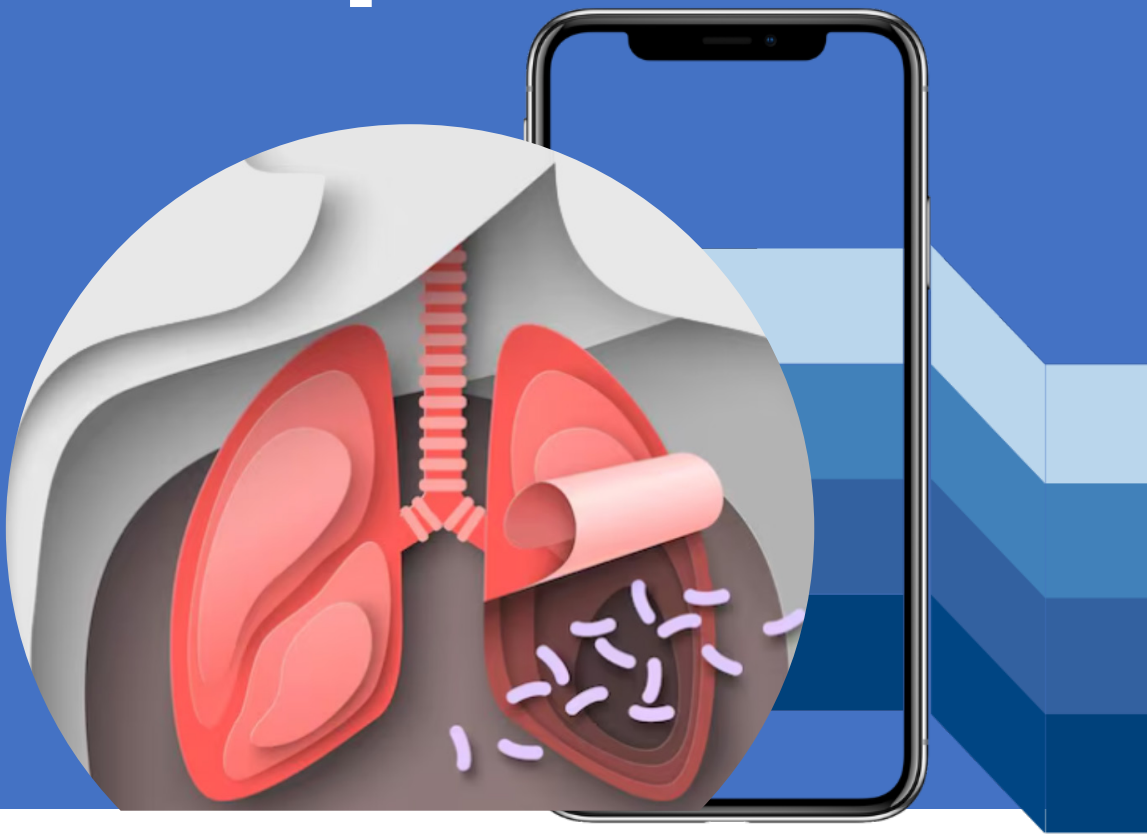
2025

SADC Annual TB Progress Report



THE LIGHT CONSORTIUM

Leaving no-one behInd: Transforming Gendered pathways to Health for TB **(LIGHT)**

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About SADC

The Southern African Development Community (SADC) is an organization founded and maintained by countries in southern Africa that aim to further the socio-economic, political and security cooperation among its Member States and foster regional integration in order to achieve peace, stability and wealth. The Member States of SADC are Angola, Botswana, Democratic Republic of Congo, Union of Comoros, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, United Republic of Tanzania, Zambia and Zimbabwe.

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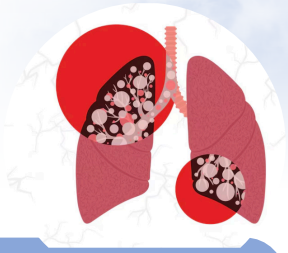

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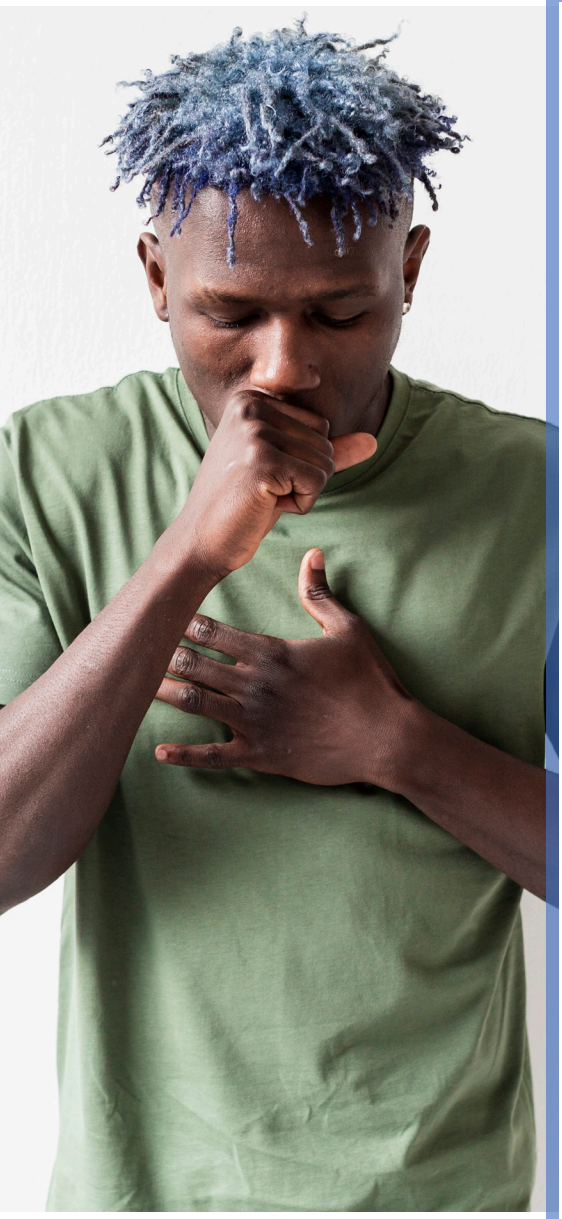
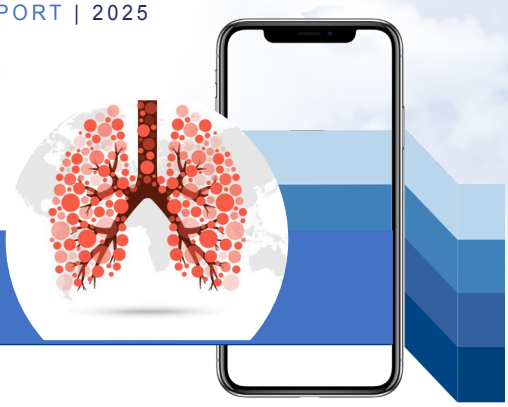


Abbreviations

ART	Antiretroviral Therapy
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
AU	African Union
CBRS	Cross Border Referral System
CDC	Centers for Disease Control and Prevention
DRC	Democratic Republic of Congo
ECSA-HC	East Central and Southern Africa Health Community
GF	Global Fund
HIV	Human Immunodeficiency Virus
MDR/RR TB	Multidrug-Resistant Tuberculosis or Rifampicin-Resistant Tuberculosis
M&E	Monitoring and Evaluation
NSP	National Strategic Plan
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
RISDP	Regional Indicative Strategic Development Plan
RST	Regional Support Team
RSTESA	Regional Support Team for Eastern and Southern Africa
SDG	Sustainable Development Goals
SADC	South African Development Community
TB	Tuberculosis
TIMS	TB in the Mining Sector
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN	United Nations
WHO	World Health Organization



Executive Summary

Tuberculosis (TB) is a preventable and curable disease, yet in 2024 it likely became the world's leading cause of death from a single infectious agent, causing nearly twice as many deaths as HIV/AIDS. Over 10 million people continue to fall ill with TB annually, with numbers rising since 2021.

Urgent action is needed to end the global TB epidemic by 2030—a goal adopted by all United Nations (UN) Member States and the World Health Organization (WHO). Africa remains at the forefront of the global tuberculosis (TB) challenge, accounting for nearly a quarter of all new TB cases worldwide in 2024—second only to South-East Asia. Southern Africa Development Community Member States (Angola, Botswana, Comoros, DRC, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia, Zimbabwe) collectively bear a disproportionately high share of Africa's TB burden.

SADC Member States account for 55% of all persons notified with TB in the WHO Africa region, despite having only ~32% of the population. Men accounted for 59% of all notified persons with TB. In 2024, SADC also accounted for 77% of rifampicin-resistant/ multidrug-resistant TB (RR/MDR-TB) cases, 76% of the treatment gap for MDR-TB, and 94% of all extensively drug-resistant TB cases in Africa. This reflects the severe concentration of TB in the region, driven by overlapping epidemics of TB and HIV and other risk factors. Indeed, many SADC countries are classified by WHO among the world's high TB-burden or high TB/HIV-burden countries – until recently Zimbabwe was on the global high-burden list (it has since transitioned off after reducing incidence to ~204/100k in 2022). Unfortunately, co-infection with HIV is common; for example, 53% of TB patients in South Africa are HIV-positive (most of whom are on antiretroviral therapy), and similarly high TB/HIV co-infection rates (often >50%) are seen in countries like Eswatini and Lesotho.

