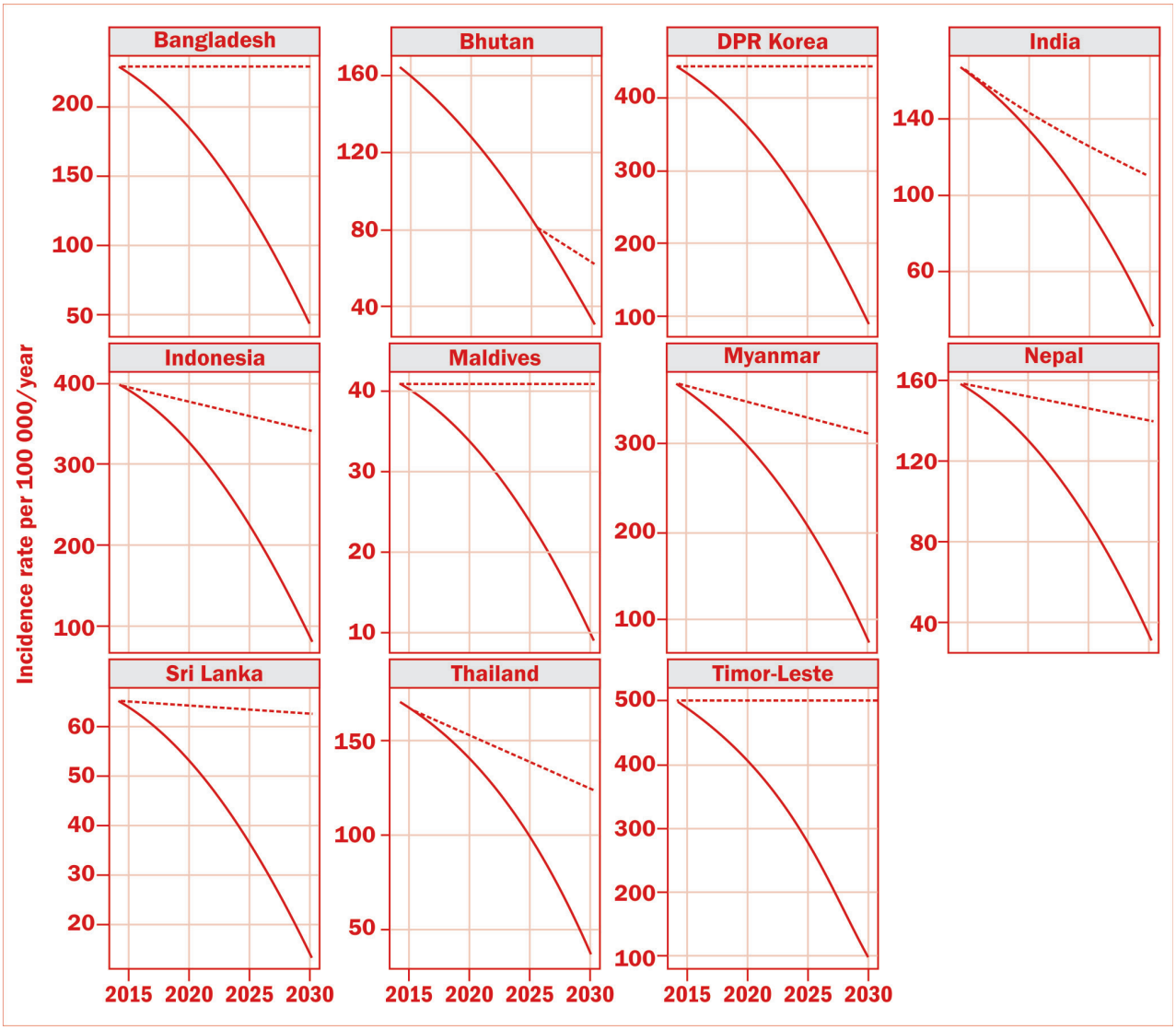
CAN WE ACHIEVE THE END TB STRATEGY TARGETS?

