# Democratic Republic of the Congo

## Overview of TB control system

TB control in DR Congo has been decentralized to peripheral health centres in an effort to reach geographically remote or disadvantaged people. However, weak access to the under-developed primary care system, especially in the troubled eastern provinces, is a serious obstacle to improving TB control. Collaboration between public primary care services and the growing private sector remains limited.

## Surveillance, planning, operations

Case notifications (all forms and smear-positive) have been steadily rising in DR Congo since the early 1990s, probably due to the combined effects of improved case finding and the spread of HIV. Case notification rates are relatively high among young adults, a pattern that is characteristic of countries in which a high proportion of TB patients are infected with HIV (24% in DRC). Seventy percent of the population had access, in principle, to DOTS by the end of 2002. Based on the current estimate of smear-positive incidence, the case detection rate in 2002 was 52%. These figures are surprisingly high, given that DR Congo has an under-developed primary care system, and contact with health services is often difficult, especially in the eastern provinces. Treatment success was 77% in the 2001 cohort, with a default rate over 10%.

The NTP is implementing the 2001–5 strategic plan for DOTS expansion that was endorsed by the government and distributed in 2002. The newly-formed NICC is now holding quarterly meetings at national level. Provincial interagency coordinating committees (each provincial committee is locally called a TB task force) were created in some provinces, and quarterly meetings are being held in provincial coordination units. TB task forces are being established in the remaining 18 provincial coordination units. World TB Day 2003 was commemorated in 20 provinces and nationally DR Congo has had good planning, and committed TB leadership, but implementation has frequently been delayed because there have not even been enough funds to hold meetings aimed at increasing funding. Despite an influx of money from the GFATM, the TB programme is still not adequately funded.

Low salaries and low levels of expertise contribute to the central staffing problem, though new funds from the GFATM should help to improve staffing. Monitoring and supervision have shown only marginal improvements recently, aided by better internet and telephone connections as the overall telecommunications system is strengthened. Similarly, recording and reporting was improved through two internet connections in provincial coordination units. An electronic register for TB data is being installed.

Access to 7 coordination units in the eastern part of the country remains weak due to political instability. Diagnostic efforts were improved through development of new laboratory QA guidelines. GFATM funds will be used to replace 400 old or broken microscopes, laboratory reagents, and other laboratory supplies. There are plans to renovate 5 provincial reference laboratories using GFATM funds, and to train all 800 laboratory technicians.

### PROGRESS IN TB CONTROL IN DR CONGO

**Indicators**

| | |
|---|---|
| • Treatment success 2001 cohort | 77% |
| • DOTS detection rate, 2002 | 52% |
| • NTP budget available, 2003 | 65% |
| • Government contribution to NTP budget, including loans, 2003 | 10% |
| • Government contribution to total TB control costs, including loans, 2003 | 58% |
| • Government health spending used for TB, 2003 | 4% |

**Constraints to achieving targets**

- Funding gap of at least US$ 3.7 million in 2003
- Ineffective drug distribution system leading to inadequate and late provision of drugs in provinces
- Lack of political commitment to TB at provincial level, coupled with instability resulting from war
- Poor quality of smear microscopy in some areas, due to insufficient training, supervision, and equipment
- Incomplete DOTS coverage
- High number of patients lost to follow-up (not evaluated, transferred, defaulted)

**Remedial actions needed to overcome constraints**

- Mobilize resources from donors
- Strengthen systems for drug management and distribution
- Continue advocacy for TB at provincial level
- Strengthen laboratory capacity by purchasing new microscopes, reagents, and laboratory materials for 400 laboratories
- Continue to expand DOTS even in areas where there is war
- Strengthen patient tracking system

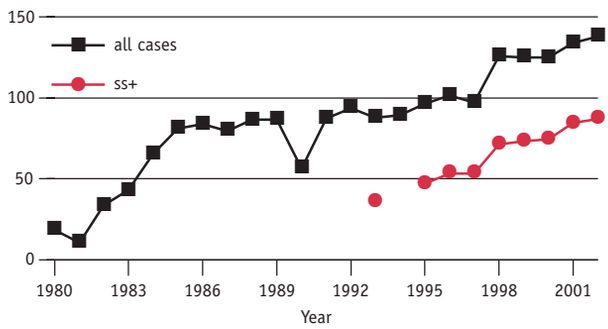
# DEMOCRATIC REPUBLIC OF THE CONGO

| LATEST ESTIMATES[a] | |
|---|---|
| **Population** | **51 201 034** |
| Global rank (by est. number of cases) | 10 |
| Incidence (all cases/100 000 pop) | 383 |
| Incidence (new ss+/100 000 pop) | 167 |
| Prevalence (ss+/100 000 pop) | 247 |
| TB mortality per 100 000 pop | 90 |
| % of adult (15-49y) TB cases HIV+ | 24 |
| % of new cases multi-drug resistant | 1.5 |