This TB/HIV syndemic amplifies the disease burden and mortality in Southern Africa. Within the region, eight SADC Member States are classified as high TB burden countries, ten as high TB/HIV burden countries, and six as high MDR/RR-TB burden countries, underscoring the complexity and scale of the epidemic.

SADC Member States have demonstrated strong alignment with regional and global commitments, including the SADC TB Declaration, the WHO End TB Strategy, and United Nations High-Level commitments. The 2012 SADC Heads of State and Government declaration continues to drive collaborative action and progress across the region.

Key Drivers and Challenges:

The TB epidemic in SADC is fuelled by multiple factors. The region's high HIV prevalence undermines immunity and increases TB risk. The mining sector, predominantly male, plays a significant role: crowded working and living conditions, silica dust exposure, and cross-border migration of mine workers have historically led to intense TB transmission (TB incidence among miners is at least 3 times higher than in the general population). Migrant labor across borders and informal settlements contribute to transmission and treatment interruptions, as health services are often not well coordinated for mobile populations. Socio-economic determinants – poverty, malnutrition, and limited access to healthcare – also

2025 Updates

- Member States account for 55% of all TB cases notified in the WHO Africa region
- Member States account for 77% of rifampicin-resistant/ multidrug - resistant TB (RR/MDR-TB) cases, 76% of the treatment gap for MDR-TB, and 94% of all extensively drug-resistant TB cases in Africa.
- 53% of TB patients in South Africa are HIV-positive
- TB incidence in the SADC region has declined by 26% since 2016
- Eight Member States are counted among the 30 highest TB-burden countries globally
- Several SADC countries have reduced TB mortality faster than incidence, implying improved treatment success rates and care quality
- The region did not meet all 2020 End TB targets and remains off-track for 2030 without a drastic acceleration

persist in parts of the region. Moreover, COVID-19 has disrupted TB services in recent years: after steady gains pre-2019, the pandemic caused sharp drops in TB case notifications in 2020–2021 (a regional 47% "missing cases" gap appeared), due to lockdowns and healthcare disruptions. Although measures like mask-wearing may have temporarily reduced transmission, the net effect was fewer diagnoses and a backslide in progress.

Regional collaboration has achieved major breakthroughs:

The cross-border referral system has been revamped and updated, with 10 Member States successfully conducting User Acceptance Testing. However, there is an urgent need to update regional harmonized standards for TB prevention, diagnosis, treatment, and management in line with current WHO recommendations to further catalyze progress. Significant strides have been made; TB incidence in the SADC region has declined by 26% since 2016, reaching 258 cases per 100,000 population in 2024. However, this progress is plateauing, and the region remains short of the 50% reduction target, signaling an urgent need for intensified interventions and innovation.

Despite these challenges, SADC countries have a strong political commitment to combat TB. All Member States have endorsed the WHO End TB Strategy (2016–2035) and the African Union's Catalytic Framework to End AIDS, TB and Malaria by 2030. SADC itself has developed a regional TB strategic plan and declarations – notably the 2012 SADC Heads of State Declaration on TB in the Mining Sector, which set out minimum standards and actions to reduce TB among miners, ex-miners and their communities. There is also a SADC End TB Scorecard/Accountability Framework to track progress on key indicators. This report provides an updated 2024 overview of TB in the SADC region, summarizing the disease burden and trends, assessing progress toward targets, and recommending priority actions to accelerate the end of TB in Southern Africa.

TB incidence varies widely across SADC.

Countries like Lesotho, South Africa, Namibia, Mozambique, and Eswatini have extremely high incidence rates (300–660+ per 100,000), reflecting intense transmission. Lesotho's rate of ~661/100k is the highest in the region, driven by widespread HIV and poverty. South Africa, with ~368/100k, and Mozambique (~361/100k) also contribute enormously in absolute case numbers. In 2022, the Democratic Republic of Congo (DRC) had the greatest number of TB cases (~314,000) in SADC, given its large population, with incidence ~317/100k. Tanzania and Zimbabwe have moderate incidence (around 195 and 204 per 100k respectively) and have made significant progress in reducing TB in recent years. At the lower end of the spectrum, the island nations (Mauritius, Seychelles) and Comoros report incidence under 40/100k, reflecting smaller epidemics and possibly better control in those settings.

Overall, eight SADC countries are counted among the 30 highest TB-burden countries globally. The heavy burden is underscored by the fact that SADC's TB incidence (population-weighted) is roughly 320 per 100,000, far above the global average (~134) and even the African regional average (~212). Southern Africa thus remains the epicenter of TB in Africa.

TB/HIV Co-infection:

The high overlap with HIV/AIDS dramatically worsens the TB burden. In several SADC countries, more than half of TB patients are co-infected with HIV. For example, South Africa's TB/HIV co-infection rate is 53%, and countries like Eswatini and Lesotho have historically reported TB/HIV co-infection rates of 60–70%. This syndemic means that TB is the leading cause of death among people living with HIV in the region. Fortunately, most co-infected patients are now started on antiretroviral therapy (ART) – e.g. 89% of HIV-positive TB patients in South Africa are on ART. Expansion of ART and TB preventive therapy for people with HIV has likely contributed to recent declines in TB incidence in high-HIV countries. Nonetheless, TB/HIV co-infection remains a major challenge: integrated TB/HIV services are critical to reduce mortality.

TB Mortality:

Encouragingly, TB deaths have been falling in many SADC states, though they remain unacceptably high. Regional data indicate that between 2016 and 2021, annual TB deaths declined by ~13% overall, and several countries achieved large reductions. Notably, Zambia, Tanzania, Eswatini, and Mozambique each reduced TB mortality by ~47–55% over this period – exceeding the End TB 2020 milestone of 35% reduction. In Mozambique, TB deaths dropped by half from 2015 to 2022. These gains reflect improved treatment outcomes and ART uptake. However, other countries saw slower progress, and Zimbabwe experienced an increase (~+86%) in TB deaths between 2016 and 2021, likely due to health system disruptions and data issues (Zimbabwe's spike underscores the need to investigate and address causes of persistently high mortality). In absolute terms, DRC, South Africa, and Tanzania each still suffer tens of thousands of TB deaths annually – for example, WHO estimated ~40,000 TB deaths in DRC, ~25,600 in Tanzania, and ~22,420 in South Africa in 2021. These three countries alone accounted for roughly 60–70% of all TB deaths in SADC. Such losses highlight that TB remains a public health crisis in the region, even as mortality trends improve overall.

Ongoing Transmission and Drug-Resistant TB:

Worryingly, over 85% of confirmed TB cases in SADC are new (not relapses), indicating ongoing active transmission in the community. This suggests that infection control and early case-finding need strengthening – many people are still contracting TB each year rather than the pool of existing cases simply being retreated. The region also contends with a high burden of drug-resistant TB. In 2021, SADC countries reported 63% of Africa's DR-TB cases. South Africa alone contributed more than half of SADC's DR-TB notifications. While new all-oral DR-TB treatment regimens (like shorter 6–9 month courses) are being rolled out, suboptimal DR-TB case finding and treatment success remain issues. On average about 70% of MDR-TB patients in SADC achieve treatment success (cure/completion), but some countries have much lower success (below 50%) due to high loss to follow-up and mortality during treatment. The variability of DR-TB regimens across countries (over 8 different regimen combinations were noted in the region) points to a need for standardized approaches. Overall, while most drug-sensitive TB patients (>80%) in SADC are successfully treated, the continued transmission and the DR-TB challenge mean that TB prevention and care requires sustained attention.

Health Systems and Social Determinants:

Several cross-cutting issues affect the TB burden in SADC. Funding shortfalls are prominent – domestic financing for TB is low in many countries, with heavy reliance on external donors. As of 2021, global TB funding was less than half of the amount needed to meet targets, and this funding gap is mirrored in SADC. Inadequate funding leads to gaps in frontline staffing, diagnostics, and outreach, hampering case detection. Additionally, poverty and catastrophic costs impede TB care. Many TB patients incur catastrophic health expenditures; Angola, for example, is flagged as a country where a particularly high share of families face catastrophic costs due to TB. This discourages care seeking and treatment completion. Furthermore, cross-border mobility (for work or displacement) means TB patients often struggle to continue treatment when they move – an issue in border areas and mining communities without harmonized referral systems.

Finally, the COVID-19 pandemic taught hard lessons:

it caused major setbacks in TB services, but also spurred innovations (like digital chest X-ray screening and integrated disease surveillance) and highlighted the importance of resilient health systems that can handle multiple concurrent epidemics. SADC countries are now working to "recover" TB programmes post-COVID, with some (e.g. Zambia, Mozambique) already bouncing back TB notifications to pre-pandemic levels through intensified case-finding as soon as lockdowns eased.

In summary, the SADC region faces a very high TB burden with wide intra-regional variation. There have been notable successes – incidence is falling in several high-burden countries and TB mortality is declining overall – yet Southern Africa's TB epidemic remains the most severe on the continent. The dual TB/HIV epidemic, pockets of MDR-TB, and systemic challenges like financing and cross-border control all require urgent, coordinated efforts.

