

COUNTRY PROFILE

Democratic Republic of the Congo

The Democratic Republic of the Congo, despite being among the poorest countries in the world, has made substantial progress in TB control in recent years; by 2004, DOTS services were available to approximately 80% of the population. While there is strong government support for the NTP, the provision of adequate TB services throughout the country has been hampered by a combination of difficulties. The country's health infrastructure has suffered in the past from an underdeveloped primary care system, lack of funds and resources as well as from the destructive effects of civil unrest and natural disasters. In spite of these constraints, TB case detection and cure rates have both improved steadily since the early 1990s, and the NTP hopes to reach the global targets by 2005. The likelihood of achieving these objectives has been greatly boosted by an award from the GFATM, as well as increased government funding, which have transformed the financial basis of TB control services and

will allow for the extension and strengthening of activities. Furthermore, the special problems posed by the epidemic of TB in people infected with HIV are being addressed in an expanding programme of collaborative TB/HIV activities.

System of TB control

The NTP was officially launched in 1980 (Programme National Antituberculeux Intégré, PATI 1) and consists of a central unit, 20 provincial coordination centres, 777 TB diagnosis and treatment centres and a network of health posts (consisting of a nurse or health-care worker) distributed in 515 health districts. Better health coverage resulted from a health mapping exercise carried out in 2004, following which the number of health districts was increased from 306 to 515. TB services follow the expanded health network to improve access by providing services closer to where the patients live and to promote health-seeking behaviour.

The TB laboratory network consists of one NRL, which was significantly upgraded in preparation for the application to the GLC, 20 provincial laboratories implementing EQA and 800 district laboratories, giving 1 laboratory per 70 000 inhabitants. There are no microscopy services in any of the peripheral health posts.

Surveillance and monitoring

As a result of progressive expansion of DOTS services, coverage of approximately 80% was reached in 2004. The TB notification rate for both smear-positive and all forms of TB has increased over the past 20 years, partly as a result of improved case-finding and partly as a result of a rise in TB incidence linked to the spread of HIV. For the Democratic Republic of the Congo, as for some other countries in central Africa, the accuracy of the estimated case detection rate (63% in 2003) is uncertain. The treatment success rate was 78% for the 2002 cohort; 7% of patients died and 13% defaulted or were lost to follow-up after transfer to other treatment centres. Both of the latter indicators were high for patients undergoing re-treatment following relapse, failure or default; the relapse re-treatment success rate was 70%. High HIV prevalence, poor health infrastructure and large numbers of displaced persons contribute to this low treatment success rate. However, preliminary data suggest that the treatment success rate for the first quarter of 2003 was 81%. Improvement of the treatment success rate is a high priority for the NTP.

Improving programme performance

Revised TB control guidelines have been prepared (Programme National Antituberculeux Intégré, PATI 4) and will be published soon. These guidelines, which include the introduction of the 6-month regimen for treatment, have already been used as the basis for training sessions on the progressive introduction of the new regimen.

PROGRESS IN TB CONTROL IN THE DEMOCRATIC REPUBLIC OF THE CONGO

Indicators

DOTS treatment success, 2002 cohort	78%
DOTS case detection rate, 2003	63%
NTP budget available, 2004	84%
Government contribution to NTP budget, including loans, 2004	5%
Government contribution to total TB control costs, including loans, 2004	64%
Government health spending used for TB control, 2004	NA

Major achievements

- Review of the national TB control guidelines (Programme National Antituberculeux Intégré, PATI 4), including introduction of 6-month treatment regimen
- Extensive training at all levels, including initiation of more than 4000 community health workers
- Establishment of a TB/HIV coordinating body to coordinate activities of the National AIDS Control Programme and the NTP
- Improved capacity of laboratories, including provision of 800 microscopes