The current rate of decline in TB incidence is slow and at this rate the Region will miss the End TB Strategy targets by a wide margin

(dotted line represents projections as per current trend and bold line is the targeted decline)



Several countries in the Region have static incidence over the past several years



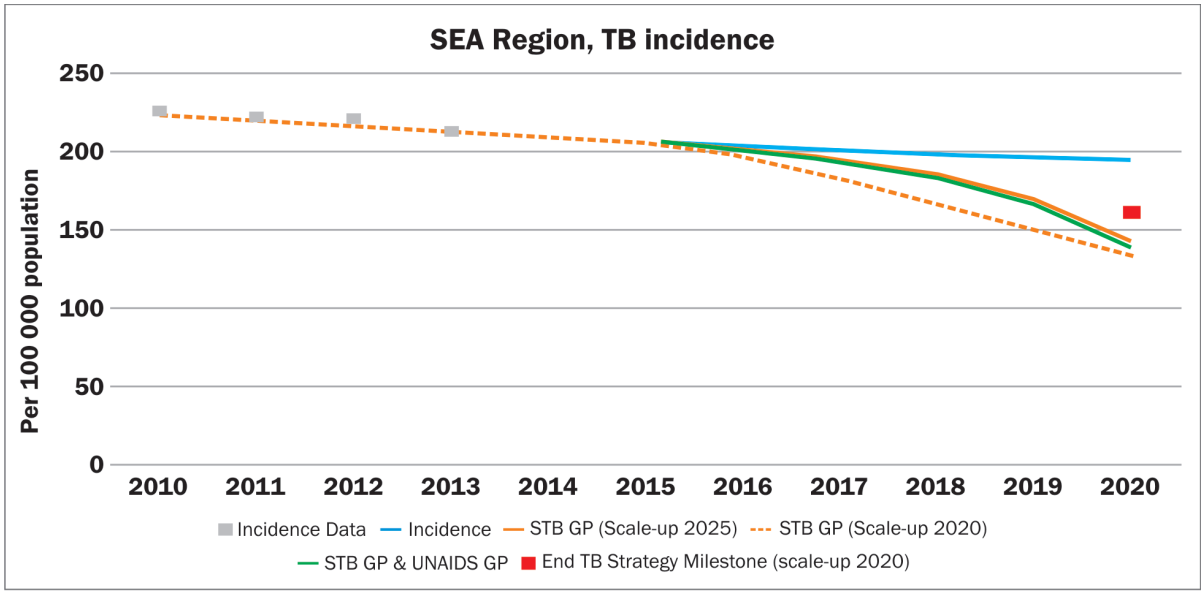
THE CURRENT PACE OF PROGRESS NEEDS TO BE ACCELERATED

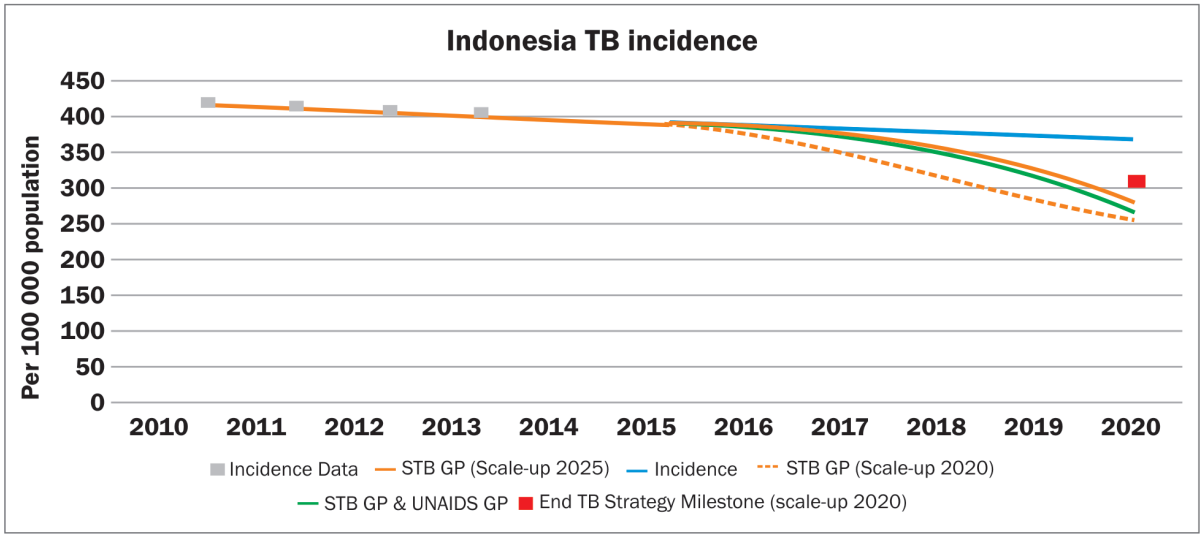
Through the implementation of the DOTS strategy (1994 – 2005) and the Stop TB Strategy (2006 – 2015), member countries – especially those with a high burden of TB – established the basics required for providing high-quality TB diagnosis and treatment. These efforts contributed greatly to meeting the TB-related target of the Millennium Development Goals (MDGs) of halting and beginning to reverse the TB epidemic. Between 2000 and 2014, improvements in quality-assured diagnosis and treatment of TB contributed to saving 43 million lives worldwide. However, while enhancing access to diagnosis and treatment remarkably improved outcomes in terms of reducing suffering and death, it had very little effect on achieving the desired impact in terms of declining the incidence rates and driving down the TB epidemic. This is because TB is not only a biomedical and a public health problem but also a disease associated with poverty; TB will continue thriving as long as poverty persists.