Progress Toward TB Targets and Commitments

SADC Member States have made meaningful progress in the fight against TB, but meeting the End TB Strategy targets remains an ongoing challenge. The WHO End TB Strategy set interim milestones for 2020 (20% reduction in TB incidence rate and 35% reduction in TB deaths compared to 2015, and zero catastrophic costs for patients) and further targets for 2025 and 2030. Additionally, the 2018 UN High-Level Meeting (UNHLM) on TB established targets for the 2018–2022 period (such as treating 40 million TB patients and providing 30 million people with TB preventive treatment globally). Here we review SADC's performance against these goals:

Incidence Reduction:

By 2020, the End TB Strategy aimed for a 20% drop in TB incidence (new cases per 100k) from the 2015 baseline. SADC as a whole did not meet this milestone, but it achieved an overall ~13.3% reduction in incidence by 2024 (vs 2015). This represents slow but steady progress. Crucially, 5 SADC countries have surpassed the 20% incidence reduction mark: Botswana (32% decline), South Africa (31%), Eswatini (30%), Mozambique (27%), and Namibia (22% decline) between 2016 and 2024.

Trends:

- TB Incidence reduction has plateaued across the region
- Substantial gap persists between notified cases and the estimated TB burden
- The predominance of male notifications has remained consistent over time
- Overall, TPT coverage has improved across most Member States compared to the 2016 baseline.

These declines – particularly in Botswana, South Africa, and Eswatini – are significant achievements, reflecting strengthened TB/HIV services and possibly impact of

interventions like preventive therapy. Other countries had modest declines, while DRC and a few others saw incidence stagnate or even increase slightly, underlining the need for intensified efforts in those settings. Overall, the region's incidence is now declining again after the COVID-related rebound, but at only ~2% per year globally, far below the >10% annual declines needed to reach 2030 targets. SADC will need to greatly accelerate TB case finding and prevention to bend the curve downward more steeply.

Mortality Reduction:

The 2020 milestone was a 35% reduction in TB deaths (absolute number) vs 2015. Four SADC countries achieved or exceeded this: as noted, Zambia (~55% fewer TB deaths in 2024 vs 2016), Tanzania (53% reduction), Eswatini (≈48% reduction), and Mozambique (≈48% reduction) have far surpassed the 35% cut in mortality. These are very encouraging trends, indicating improvements in treatment outcomes and possibly better patient support. Most other reporting countries saw TB deaths drop between 2% and ~30%. The regional TB mortality decline is on track but still short of the 35% mark – additional efforts are needed, especially in countries like Zimbabwe (which saw an 86% increase in reported TB deaths, likely due to earlier under-estimation or healthcare disruptions). Moving toward the 2025 target (75% reduction in TB deaths) will require closing gaps in diagnosis and treatment. Notably, several SADC countries have reduced TB mortality faster than incidence, implying improved treatment success rates and care quality. This is a positive sign of health system impact.

Treatment Coverage and "Missing Cases":

A key end-target is to detect and treat 100% of TB cases (so that no one is left untreated). In 2024, about 70% of incident TB cases were notified globally. SADC has historically had large gaps between estimated incidence and notifications – for example, in 2020–2021 the region faced a 47% shortfall ("missing" cases) due to COVID-19 disruptions. Some recovery has occurred: by 2022, many countries' notifications rebounded. However, treatment coverage remains uneven. South Africa has improved notification dramatically (closing its gap from ~160k missing cases to 80k), and Mozambique and Tanzania have also made strides in case finding. Yet others like DRC still likely miss a large share of cases. Achieving universal coverage will require community TB screening, contact tracing, and scaled-up use of rapid diagnostics (e.g. GeneXpert) across the region. On a positive note, treatment success rates for drug-sensitive TB now average about 80–85% in SADC, approaching the global target of 90%. Maintaining high treatment success (through patient support, nutrition, and adherence programmes) is vital to reaching the mortality and incidence goals.

UNHLM 2018 Targets:

Globally, the 2018–2022 UNHLM targets were not fully met – for instance, only ~34 million of the targeted 40 million TB patients were treated in that period, and the 30 million preventive therapy target fell short. In SADC, countries aligned their national strategies with these targets. Many selected priority actions under UNHLM, such as expanding preventive treatment for people living with HIV and household contacts. By 2022, progress was mixed: for example, Malawi increased TB preventive therapy coverage and saw a 31% drop in TB incidence over 7 years. South Africa provided TB preventive therapy to over 500,000 people with HIV in recent years as part of UNHLM efforts. However, most SADC countries did not reach all UNHLM targets by 2022 – e.g., preventive therapy coverage for contacts and PLHIV remains well below 100% in many places, and no SADC country has yet conducted a national catastrophic cost survey showing zero TB-affected families facing catastrophic costs (the goal was 0% by 2020). On a positive note, political commitment has grown: all SADC Heads of State reaffirmed ending TB by 2030 at the UN General Assembly in September 2023, renewing global and regional momentum.

Regional Commitments:

Beyond global targets, SADC's own End TB Strategy (aligned with WHO's) and the SADC TB in Mining Declaration have specific indicators. The region has established a SADC TB scorecard to monitor the "top 10 TB indicators", which include TB incidence, TB/HIV indicators, treatment success, MDR-TB detection, preventive therapy, and financing. According to the SADC TB Report 2022, Member States made progress on many indicators but fell short on others. For instance, all countries now test >90% of TB patients for HIV and initiate ART for those co-infected, which is a success on the TB/HIV front. Conversely, domestic financing for TB (one of the indicators) remains very low – most SADC TB programmes rely over 50% on external funding. The use of rapid molecular diagnostics has expanded (several countries testing >50% of new patients with GeneXpert), but preventive therapy uptake (e.g. isoniazid preventive therapy for people with HIV or TB contacts) needs improvement in order to hit the 2025

Secure Sustainable Financing

Financial shortfalls pose the biggest threat to TB elimination. Member States should boost national funding for TB programmes to reduce over-reliance on donors. Governments should allocate greater budget resources for TB prevention and care – covering frontline health worker salaries, diagnostics, and medicines.

targets. SADC's 2022 regional TB report acknowledges these gaps and calls for accelerated efforts on the "top 10" indicators to get on track.

In summary, Southern Africa has made important strides:

TB incidence and deaths are trending downward in many high-burden countries, and some 2020 milestones (like the incidence drop in specific nations and >35% death reductions) have been met or exceeded. However, the region as a whole did not meet all 2020 End TB targets and remains off-track for 2030 without a drastic acceleration. The COVID-19 setback has largely been recouped in terms of case finding, but it underscored the fragility of progress. Urgent attention is needed to close the remaining gaps – finding the "missing" TB cases, funding the TB response sustainably, expanding preventive therapy, and ensuring no patient faces financial ruin due to TB. The next section outlines key recommendations to address these challenges and speed up progress toward ending TB in SADC.

Key Recommendations for Accelerating TB prevention and care in SADC

To achieve the End TB Strategy targets and the top 10 TB indicators, SADC Member States must address persistent gaps through bold policy and programmatic actions. Building on evidence and best practices (including the recommendations of the 2025 SADC TB Programme Managers and the 2023 SADC TB Report), the following priority recommendations for SADC governments and partners: Increase Domestic Financing & Sustainability, Strengthen Cross-Border TB prevention and care & Mining Sector Initiatives, Integrate gender-responsive approaches in TB prevention, treatment, and policy, Harmonize Treatment Protocols and Drug Procurement, Enhance TB Detection with Modern Diagnostics and Outreach, Bolster Data Systems and Monitoring, Prioritize TB Preventive Therapy and Vulnerable Populations, and Invest in TB Research and Innovation.

These recommendations align with the evidence and commitments already made by SADC leaders. By securing adequate financing, strengthening health systems, integrating gender-responsive approaches, and empowering regional collaboration, Southern African countries can overcome the remaining barriers in TB prevention and care. For instance, improved cross-border coordination will directly reduce loss-to-follow-up among migrant patients, and increased domestic funding will allow procurement of more diagnostic equipment and the hiring of community health workers, which in turn boosts case finding.

In conclusion, the SADC region stands at a pivotal moment in its TB response. The trends are moving in the right direction, but not quickly enough to meet the 2030 targets without concerted action. The COVID-19 pandemic, if anything, has demonstrated the importance of resilient health systems and regional solidarity. With strong political will – evidenced by recent declarations – and the implementation of the key strategies outlined above, SADC can accelerate progress to end TB.

Achieving the top 10 TB indicators (from incidence and mortality reductions to high treatment success and zero catastrophic costs) is possible through focused efforts. The lives of tens of thousands of people in Southern Africa are at stake each year; accelerating TB prevention and care is both an urgent public health imperative and a means to improve the quality of life and economic wellbeing across the region. By working together, investing in what works, and innovating, the SADC Member States can make the vision of a TB-free Southern Africa a reality in the coming decade.

THE LIGHT CONSORTIUM
Leaving no-one behInd: Transforming Gendered pathways to Health for TB (LIGHT)

Special focus on TB and Gender

2025 SADC TB and Gender commitments

Background

SADC secretariat and the LIGHT Consortium co-hosted the 2025 SADC TB Managers meeting at the Capital Empire Sandton, South Africa on 24th to 25th October.

LIGHT is a six-year cross-disciplinary global health research programme funded by UK aid, led by the Liverpool School of Tropical Medicine working with partners in Nigeria, Kenya, Malawi, Uganda and the UK. LIGHT is generating new evidence to inform and strengthen policy and implementation of gender responsive TB programming to reduce TB transmission, TB morbidity and mortality and associated catastrophic costs ensuring that no one is left behind in ending this preventable and treatable disease.