Major planned activities

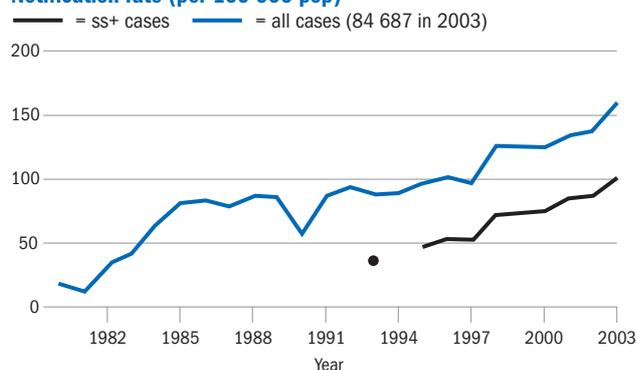
- Host external monitoring mission planned for February 2005
- Prepare five-year strategic plan (2006–2010)
- Implement a national drug resistance survey
- Update and revise NTP technical guidelines
- Expand collaborative TB/HIV activities, following recent award from the President's Emergency Plan for AIDS Relief

NA indicates not available.

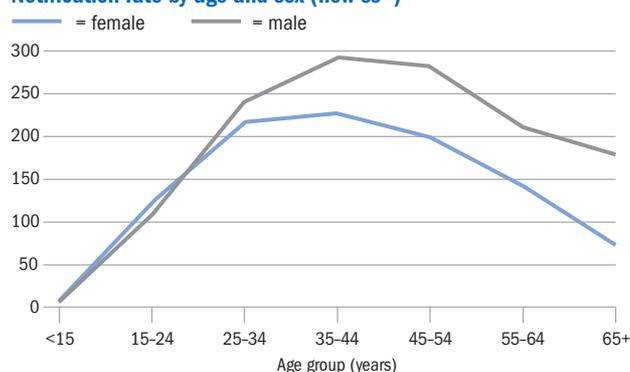
DEMOCRATIC REPUBLIC OF THE CONGO

LATEST ESTIMATES ^a		TRENDS	2000	2001	2002	2003
Population	52 771 230	DOTS coverage (%)	70	70	70	75
Global rank (by est. number of cases)	11	Notification rate (all cases/100 000 pop)	125	134	138	160
Incidence (all cases/100 000 pop/year)	369	Notification rate (new ss+/100 000 pop)	74	84	87	102
Incidence (new ss+/100 000 pop/year)	160	Detection of all cases (%)	39	40	39	44
Prevalence (all cases/100 000 pop)	564	Case detection rate (new ss+, %)	53	58	57	63
TB mortality (all cases/100 000 pop/year)	81	DOTS case detection rate (new ss+, %)	53	58	57	63
TB cases HIV+ (adults aged 15-49, %)	21	DOTS case detection rate (new ss+)/coverage (%)	76	83	81	84
New cases multidrug resistant (%)	1.5	DOTS treatment success (new ss+, %)	78	77	78	—

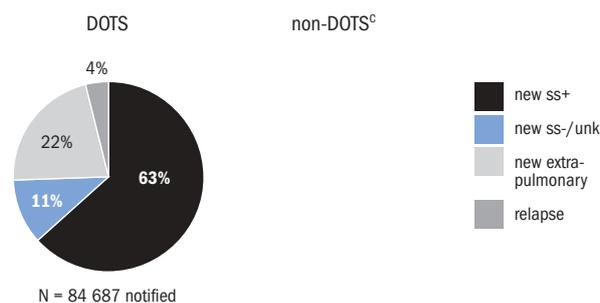
Notification rate (per 100 000 pop)



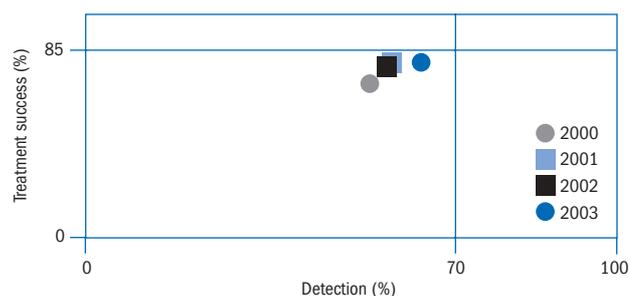
Notification rate by age and sex (new ss+)^b



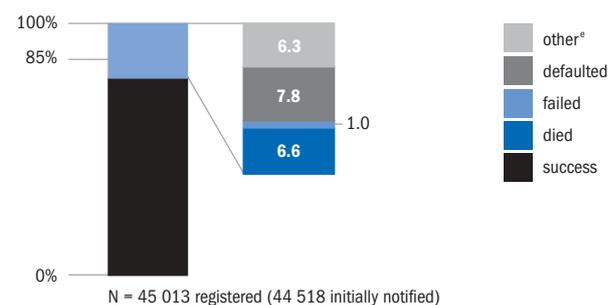
Case types notified



DOTS progress towards targets^d



DOTS treatment outcomes (new ss+)



Non-DOTS treatment outcomes (new ss+)

Notes

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

Absence of a graph indicates that the data were not available or applicable.