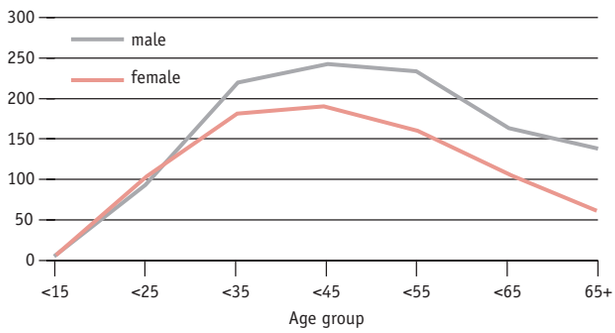
| TRENDS | 1999 | 2000 | 2001 | 2002 |
|---|---|---|---|---|
| DOTS population coverage (%) | 62 | 70 | 70 | 70 |
| Notification rate (all cases/100 000 pop) | 125 | 125 | 134 | 138 |
| Notification rate (new ss+/100 000 pop) | 73 | 74 | 84 | 87 |
| Detection of all cases (%) | 40 | 37 | 38 | 36 |
| Detection of new ss+ cases (%) | 54 | 51 | 54 | 52 |
| DOTS detection of new ss+ (%) | 54 | 51 | 54 | 52 |
| DOTS detection of new ss+/coverage(%) | 88 | 73 | 78 | 75 |
| DOTS treatment success (new ss+, %) | 69 | 78 | 77 | — |

## Notification rate (per 100 000 pop)

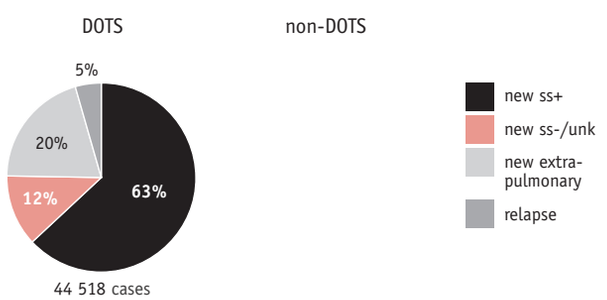
Notification (all cases) = 70 625 in 2002



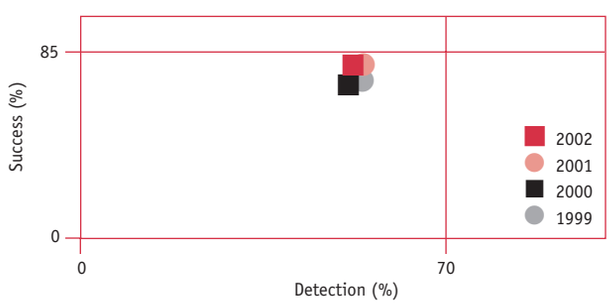

## Notification rate by age and sex (new ss+)[b]




## Case types notified[c]




## DOTS progress towards targets[d]




## Treatment outcomes[c]


**Notes**

ss+ Indicates smear-positive; ss-, smear-negative; pop, population; unk, unknown.

[a] See Methods for data sources.

[b] The sum of cases notified by age and sex is less than the number of new smear-positive cases notified for some countries.

[c] Non-DOTS is blank for countries which are 100% DOTS, or where no non-DOTS data were reported.

[d] DOTS progress towards targets: DOTS detection rate for given year, DOTS success rate for cohort registered in previous year.

[e] "Other" includes transfer out and not evaluated, still on treatment, and other unknown.

In response to provision of drugs by the GDF, new guidelines were produced for both drug management and laboratory QA. Although the GDF has provided drugs, supply throughout the country is hampered by the poor transportation infrastructure and security risks. Despite new guidelines, drug management also remains poor, and there are inadequate drug storage facilities. Plans to build or rehabilitate drug stores at central level and in 5 provinces have been delayed due to a lack of funds for training pharmacists. The drug management committee is developing an approach to overcome some of these obstacles.