Globally and in Africa, TB disproportionately affects men due to gender norms and social behaviours, leading to greater exposure and less timely diagnosis and treatment. Most new infections in men, women, and children are attributed to transmission from men. LIGHT aims to inform gender-responsive TB policy and programming to address these gaps.

At the annual review meeting, the LIGHT Consortium presented research findings showing higher TB infection and exposure in males from adolescence onwards, with nearly two-thirds of global TB transmission originating from men. Structural and social determinants—such as smoking, alcohol use, and incarceration—further contribute to these disparities. LIGHT identified gender gaps in TB care cascades in countries like Nigeria and Kenya, including lower screening, testing, and treatment completion rates among men and insufficient sex-disaggregated data systems.

To address these challenges, LIGHT co-designed and evaluated gender-responsive interventions, including community-based TB screening in male-dominated spaces, digital X-ray screening, stigma-reduction campaigns, and male-friendly health services. Modelling showed that gender responsive strategies could significantly reduce TB incidence and mortality for men, women, and children by 2035. Participatory research with affected communities further underscored the need for inclusive, person-centred approaches.

Member states reflections on TB and Gender

Gender disparities in TB epidemiology: Men are disproportionately affected by TB, with higher prevalence and notification rates. Despite this, fewer men are identified as presumptive cases and tested for TB, and they experience poorer treatment outcomes compared to women.

Gender-responsive interventions are essential to address these disparities and accelerate the End TB goals.

Data disaggregation in TB care cascade: Understanding gender dynamics in TB programming is crucial. While most member states can disaggregate data by sex at the notification stage, many struggle to do so at the screening, diagnosis, and treatment outcome levels. This limitation hinders the development of targeted interventions. Addressing these gaps is essential for effective TB prevention and care and achieving gender equity in health outcomes.

Inclusion of TB and gender in policy documents: Some member states have implemented interventions targeting men, such as screening for TB in mines, male prisons, and soccer tournaments, and carried out Community, Rights, and Gender (CRG) Assessments. However, the inclusion of gender-responsive programming in TB policy documents remains limited. Although some member states have incorporated TB and gender considerations into their National Strategic Plans, many still lack gender-responsive programming in their TB policy documents and guidelines. This gap underscores the need for more comprehensive and inclusive policies to address the unique challenges faced by different genders in TB prevention and care efforts.

The SADC strategic plan for Tuberculosis Control 2025-2030 aims to provide strategic leadership, expertise, and coordination in delivering high-quality, evidence-based TB interventions, strengthening health systems, and promoting universal access, equity, and gender responsiveness to the health threat in the SADC region. However, no gender-responsive strategies have been outlined.

SADC Member states commitments on TB and Gender

Member states reached a consensus to integrate gender-responsive approaches in TB prevention, treatment, and policy within the Southern African Development Community. The key strategies are:

I. Policy and Strategic Integration

- Integrate gender-responsive priorities within National Strategic Plans for TB, aligned with the SADC TB Strategy (2024) and the End TB Strategy.
- Institutionalize routine sex- and age-disaggregated data collection, analysis, and reporting across the TB prevention and care cascade.
- Identify a Gender focal person in the NTP to coordinate policy implementation and monitoring.

II. Programmatic Implementation

- Review the Community, Rights and Gender (CRG) assessments and extract the recommendations for implementation.
- Scale up gender-tailored models of care addressing men's access barriers and women's vulnerabilities — including workplace, community, and faith-based screening initiatives.
- Embed gender, human-rights, and stigma-reduction modules in national TB training curricula.
- Strengthen community and civil-society engagement, ensuring affected men, women, and youth participate in the design and monitoring of TB interventions.

III. Financing and Resource Mobilization

- Include gender-responsive interventions, indicators, and budgets in Global Fund grant writing, and other donor funding requests.
- Allocate a defined proportion of domestic TB resources to gender-responsive programming and community engagement activities.
- Lobby for more domestic resources.
- Engage the TB caucus and parliamentarians on TB and Gender advocacy.

IV. Accountability and Multisectoral Action

- Develop national TB- and Gender scorecards to track commitments, funding, and progress annually at the TB managers meeting.
- Strengthen collaboration with ministries of gender, labour, education, and justice to address social and structural determinants of TB.

V. Regional Cooperation and Follow-up

- Include a recommendation on TB and Gender in the SADC ministers' meeting report.
- Incorporate TB and Gender strategic interventions during the reprioritisation of the SADC TB strategic plan (2025-2030).
- Review progress and update commitments during the 2026 SADC TB Managers Meeting, ensuring accountability through the annual SADC TB Report.

The 2023 United Nations high-level meeting on TB reaffirmed global commitments to a people-centred, community-based and gender-responsive TB response.

Background

About SADC

The Southern African Development Community (SADC) is a regional body comprising 16 Member States: Angola, Botswana, Comoros, the Democratic Republic of the Congo (DR Congo), Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia, and Zimbabwe. Collectively, SADC represents an estimated population of 417 million people and spans an area of approximately 9.67 million square kilometers.

SADC's vision is "a common future within a regional community that ensures economic well-being, improved standards of living and quality of life, freedom, social justice, and security for the people of Southern Africa." Its mission is "to promote sustainable and equitable economic growth and socio-economic development through efficient productive systems, deeper cooperation and integration, good governance, and lasting peace and security, enabling the region to emerge as a competitive and effective player in the global economy."

To achieve this mission, SADC adheres to core principles, including:

- Sovereign equality of all Member States
- Solidarity, peace, and security
- Human rights, democracy, and the rule of law
- Equity, balance, and mutual benefit
- Peaceful resolution of disputes

The organization's primary role is to coordinate and implement regional programmes and activities that advance integration and development across Member States.

Recognizing that a healthy population is a cornerstone of economic and social progress, SADC addresses health issues through its Directorate of Social and Human Capital Development.

This report provides an overview of the tuberculosis (TB) burden in the SADC region and assesses progress made by Member States toward meeting regional and global TB targets and commitments. It reviews achievements up to the end of 2024, aligned with the Global End TB Strategy pillars, which aim to eliminate TB by 2030. The report serves as a monitoring and decision-making tool for SADC Ministers of Health, offering evidence to guide strategies for strengthening TB responses across the region. Additionally, it presents recommendations on priority actions for Member States to accelerate progress toward achieving the top 10 TB indicators.

SADC Health Context

SADC's current health strategies are anchored in Article 5 of the SADC Treaty, which defines the Community's common agenda. This agenda is operationalized through the SADC Regional Indicative Strategic Development Plan (RISDP), currently covering the period 2020–2030.

Under RISDP 2020–2030, Pillar 3: Social and Human Capital Development addresses the health sector. The regional tuberculosis (TB) response aligns with Pillar 3's strategic objective:

"Strengthened and harmonized health systems for the provision of standardized and accessible health services to all citizens and addressing threats caused by health pandemics."

This objective is supported by two key outcomes:

- Improved, accessible, and responsive regional health systems
- Enhanced investment in nutrition to address all forms of malnutrition

In addition, SADC Member States' TB response is guided by the Protocol on Health in the Southern African Development Community, which promotes cooperation among Member States in priority health areas. At the SADC Secretariat, the Directorate of Social and Human Development coordinates social and health development initiatives, including TB programmes.

TB in SADC Region

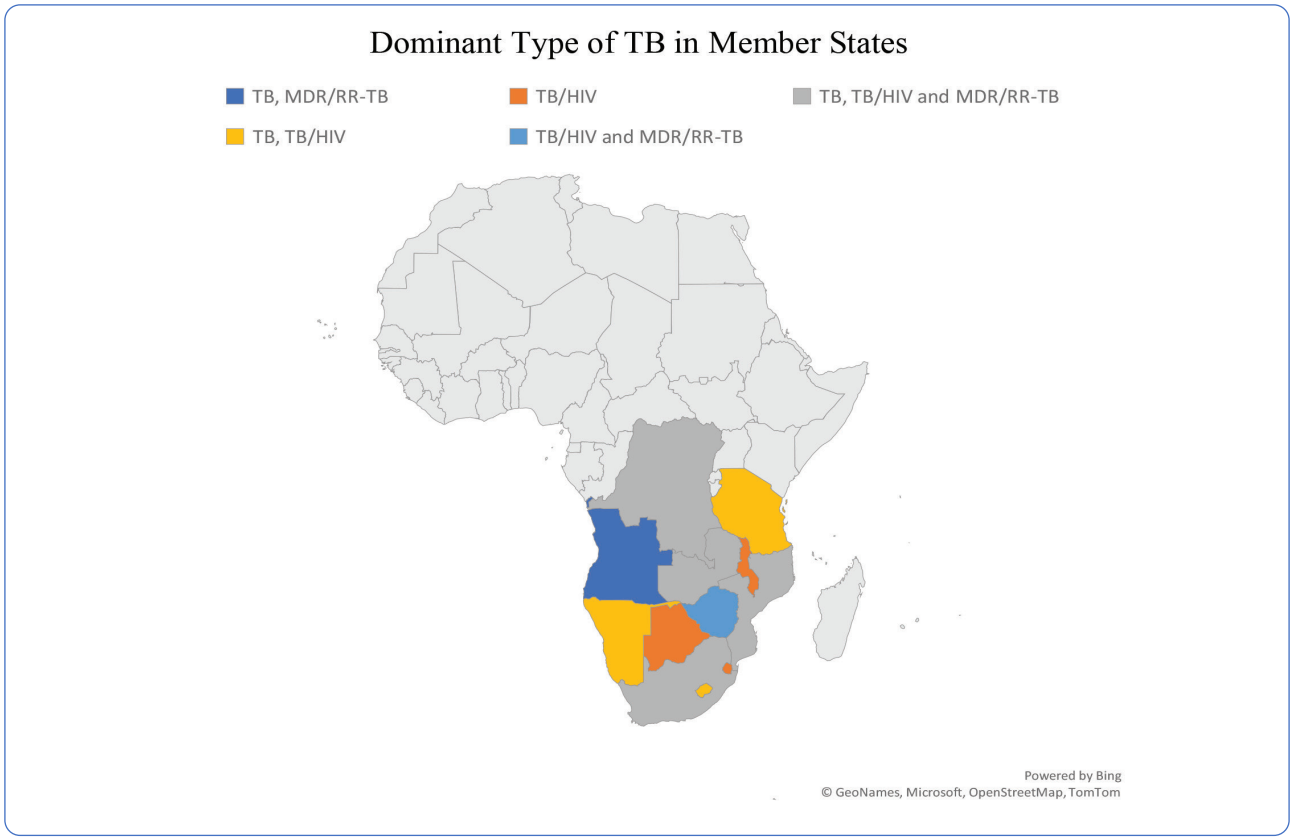
Tuberculosis (TB) remains one of the leading causes of death from a single infectious agent, surpassing HIV. Ending TB by 2030 is a key health target under the United Nations Sustainable Development Goals (SDGs).