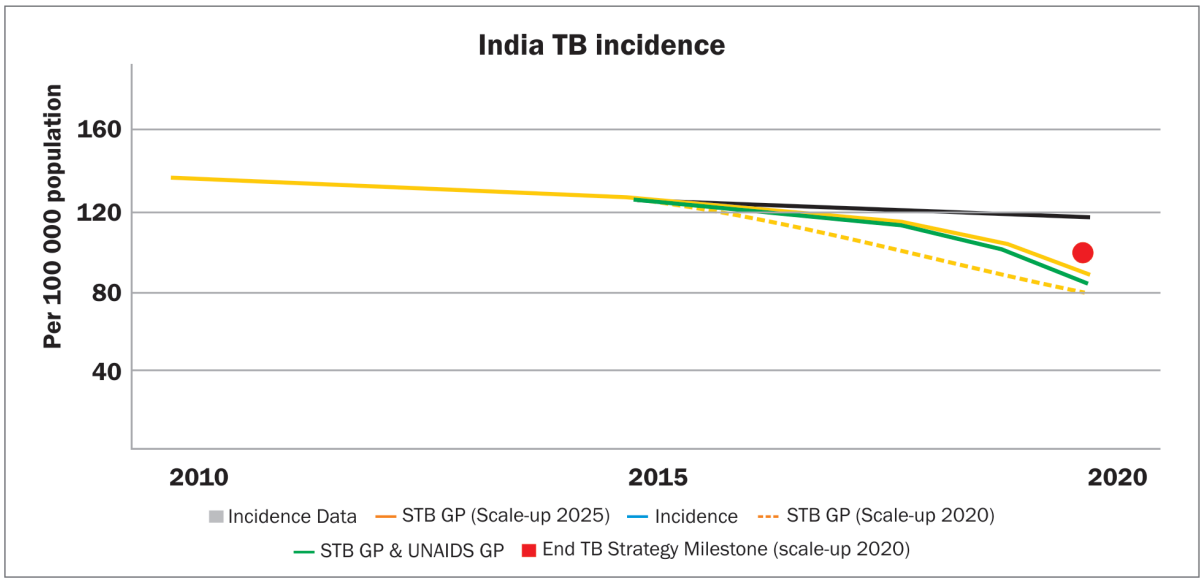
The current trend of decline in TB incidence is at 1.5 – 2% per year. However, to achieve the End TB target milestones for 2020, the decline has to be accelerated to at least 10% per year, and by 2025 this decline has to be further accelerated to 17% per year.

Not being able to achieve the targets by 2035 would mean around 1.2 million more cases emerging and nearly 350 000 additional deaths each year.

[3]







[3]*The SEAR, India and Indonesia graphs have been prepared by the Stop TB Partnership and Avenir Health. They are being reproduced here as examples*

GLOBAL PLAN TO END TB

The Global Plan to End TB 2016–2020 developed by the Stop TB Partnership is the costed plan for implementing the first five years of the End TB Strategy. It takes the End TB Strategy as its foundation and provides countries and policy-makers with a path towards achieving the Strategy's milestones. The Global Plan presents a means for how the world can break out of the current trend of slow decline and "bend the curves" of incidence and mortality towards ending TB. It provides a set of people-centred targets that countries can use to guide their planning and an overview of the funding needed to end TB.

The Global Plan introduces three people-centred targets, called the 90-(90)-90 targets: reach 90% of all people who need TB treatment, including 90% of people in key populations, and achieve at least 90% treatment success.

The 2020 milestones of the End TB Strategy for reductions in people falling ill with TB and deaths due to TB can be met if countries aggressively scale up interventions in line with the 90-(90)-90 targets. The Global Plan's standard investment scenario calls for countries to take action to meet these targets by 2025, preventing 38 million people from getting ill with TB and saving 8.4 million lives. The Global Plan's accelerated investment scenario calls for meeting these targets earlier by 2020, preventing 45 million people from getting ill with TB and saving 9.5 million lives.[4] In either scenario, achieving the 90-(90)-90 targets would generate massive economic and social benefits for TB-affected countries.