^a See Methods for data sources. Prevalence and mortality estimates include patients with HIV.

^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 case detection rate for given year, DOTS treatment success rate for cohort registered in previous year.

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

A new strategic plan will be prepared for the period 2006–2010.

The supply of anti-TB drugs is adequate, thanks to a second GDF grant approved in 2004 for another three-year period. However, the country's drug policy and system of drug management need to be revised to ensure sustainable supply and better drug distribution, with regular reporting on drug stocks at every level.

A national drug resistance survey is planned for 2005. The protocol has been finalized and implementation should start soon. A national policy for the diagnosis and treatment of MDR-TB is being developed.

Extensive training activities were carried out in 2003 at all levels, including initiation of more than 4000 community health workers.

Supervision of laboratory, medical, financial and administrative functions is carried out on a regular basis, but the time devoted to each visit is inadequate and only half of the planned visits were carried out in 2003. Nonetheless, supervision has resulted in improvements in the procedures for recording and analysis of observations made during patient visits. There has also been a striking improvement in

the management and flow of funds because of a revision of financial and administrative procedures under the guidance of a newly-recruited finance officer at central level.

Data collection is more reliable than in the past, although delays are experienced and data collection forms remain unnecessarily complicated.

The award of a GFATM grant has greatly increased the funding available for TB control in 2004, making it possible to address the problems of staffing, training, medical supplies and equipment. With improvements in the facilities for diagnosis and patient care, case detection and cure rates should continue to rise in the coming years.

Three areas where programme performance particularly needs to be improved are laboratory services for culture and DST, TB/HIV coordination and links with other health-care providers.

Diagnostic and laboratory services

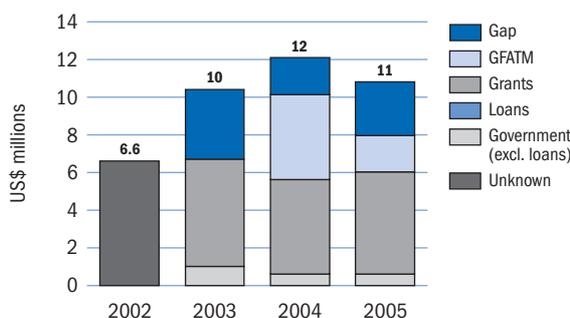
The quality of DOTS implementation relies on an effective laboratory network. New equipment was installed during 2003 and 2004 in most peripheral laboratories, and EQA is imple-

mented in most laboratories. EQA included external laboratory supervision in half of the provinces in 2003. On-the-spot slide reading is carried out in half of the districts visited during the external visits. The link between the NRL and the NTP needs to be strengthened to ensure effective co-ordination. The central laboratory is poorly equipped and the quality of slide reading is poor in laboratories where microscopes are old and need to be replaced.

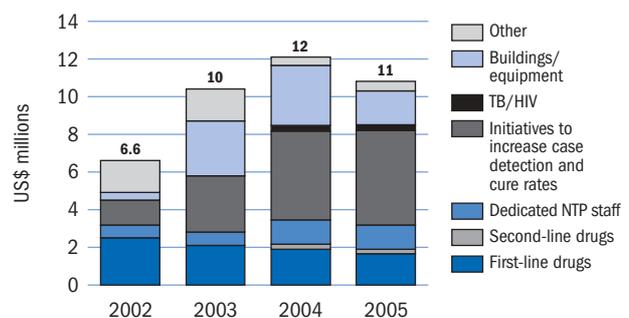
TB/HIV coordination

More than 20% of adult TB patients are infected with HIV (WHO estimate). The National AIDS Control Programme and the NTP have established a TB/HIV coordinating body in 2003, and one NPO has been recruited to support these activities. Since 2002, several DOTS centres have started collaborative TB/HIV activities in Kinshasa, with financial and technical support from WHO, MSF and the World Bank. Following a recent award from the President's Emergency Plan for AIDS Relief, collaborative TB/HIV activities will be expanded in 2005.