According to the Global TB Report 2024, an estimated 10.6 million people developed TB globally in 2024, marking a 2.8% increase from 10.3 million in 2021. The TB incidence rate rose by 3.6% between 2020 and 2021, reversing a two-decade trend of approximately 2% annual decline. This setback underscores the impact of COVID-19-related disruptions to essential TB and broader health services.

At the regional level, Africa accounted for 22.7% of global TB cases in 2024—the second highest after South-East Asia (48%). Within Africa, eight SADC Member States are classified among the global high TB burden countries, while ten countries face a high TB/HIV co-infection burden, and six countries are listed among those with a high burden of multidrug-resistant or rifampicin-resistant TB (MDR/RR-TB).

Conversely, Mauritius, Comoros, Seychelles, and Madagascar report low TB incidence rates and are not included among the global top 30 high TB burden countries.

Figure 1: Dominant type of TB per SADC member State, 2024



TB prevention and care in the SADC Region and Global Commitments

SADC Member States have aligned the TB response with the global, continental and regional commitments as follows:

Global Commitments

1. **The United Nations Sustainable Development Goal:** The TB specific target is "By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases".
2. **The WHO End TB Strategy 2015-2035:** The goal of this strategy is to "End the global TB epidemic". Member States TB responses are aligned to three pillars of this strategy: a) Integrated, patient-centred TB care and prevention; b) Bold policies and

supportive systems; and c) Intensified research and innovation.

3. **The strategy sets three high-level indicators and related targets for 2030:** linked to the SDGs – and for 2035, and milestones to monitor progress for 2020 and 2025. The three high level indicators and targets are shown in the table below. SADC Member states are committed to achieving the 2025 TB milestones.

Table 1: SDG Commitments on TB , 2020, 2025, 2020 and 2035 Targets

Indicators	Milestones		Targets	
Year	**2020**	**2025**	**2030**	**2035**
Percentage reduction in the number of TB deaths	35%	75%	90%	95%
Percentage reduction in the number of TB incidence rate	20%	50%	80%	95%
Percentage of TB-infected households facing catastrophic costs due to TB		0%	0%	0%

4. **Global Plan to End TB 2023-2030:** The Stop-TB Partnership has developed a Global Plan to End TB 2023-2030 building on the previous plan that covered the period 2018-2022. The plan sets out strategies for scaling up of TB diagnosis and care, and TB prevention; strengthening of partnerships communities and private sector; ending TB through universal health coverage, pandemic preparedness and socio-economic actions; and lastly promoting human rights and gender and eliminating TB related stigma among other strategies. This plan sets out the global actions to reach the milestones and targets set out in the End TB Strategy and the UN High Level Meeting targets for TB.

5. **United Nations High-Level Meeting (UNHLM) on TB:** A second meeting was held in 2023 and endorsed an ambitious political declaration to accelerate progress towards the End TB targets for the period of 2023 - 2027. SADC Member States, in solidarity with other countries globally, are implementing actions towards achievement of the UNHLM targets.

Continental Commitments

1. Resolution AFR/RC 55/RS, adopted by the WHO Regional Committee for Africa at its 55th session in Maputo, Mozambique in 2005, declared TB an emergency, and called upon Member States to declare TB an emergency in their countries.

2. The Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services of 2001, which called for the prevention of multidrug-resistant TB, and for universal access to prevention, treatment, care and support for TB. In 2013 the African Union Heads of States signed the Declaration called Abuja actions towards the elimination of HIV and AIDS, tuberculosis and malaria in Africa by 2030. This declaration calls for further scale up of activities to eliminate the three diseases.

3. The African Continental End TB Accountability Framework for Action and the End TB Scorecard initiative.

4. African Leaders Meeting Declaration (ALM) on health financing. This declaration committed Africa Leaders towards increasing domestic health financing to close the funding gap as one strategy for achieving universal health coverage. The declaration also committed leaders to improving coordination with and investment by private sector players in health.

5. In 2012, Head of States of the SADC member states signed a declaration for TB prevention and care in the mining sector, the declaration reaffirms member states their commitments to reduce the burden of TB and occupational lung diseases associated with mining exploration. The result of this declaration is the SADC regional project for TB in the mining sector (TIMS) 2016 – 2024.

Regional Commitments

1. SADC Minimum Standards for Child and Adolescent HIV, TB and Malaria Continuum of Care and Support (2013-2017)

2. Harmonized Minimum Standards for the Prevention, Treatment, and Management of Tuberculosis in the SADC region.

3. The Declaration on Tuberculosis in the Mining Sector through which SADC Member States reaffirms their commitment to improving practices and standards of environmental health, health, and safety in the mining sector as a way of addressing TB in the mining sector according to provisions of SADC Protocols for Mining and Health. The protocol

lays out priority areas for addressing TB in the mining sector in the region.

Methodology

This report was developed using data submitted by SADC Member States' National Tuberculosis Programmes (NTP), consolidated and analyzed to assess trends in TB response at both country and regional levels. The analysis was guided by the SADC TB Strategy Monitoring and Evaluation (M&E) Framework.

Data was sourced from the SADC TB Dashboard, representing submissions for the 2024 TB cohort from all Member States. Compilation was undertaken by selected members of the NTP Managers Committee within the SADC End TB Committee. Validation of the dataset was conducted by NTP Managers from each Member State during meeting in Johannesburg (Oct 23-24, 2025).

The SADC Annual TB Report 2024 was structured to provide a comprehensive overview of the TB program's status, as outlined in the SADC Strategic Plan for Tuberculosis Control 2020–2024. The report compares 2023 performance against annual targets and baseline indicators established in 2015. To ensure systematic tracking, results are organized according to the four pillars of the Strategic Plan, which align with the WHO End TB Strategy, with an additional pillar addressing regional coordination of TB response.

Performance was assessed for individual Member States and aggregated at the regional level using indicators defined in the SADC TB M&E Framework. These indicators measure contributions to each strategic pillar, enabling evaluation of the collective impact of the Strategic Plan on the TB epidemic. The ultimate goal is to accelerate progress toward ending TB as a public health threat in the SADC region.

Progress made by SADC Member States towards achieving the SADC End-TB Strategy Targets

This section presents the state of TB burden in the SADC region and progress made towards achieving the End-TB Strategy milestones and targets. It shows the overall performance of the SADC region and individual SADC Member States in TB response.

The table below highlights the status of implementation of the recommendations by the SADC Health Ministers, that were made in the SADC Health Minister meeting of 2023, in Angola.

Status of Implementation of the 2023 SADC Health Ministers Forum Recommendations

	Recommendation	Status	Comments
1	Regarding the low coverage of the WHO recommended first line tools for TB diagnosis, Member States should consider increasing investment to and strengthening the TB laboratory network especially for identification of drug-resistant TB.		In the 2023 report, only six countries had 80% or more of their patients tested using the Molecular WHO-Recommended TB Diagnostic tools (mWRDS). With Angola and the Comoros reporting on the use of mWRDS for the 1st time.
2	Some of the SADC Member States have not undertaken key studies that help to improve the TB programme such as drug resistance and catastrophic costs surveys and community rights and gender assessments. In view of this, Member States should consider allocating resources to undertake these key studies to provide evidence required for decision making and for planning.		Significant progress has been made in key research areas, with 9 out of the 16 member states having conducted and disseminated patient cost surveys. Additionally, there is good traction in conducting TB prevalence and drug-resistant surveys
3	Although efforts to prevent TB have been improved especially among People Living with HIV, TB prevention among children, people with chronic diseases and those exposed to TB due to the nature of their occupation is low. Member States should consider implementing fully the WHO guidelines on TB Preventive Therapy.		Notable data gaps on TPT use in high-risk populations other than PLHIV and children
4	It is encouraging that Member States have started reporting on TB in the mining sector. However, the reporting is not complete, does not cover all indicators while some countries are not yet reporting. Member States are requested to improve the reporting on TB in the mines indicators for the next report.		M&E frameworks have not made provisions for robust data collection of data about TB in the mining sector particularly on occupational lung disease
5	To address the determinants of TB, WHO and the UN High Level Meeting on TB recommended that countries establish a multi-sectoral accountability framework. Progress in establishing this framework is slow. Member States should establish the Multi-sectoral Accountability Frameworks to better coordinate all sectors that can contribute to TB prevention and treatment		Member states have developed the MAF-TB frameworks, including action plans.

