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Transitioning from ‘stopping’ to ‘ending’ the tuberculosis epidemic

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The World Health Organization’s (WHO’s) ‘End TB Strategy’, endorsed by all member states in May 2014, sets an ambitious target of ending the tuberculosis (TB) epidemic by 2035, with 90% and 95% reductions in TB incidence and deaths, respectively.¹ Core contents of the strategy include achieving universal access to quality TB care and prevention, eliminating catastrophic costs to affected families, addressing weaknesses in health care delivery systems, and developing innovative approaches. In this issue of the *Journal*, Senkoro et al. report a health-seeking behaviour study nested within a national TB prevalence survey in Tanzania.² Their study demonstrates serious deficiencies in the service delivery system in providing quality care, in the awareness of the public and in mitigating financial barriers for seeking care,² all major barriers to the success of the End TB Strategy.

Disrupting TB transmission depends on a high level of TB awareness among the general public. People with symptoms of TB need to seek care promptly to protect their own health and reduce their risk of infecting others. Non-governmental and other civil society organisations working on human immunodeficiency virus (HIV) infection, maternal and child health, livelihood programmes, agriculture and other areas need to incorporate TB prevention and care services into their routine community-based activities.³ These organisations have unique knowledge of the local epidemic and culture, as well as the reach, spread and legitimacy to generate demand for TB services.³ The demand generated needs to be matched with quality TB prevention, diagnosis, treatment and care services. In high HIV prevalence settings such as Tanzania, HIV testing should be a routine part of TB care, and symptom-based TB screening should be performed for all people living with HIV to rule out TB and provide TB preventive therapy, or to investigate them further for TB and other illnesses.⁴ The Xpert[®] MTB/RIF assay should be used to expedite the diagnosis of TB,⁵ and all possible efforts must be exerted to enable its utility for people living with HIV, including harmonised transportation of specimens wherever feasible. Existing primary health care service platforms should be used to provide and scale up integrated TB and HIV prevention and care with other priority health programmes, depending on the national and local context (e.g., maternal and child health services and non-communicable diseases). Programmes should collaborate closely to maximise efficiency, reduce costs, and enhance impact of

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services; opportunities exist to share laboratory services, health information systems, procurement and supply chain systems, and staff supervision and programme evaluation. To match demand to supply, countries need to achieve universal health coverage that pays for evaluation of people with presumptive TB, treatment of TB, and supportive services to coordinate care for TB and co-morbid conditions, such as HIV.

A multi-sectoral approach and bold policies are needed to achieve the End TB Strategy. National TB programmes (NTPs) will need to be empowered and open to working across ministries and departments, not only to address the medical and non-medical needs of TB patients, including universal health coverage and social protection, but also to influence the development and enforcement of effective TB infection control, rational use of TB diagnostics and drugs, mandatory disease notification, functioning vital registration systems, and protection of the legal rights of people with TB. Such transition of NTPs is key to the success of the End TB Strategy and will be pivotal to transform the global response from 'stopping' to 'ending' the TB epidemic.

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