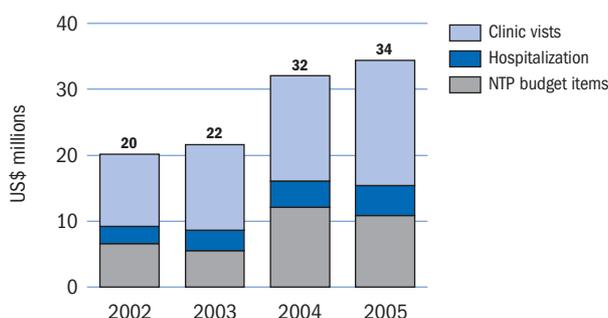
(a) NTP budget by source of funding



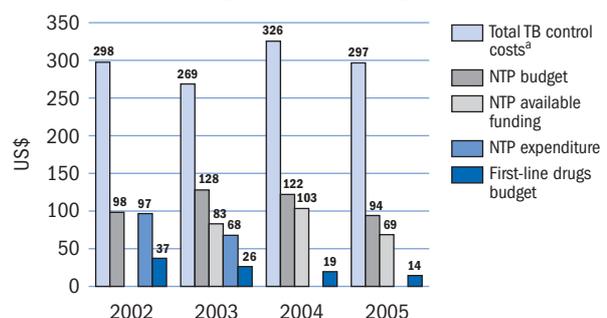
(b) NTP budget by line item



(c) Total TB control costs by line item^a



(d) Per patient costs, budgets, available funding and expenditures



^a Total TB control costs for 2002 and 2003 are based on expenditures, whereas those for 2004 and 2005 are based on budgets. Estimates of the costs of clinic visits and hospitalization are WHO estimates based on data provided by the NTP and from other sources. See Methods for further details.

Links with other health-care providers

The NTP is collaborating with general hospitals, medical colleges, and military and police health services; specialist TB hospitals and the prison health-care service do not implement DOTS. Limited formal involvement of the private sector has started with the training of private physicians in DOTS activities. These providers are also represented in some provincial and national task force meetings.

Partnerships

The Democratic Republic of the Congo benefits from several financial and technical partnerships for TB control. The GFATM is a principal source of funds, and the national budget for TB control has increased in 2004. Additional support from the Government of Belgium was agreed in 2004. UNDP, the principal recipient of the GFATM funds, has established four public and private recipients for the TB control proposal (the NTP, La Ligue Nationale

Antituberculeuse et Antilépreuse du Congo, DFB and the National School of Public Health). Through this arrangement, other partners have been included.

Budgets and expenditures

The NTP budget has been between US\$ 10 million and US\$ 12 million for the years 2003–2005, compared with about US\$ 7 million in 2002. Almost all of the available funding for 2003–2005 comes from grants, with the government contributing less than 10% of the NTP budget (no breakdown of the budget by funding source in 2002 has been provided to WHO). This makes the Democratic Republic of the Congo largely dependent on external financing. Despite the approval of the GFATM grant in round 2, and sustained commitment from other donors, an important funding gap remains: US\$ 2.9 million (26% of the NTP budget) in 2005.

The budget for first-line drugs has

decreased from US\$ 2.5 million in 2002 to US\$ 1.7 million in 2005, reducing the first-line drug budget per patient treated from US\$ 37 to US\$ 14. In contrast, the budget for initiatives to increase case detection and cure rates has grown from US\$ 1.3 million in 2002 to US\$ 5 million in 2005 and is now the largest single budget item.

The total cost of TB control, which includes the cost of clinic visits and dedicated TB hospital beds, in addition to the NTP budget, is projected to increase from an estimated US\$ 20 million in 2002 to US\$ 34 million in 2005, in line with anticipated increases in the numbers of patients to be treated (the cost per patient treated is around US\$ 300 per patient in both 2002 and 2005). The government contribution to the total cost of TB control is much larger than to the NTP budget, varying from 60% to 76% of total costs.