Key

- Done with optimal coverage
- Good progress
- Not done or suboptimal progress

Pillar

01

Integrated Patient-Centred TB Care and Prevention

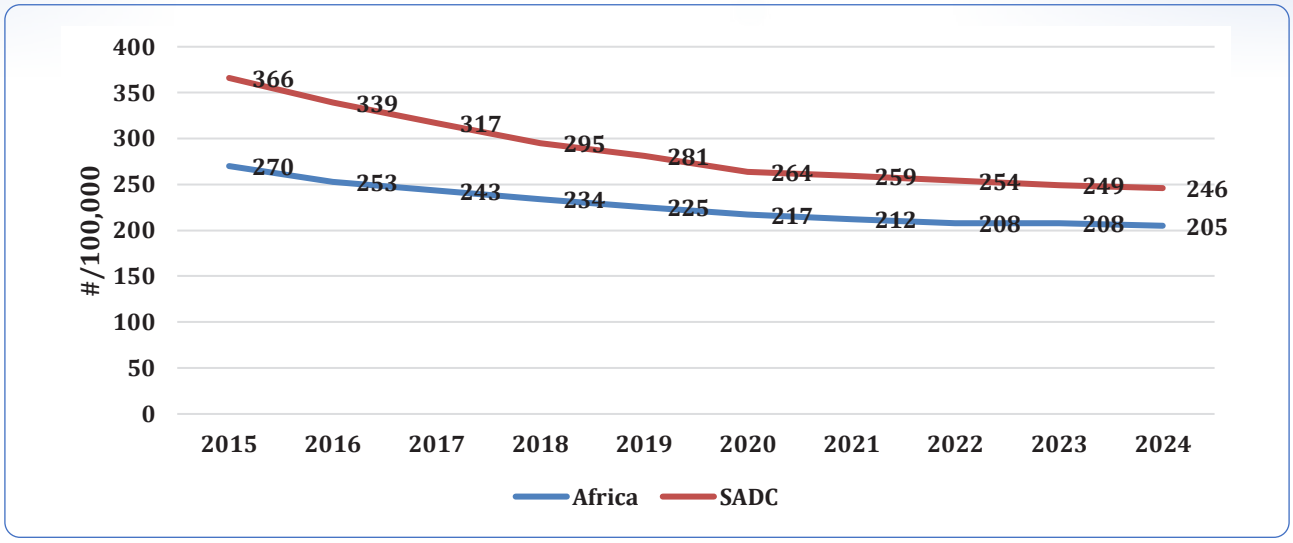
This section covers progress on TB incidence, prevention, and treatment across SADC Member States

TB Incidence

Progress Toward TB Incidence Reduction Targets

SADC Member States have collectively committed to achieving a 50% reduction in tuberculosis (TB) incidence by 2025. Despite notable advancements in TB prevention and care, the regional incidence remains substantially elevated. As of the latest reporting period, the aggregated TB incidence across SADC countries is 258 cases per 100,000 population, representing a 26% reduction from the 2016 baseline of 348 cases per 100,000 population. This progress, while significant, falls short of the targeted 50% reduction. Trend analysis indicates that the decline in TB incidence within the SADC region—and across the broader African continent—has plateaued. This stagnation suggests that existing interventions may have reached their operational limits, highlighting the need for intensified, innovative strategies to accelerate the downward trajectory of TB incidence and achieve the 2025 targets.

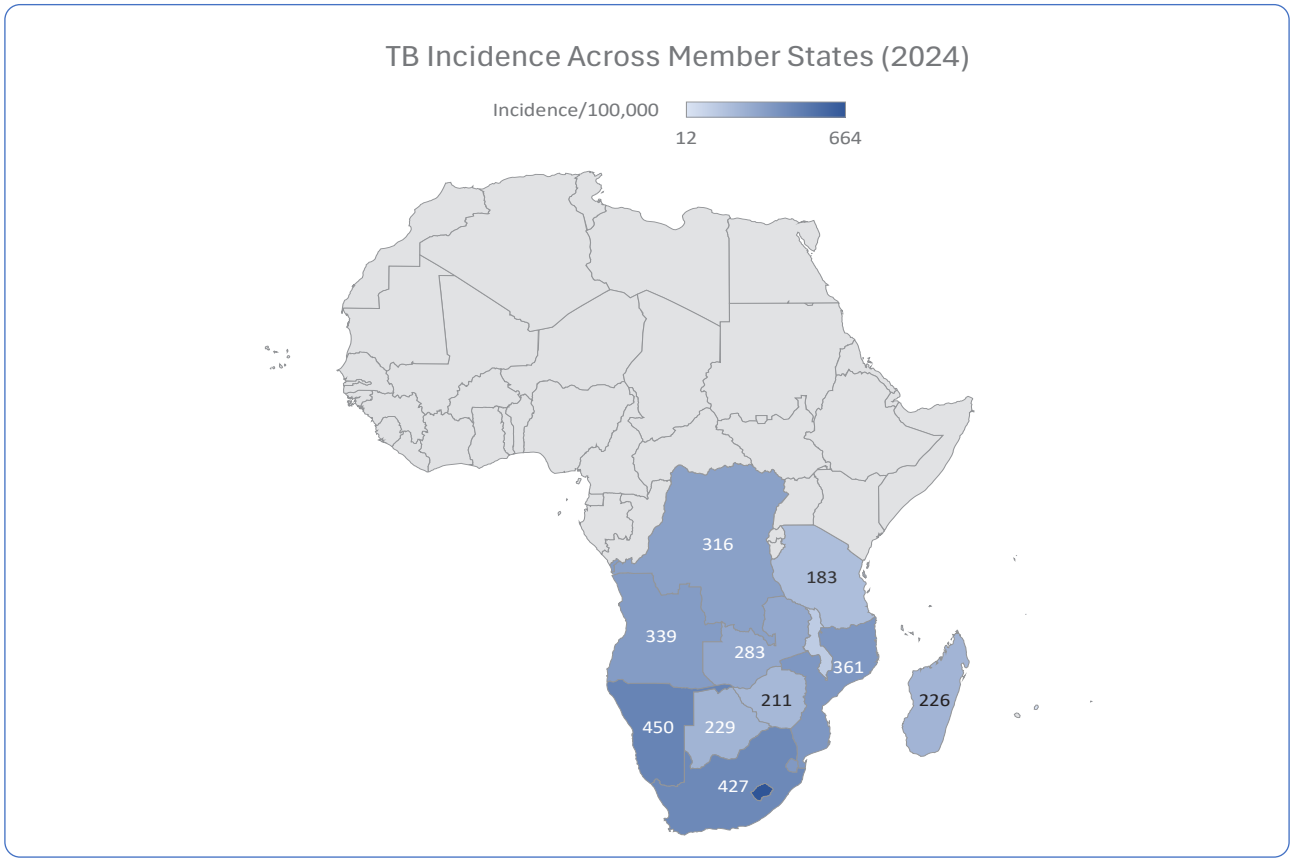
Figure 2: TB incidence, Africa Vs SADC Member States, 2016-2024



The spatial distribution of tuberculosis (TB) incidence across the SADC region is depicted in the map below. Lesotho exhibits the highest incidence rate at 664 cases per 100,000 population, followed by Namibia (450 per 100,000) and South Africa (427 per 100,000). Using 2015 as the baseline year, only South Africa (57%) and Zambia (53%) have achieved the 50% reduction target for TB incidence set for 2025. Eswatini (46%), Malawi (40%), and Tanzania (40%) demonstrate substantial progress and remain on track to meet the target.

Conversely, certain Member States exhibit an upward trend in TB incidence. Seychelles recorded an increase from an estimated 9 cases in 2015 to 19 cases in 2023, while Madagascar reported a rise from 213 per 100,000 population in 2015 to 226 per 100,000 population in 2023.

Figure 3: TB Incidence Across SADC Member States



A detailed summary of TB incidence across all SADC Member States from 2015 (baseline) to 2024 is presented in Table 2.

Table 2: TB incidence trends per 100,000, all forms 2016-2024

Country	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Angola	366	362	359	355	351	333	322	322	339	492
Botswana	356	326	300	275	250	235	221	210	229	238
Comoros	35	34	35	35	35	35	35	35	35	42
DRC	324	323	322	321	320	319	318	317	316	314
Eswatini	648	537	502	441	363	319	348	325	350	340
Lesotho	780	724	665	611	654	592	614	661	664	651
Madagascar	213	253	253	233	233	233	233	233	226	218
Malawi	197	176	162	153	146	141	132	125	119	119
Mauritius	13	12	12	13	12	12	12	12	12	14
Mozambique	361	551	551	551	361	368	361	361	361	361
Namibia	639	604	565	524	486	460	457	450	450	435
Seychelles	9	14	18	17	15	10	10	15	19	17
South Africa	988	781	567	520	615	554	513	468	427	410
Tanzania	306	287	269	269	253	222	208	195	183	175
Zambia	391	376	361	346	333	319	307	295	283	270
Zimbabwe	242	208	221	210	199	193	190	204	211	205
SADC	367	348	323	305	289	272	268	264	258	246

TB Mortality in SADC Region

Tuberculosis Mortality Trends in SADC Member States

Most SADC Member States have recorded declines in TB-related mortality; however, Comoros is the only country that reported an increase, with mortality estimates rising by 30%. Among countries with reductions, declines range from 3% to 100%. Analysis of the data indicates that six Member States—Eswatini, Malawi, Mozambique, Seychelles, Tanzania, and Zambia—have achieved or remain on track to meet the 2025 End TB milestone of a 75% reduction in mortality relative to the 2015 baseline. Conversely, the remaining Member States are unlikely to meet the 2025 target based on current trajectories.