Anti-TB radio and TV programmes, banners throughout the provinces, and other educational materials were used to boost social mobilization efforts. Community-based DOTS projects in the cities of Kinshasa, Matadi, and Boma have been unsuccessful due to the lack of money and staff, the low coverage of primary health care, poor links with the private sector, high social stigma associated with TB, and continuing war. WHO, USAID, and other partners are working with the NTP to develop strategies for overcoming these obstacles. For example, PPM projects have recently begun to improve coordination between the NTP and private hospitals in the large cities of all provinces.

Collaborative TB/HIV activities are carried out by the MoH, by research organizations, and by NGOs in 3 of 306 districts. National and provincial TB/HIV coordinating bodies have been established. There are plans to test TB patients for HIV, and to involve TB programmes in ART in 2004. Pilot TB/HIV projects have been proposed for 2 health districts of Kinshasha city. The most recent survey of drug resistance was carried out in Kinshasa in 1999, and found MDR-TB in 5.8% of new and previously treated patients.

## Partnerships

Overall technical support is provided by WHO, DFB, and IUATLD. For the period 2000–2005, the Ministry of Health has entrusted programme monitoring to IUATLD, acting on behalf of the Stop TB Partnership. Various donors are providing financial support, advice on management, and materials including drugs, reagents, and laboratory equipment. These donors include DFB, TLMI, ALM, and ALTI. Other partners provide support through NGOs already based in the country, including the European Union and Coopération Belge via DFB, and the Ligue Nationale Antituberculeuse et Antilepreux du Congo. Solidarité Protestante works through TLMI. USAID directs funds through IUATLD. Diagnostic and treatment centres that are part of the primary health care system are often supported by religious missions. The GDF provides drugs to cover part of the country.

## Budgets and expenditures

The NTP budget for the fiscal year 2003 (from 1 January) was US$ 10.4 million. The NTP estimated that it would treat 79 272 patients during this period, implying a budget per patient of US$ 131. The government provided US$ 1 million of the required funding for the NTP, which represented an increase of US$ 600 000 from 2002. The total government contribution to TB control covered

**Budget estimates, existing funding, and budget gaps for fiscal year 2003, US$ millions**

| | REQUIRED FUNDING | EXPECTED FUNDING | | | | FUNDING GAP |
|---|---|---|---|---|---|---|
| | | GOVERNMENT | LOANS | GRANTS | OTHER | |
| **NTP budget** | | | | | | |
| Drugs | 2.1 | 0.6 | — | 1.4 | — | 0.1 |
| Dedicated staff working exclusively for TB control | 0.7 | 0.01 | — | 0.6 | — | 0.1 |
| New activities to raise case detection and cure rates | 3.0 | — | — | 0.6 | — | 2.4 |
| Buildings, equipment, vehicles | 2.9 | 0.4 | — | 2.2 | — | 0.3 |
| All other line items | 1.7 | — | — | 0.9 | — | 0.8 |
| **TOTAL NTP BUDGET** | **10.4** | **1.0** | **—** | **5.7** | **—** | **3.7** |
| **Costs not covered by NTP budget** [a,b] | | | | | | |
| Hospital stay | 1.0 | 1.0 | — | — | — | — |
| Clinic visits for DOT and monitoring | 11.2 | 11.2 | — | — | — | — |
| **TOTAL COSTS NOT COVERED BY NTP BUDGET** | **12.2** | **12.2** | **—** | **—** | **—** | **—** |
| **TOTAL TB CONTROL COSTS** | **22.6** | **13.2** | **—** | **5.7** | **—** | **3.7** |

— Indicates zero; NA, not available

[a] WHO estimates, data not provided by the NTP

[b] Estimates differ from those in Global TB Control 2003 due to a change in methods made possible by the availability of new data. See Methods for full details.

58% of the costs in the public sector. TB control activities accounted for 4% of the government's spending on health.

In 2003, approximately US$ 1.9 million was received from the GFATM, reducing the anticipated financing gap. However, a gap of US$ 3.7 million remained. Compared to 2002 expenditures, there were large increases in the 2003 budget for new activities to expand DOTS as well as for buildings, equipment, and vehicles. The drug budget decreased by US$ 341 000 between 2002 and 2003 as a large buffer stock was established in 2002.

Costs associated with TB control that were not funded from the NTP budget amounted to an estimated US$ 12.2 million, of which US$ 1 million was for hospital admissions during treatment and US$ 11.2 million was for clinic visits during treatment. These data imply total TB control costs of US$ 22.8 million in 2003, and US$ 288 per patient.