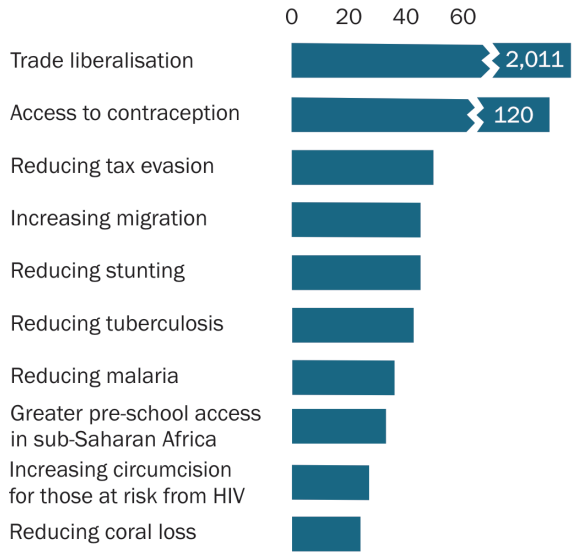
[4] *UNOPS, Stop TB partnership. The paradigm shift 2016-2020: global plan to end TB. Geneva, 2015.*

What are the best targets to fight infections diseases?

Reduce TB deaths by ***95%*** and TB incidence by ***90%*** which return ***US$ 43*** for every dollar spent

No-brainers

Benefit per dollar spent for various development targets, $



Source: Copenhagen Consensus Centre 2015

COST EFFECTIVENESS OF TB INTERVENTIONS

The economics of optimism: The debate heats up about what goals the world should set itself for 2030 (http://www.economist.com/news/finance-and-economics/21640361-debate-heats-up-about-what-goals-world-should-set-itself-2030)

Most poverty-reduction measures are more expensive than cutting tariffs, but many are still well worth it. Providing contraception and other reproductive-health services to all who want them would cost US$ 3.6 billion a year, according to Mr Lomborg's researchers, yet generate annual benefits of US$ 432 billion, US$ 120 per dollar spent. Increasing the nursery school enrolment rate in sub-Saharan Africa to 59% from its current 18% would generate benefits of US$ 33 per dollar spent. Reducing by 40% the number of children whose growth is stunted by malnutrition would be worth US$ 45 per dollar spent; reducing deaths from tuberculosis US$ 43.

Benefits and costs of the Education Targets for the Post-2015 Development Agenda Post-2015 consensus

Anna Vassall
London School of Hygiene and Tropical Medicine

The economic case for investment in tuberculosis (TB) control is compelling. TB control has been part of an essential package of health services for most low and middle-income countries (LMICs) for decades, based on TB control's relatively high returns. The economic case, put simply, is that TB treatment is low-cost and highly effective, and on average may give an individual in the middle of their productive life around 20 additional years of life resulting in substantial economic and health return.

Moreover, the delivery of high- quality TB services can prevent the spread of the disease to others; slow the emergence of drug-resistant forms of the disease, a dangerous and costly form of TB; and, disproportionately benefit the poor.

Tackling drug-resistance infections globally: Final report and recommendations

Chaired by Jim O'Neil

Tuberculosis is the cornerstone of the global antimicrobial resistance (AMR) challenge: drug resistance is a major challenge today not only for TB but also for HIV and malaria. TB kills more people annually than any other infectious disease: 1.5 million die of TB every year, of whom 200 000 die of multi drug-resistant TB (MDR-TB). Analysis shows that of the 10 million total deaths that might be associated with drug resistance each year by 2050, around a quarter will come from drug-resistant strains of TB. The report suggests that the global response to AMR is fundamentally incomplete if it does not directly address the particular issues related to TB.

BENDING THE CURVE – WHAT IT TAKES?

FAST-TRACKING INTERVENTIONS

There are several interventions that could be fast-tracked depending on country needs and availability of resources. To name a few:

- Address the barriers to implementation:
  - Fast-track the adoption of new tools and technologies for diagnosis, treatment and care, including treatment adherence.
  - Universal health coverage, social protection and innovative service delivery mechanisms.
  - More accurate disease burden estimates, continuous surveillance and micro-planning.
- Identify and prioritize high-impact interventions:
  - In HBC for high impact aimed at reaching out to ”missing cases” through early and active case-finding
  - In LBC for moving them to pre-elimination phase targeting specific pockets and groups for latent TB.
- Synergy of regional efforts
  - Working coalition of all partners advancing towards common goal.
  - Rapid scale-up of pilot studies that have demonstrated effectiveness.
- Innovative resource mobilization through ambitious goal setting

Strategy, Implementation and Resources

1. Faster adoption of new tools and technologies
2. Community and partner engagement
3. International Partners need
4. Make a Bigger Investment
5. High-impact interventions

HOW TO BEND THE CURVE?