Notably, Angola, Botswana, Eswatini, Lesotho, Namibia, and South Africa exhibit the highest mortality estimates yet demonstrate minimal progress toward this indicator. These findings underscore the urgent need for targeted TB mortality studies to identify determinants of mortality and inform epidemiological estimates, as well as guide the implementation of corrective interventions.

Zimbabwe presents a unique case: after an initial 20% reduction in mortality, the trend reversed, resulting in only a 6% cumulative decline between 2015 and 2023. This reversal may be partially explained by Zimbabwe's reclassification—from a high TB/HIV burden country to a high MDR/RR-TB burden country—which likely contributes to the observed increase in mortality since the 2019 Global Tuberculosis Report.

By the end of 2024, the SADC region achieved a 37% reduction in TB-related mortality compared to 2015. While this represents significant progress, it remains insufficient to meet the 2025 Sustainable Development Goal (SDG) milestone. Accelerating progress will require scaling up high-impact interventions, including Tuberculosis Preventive Therapy (TPT), patient-friendly drug formulations, and patient-centered care models.

Table 3: Reduction in TB Mortality 2016-2024

Member States	Years										% reduction
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	
Angola	62	62	60	68	66	64	62	60	60	58	3%
Botswana	84	84	54	78	70	97	82	76	76	69	10%
Comoros	10	10	7	8	6	9	9	9	13	17	-30%
DRC	66	66	60	51	49	49	41	34	41	25	38%
Eswatini	199	163	153	127	86	75	85	79	77	31	61%
Lesotho	278	278	287	252	200	223	234	165	221	189	21%
Madagascar	50	52	50	48	44	48	43	40	39	30	22%
Malawi	68	57	45	43	37	36	39	28	23	11	66%
Mauritius	2	2	2	2	2	2	2	2	2	2	0%
Mozambique	194	189	163	145	37	40	43	29	29	4	85%
Namibia	146	145	131	126	107	104	110	98	98	65	33%
Seychelles	2.2	0	2,1	2,1	2	2	2	1	0	0	100%
South Africa	112	112	107	103	100	96	93	91	91	73	19%
Tanzania	104	98	86	67	55	45	40	27	27	8	74%
Zambia	108	103	106	102	86	81	40	27	24	6	78%
Zimbabwe	51	34	50	31	42	54	46	37	48	43	6%
SADC											37%

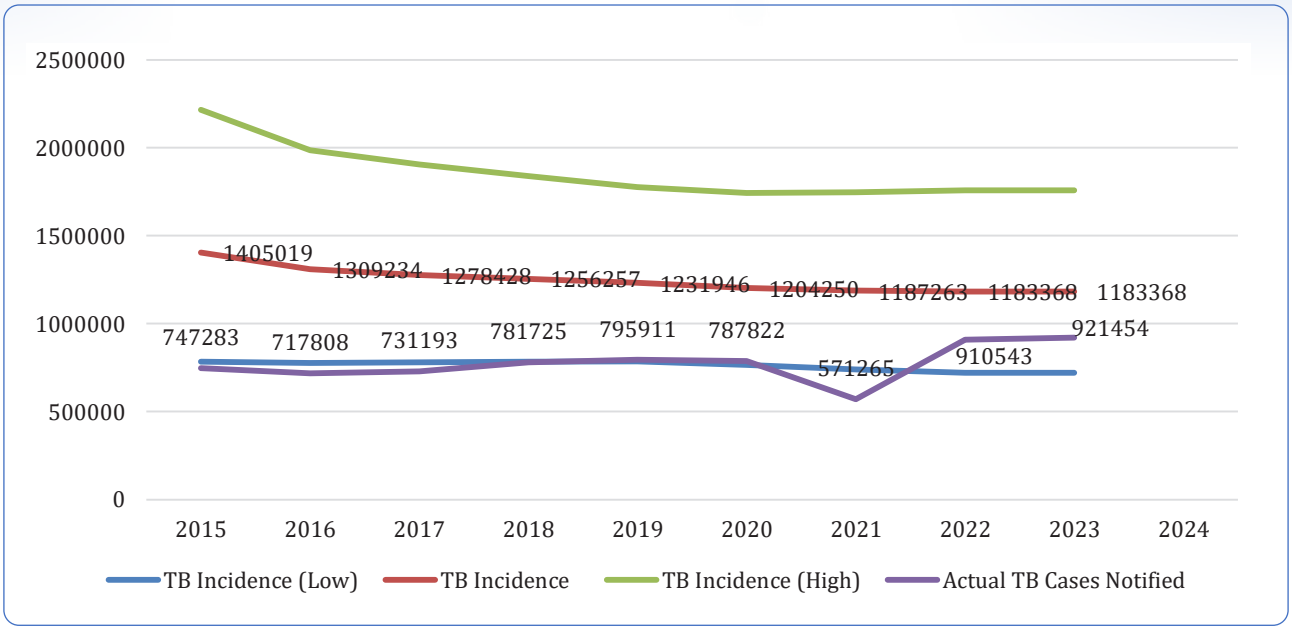
TB Case Notifications

Trends in Tuberculosis Notifications

The total number of reported tuberculosis (TB) cases in the SADC region has exhibited a sustained increase, rising from 747,283 cases in 2015 to 921,454 cases in 2024. Despite this upward trajectory, a substantial gap persists between notified cases and the estimated TB burden in the region. Reported notifications consistently fall at the lower bound of the estimated range, with only marginal improvements observed since 2021.

Following significant declines in notifications during 2019–2020 (-1.02%) and 2020–2021 (-27.49%), the region has demonstrated recovery. Between 2022 and 2023, a modest increase of 1.16% was recorded. This improvement is likely attributable to the implementation of effective recovery strategies by Member States, enhanced access to health services, and the adoption of advanced diagnostic technologies, including digital chest radiography.

Figure 3: TB incidence trends per 100,000; 2016-2024



Sex-Disaggregated Tuberculosis Notification Trends

Globally, tuberculosis (TB) disproportionately affects men compared to women. This pattern is mirrored in the SADC region, where in 2024, men accounted for 59% of all TB cases, while women represented 41%. The predominance of male notifications has remained consistent over time. Despite an overall increase in TB notifications, the number of cases among women declined by 2,278 between 2022 and 2023, signalling a potential gap in gender-responsive TB services. This trend underscores the need for enhanced interventions targeting women across all age groups, alongside systematic monitoring and corrective measures.

Analysis of country-level data reveals a sustained increase in TB notifications in five Member States—Mozambique, the Democratic Republic of the Congo, Madagascar, Tanzania, and Zambia—which collectively account for approximately 75% of regional notifications. While Mozambique, DRC, Madagascar, and Tanzania continue to exhibit upward trends from 2015 to 2023, Zambia's trajectory has begun to plateau, indicating the need for renewed efforts to maintain momentum and prevent stagnation.

Several SADC Member States have exhibited a downward trajectory in TB notifications since 2014. However, Eswatini, South Africa, Zimbabwe, and Lesotho have demonstrated an uptick in notifications between 2022 and 2023, relative to 2020. In contrast, Botswana has maintained a consistent decline in notifications since 2014, raising the question of whether this reflects a genuine reduction in TB burden. To validate this trend, a TB prevalence survey is recommended to accurately determine the current epidemiological status in Botswana.