1. Strategy

- How can the interventions be tailored to local needs – for countries as well as for sub-national levels?
- How can ending TB be linked with health system policies and broader development agenda of the countries to attract highest possible political attention? How can heads of States be advocated to issue 'Call to action'?
- What are the 1-2 high-impact interventions that have not received adequate attention in the SEA Region (or globally) and what are the interventions that need to be fast-tracked as part of bold policies for:
  a. Substantial impact on incidence and mortality in high-burden countries.
  b. Low-burden countries to reach the pre-elimination stage specifically with resource constraints.
- How can the programmes fast-track adoption of new tools and technologies without compromising on the ethical needs of evidence availability?

2. Implementation

- What are the major barriers to implementation of the identified strategies and how can we overcome them?
- How can we replicate successful models of community engagement and partner engagement specifically the private sector?
- What is the support required by the Member States from WHO and technical partners in this regard?

3. Resource Mobilisation

- What is the actual gap in resources available and required for TB prevention and care?
- How can innovation be encouraged and funded?
- What can be done to make a bigger investment case for TB and what are the untapped resources for funding mobilization?
- How can we ensure adequate human resource deployment for all TB control related activities?

Overarching question - What is the support required by the Member States from WHO and technical partners in this regard?

ADDITIONAL INFORMATION

Optimizing the use of current and new tools emerging from the pipeline:

While improving access to diagnosis, treatment and care for TB is a basic necessity, it is essential that all elements of TB control are incorporated while planning services. These include, but are not limited to

1.1. Active screening for TB among risk groups or pockets of unreached populations. Use of digital X-rays, GeneXpert, mobile vans and other newer technologies could be considered for the purpose.

1.2. Universal DST for all patients using WHO recommended rapid diagnostics. Resource permitting, rapid diagnostics such as Gene Xpert should be used for diagnosing TB.

1.3. Adoption of new guidelines for diagnosis and treatment of drug-resistant TB. The new recommendations from WHO on management of rifampicin resistant (RR) and MDR-TB include shorter regimen. These are expected to improve treatment outcomes because of less duration and being potentially less toxic

1.4. Strengthening of TB-HIV coordination. Ideally all TB cases need to be screened for HIV infection and vice versa. A close coordination between the two programmes at the level of planning, monitoring and implementation is required.

1.5. Using available tools for diagnosis and treatment of paediatric TB, including roll-out of new paediatric-friendly formulations. Paediatric formulations have been introduced recently and make administration of paediatric drugs easier because these formulations have the right drug combination ratios, are dispersible and come in flavours to taste better.

1.6. Addressing latent TB infection (LTBI). WHO recommends that systematic testing and treatment of LTBI should be performed in people living with HIV, adult and child contacts of pulmonary TB cases and others[5]. Systematic testing and treatment of LTBI should also be considered for prisoners, health-care workers, immigrants from high-TB burden countries, homeless persons and illicit drug users.

1.7. TB diagnosis and treatment adherence enablers and patient support, including nutrition status assessment and counselling.

Universal health coverage (UHC)

UHC is defined as “the situation where all people are able to use quality health services they need and do not suffer financial hardship paying for them”.[6] The full spectrum of essential, quality health services should be covered, including health promotion, prevention and treatment, rehabilitation and palliative care.

Policies, strategy and systems towards UHC should expand the following[7]:

1.1. Access to the full range of high-quality services recommended in this Strategy, as part of general health services;

1.2. Financial coverage, including costs of general (pre-TB diagnosis) consultations and testing, medicines, follow-up tests and all expenditures associated with staying in complete curative or preventive treatment, in the public and private sectors; and

1.3. Access to services for all people in need, especially the vulnerable and marginalized groups with least access to services.

[5] *World Health Organization. Guidelines on the management of latent tuberculosis infection. Doc no. WHO/HTM/TB/2015.01. Geneva, 2015.*

[6] *World Health Organization. Universal health coverage (UHC). Geneva, 2015.*

[7] *World Health Organization. Implementing the end TB Strategy: the essentials. Doc no. WHO/HTM/TB/2015.31. Geneva, 2016.*

As we enter a new era in TB care and control, the word 'bold' has increasingly come to define our thoughts, words and policy prescriptions.[1]

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[1]*From the Regional Director's address. Unite to End TB. International meeting for ending TB. New Delhi, India, 21 March 2016. SEA-TB-365*