Figure 4: TB case notification by gender; 2021-2024

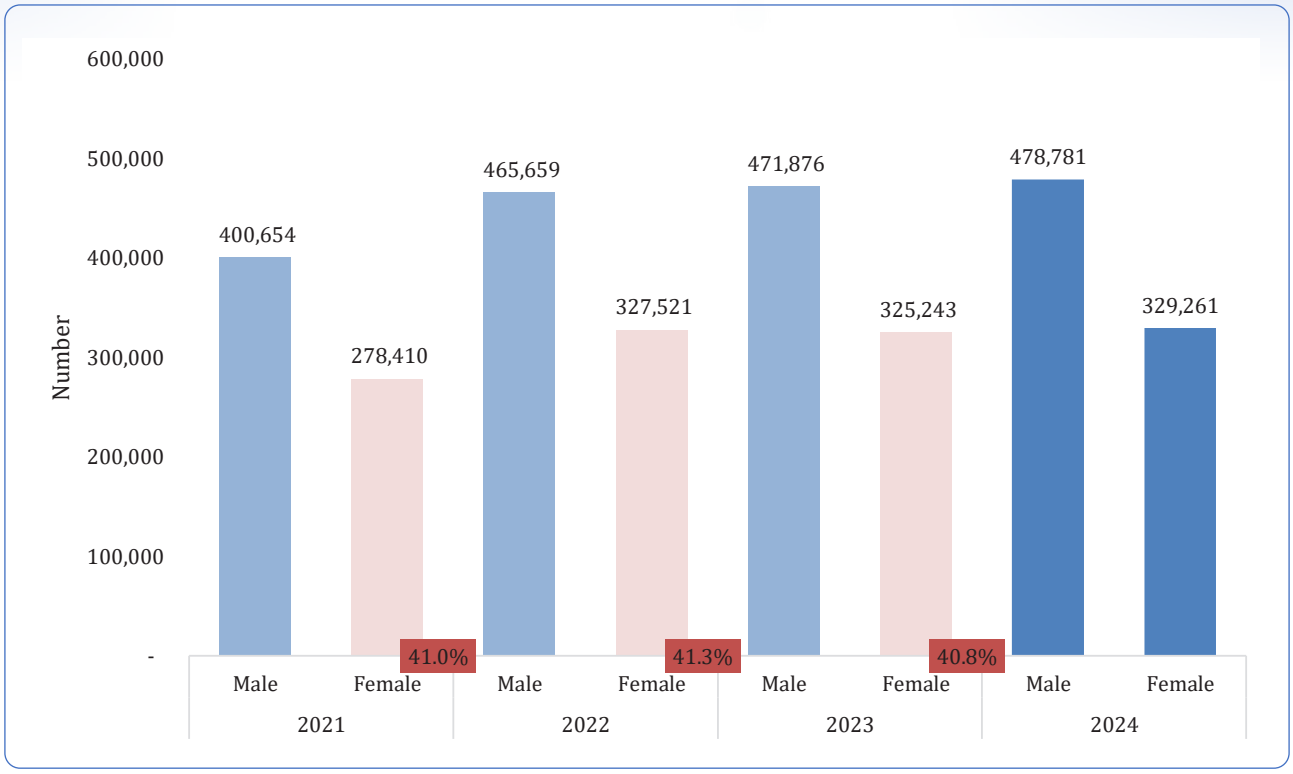
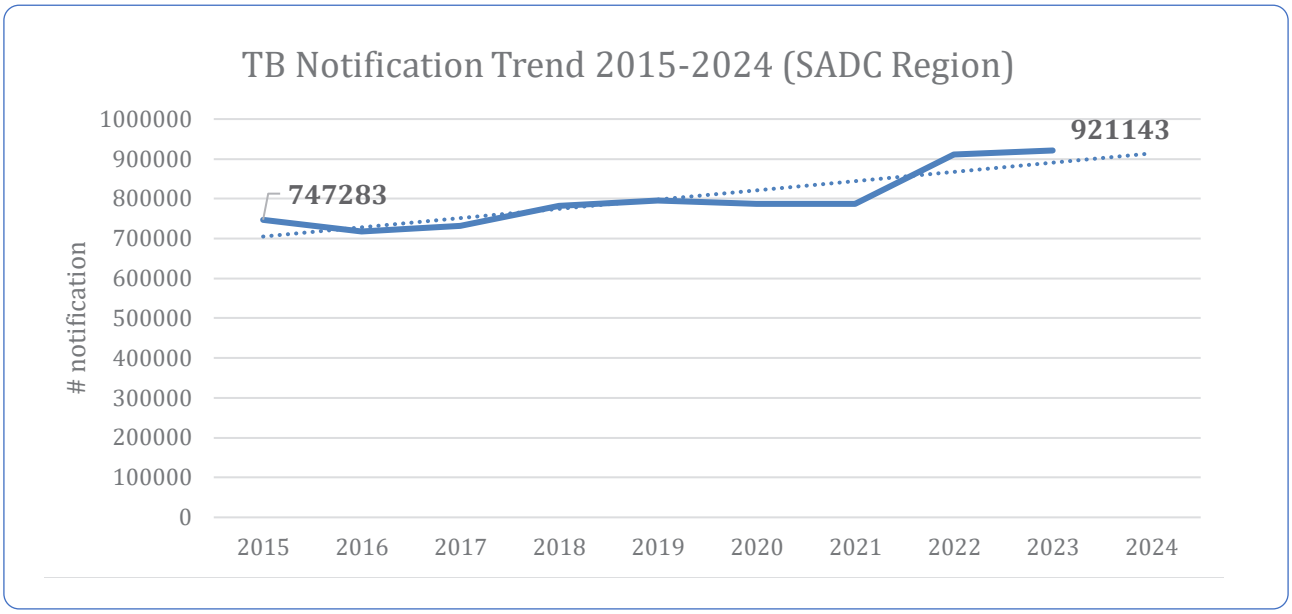


Figure 5: TB case notification trend; 2015-2024



At the regional level, TB notifications have continued to increase overall, despite declines in some Member States. The increase observed between 2022 and 2024 is modest compared to the growth recorded between 2021 and 2022. These findings underscore the need for intensified, coordinated interventions to accelerate progress in TB case detection and reporting across the SADC region.

TB Prevention

TB Preventive Therapy (TPT)

Tuberculosis Preventive Therapy is a critical intervention within the World Health Organization (WHO) End TB Strategy and is essential for achieving global TB elimination targets. Among individuals infected with

Mycobacterium tuberculosis, the estimated lifetime risk of progression to active TB disease is approximately 5–10%. This risk is markedly higher in children under five years of age and in individuals with compromised immune systems, such as those living with HIV.

At the second United Nations High-Level Meeting on TB (2018), Member States committed to providing TB preventive treatment to at least 45 million individuals during 2023–2027, including 15 million people living with HIV (PLHIV) and 30 million household contacts of TB patients. TPT remains one of the most effective strategies to reduce the risk of latent TB infection progressing to active disease, thereby contributing significantly to global TB prevention and care and elimination efforts.

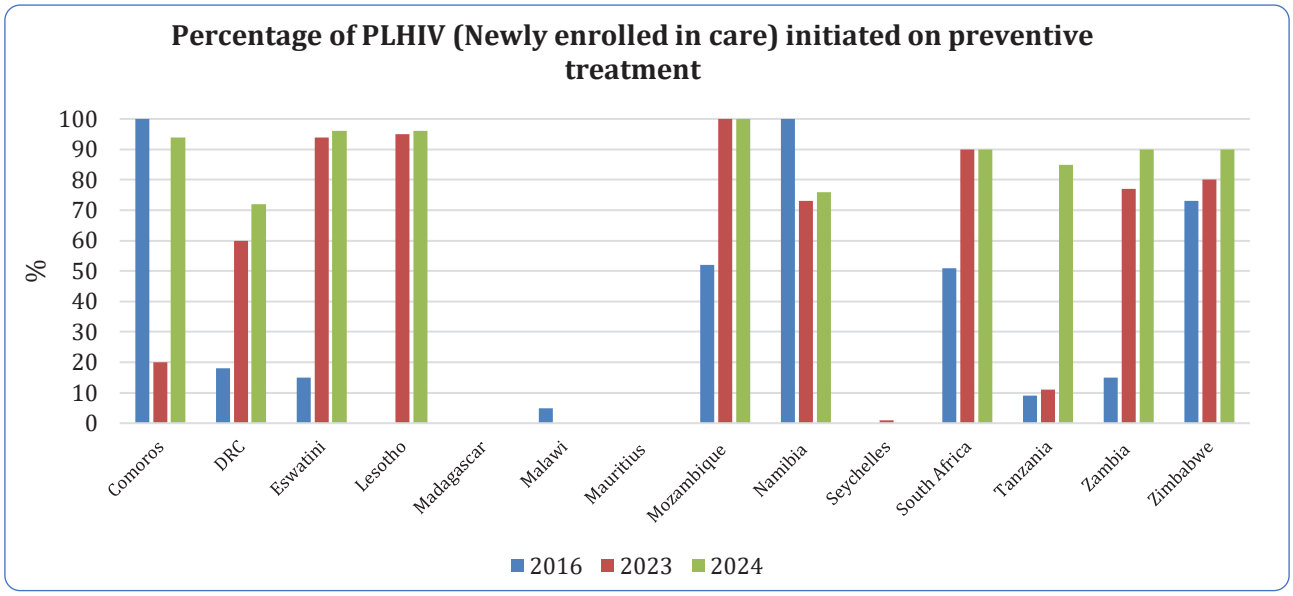
TB Preventive Therapy (TPT) for PLHIV

Coverage of Tuberculosis Preventive Therapy (TPT) Among PLHIV

The recommendation for Tuberculosis Preventive Treatment (TPT) for all people living with HIV (PLHIV) was first issued by the World Health Organization (WHO) in 2011, and all SADC Member States have adopted this guidance. Overall, TPT coverage has improved across most Member States compared to the 2016 baseline.

Currently, Comoros and Mozambique report 100% TPT coverage among newly diagnosed PLHIV. Significant progress has also been observed in Eswatini, Lesotho, and South Africa, each recording more than a 50% increase in coverage in 2023 compared to 2019, and all are approaching universal access. Continuous year-on-year improvements since 2016 have been documented in Democratic Republic of the Congo (DRC), Zambia, and Zimbabwe. Conversely, Namibia demonstrates a declining trend, with TPT coverage among eligible PLHIV decreasing by 27% in 2023 compared to 2016. These disparities highlight the need for targeted interventions to sustain and accelerate progress toward universal TPT coverage.

Figure 6: Percentage of HIV positive people (Newly enrolled in care) initiated on Preventive Treatment, 2024



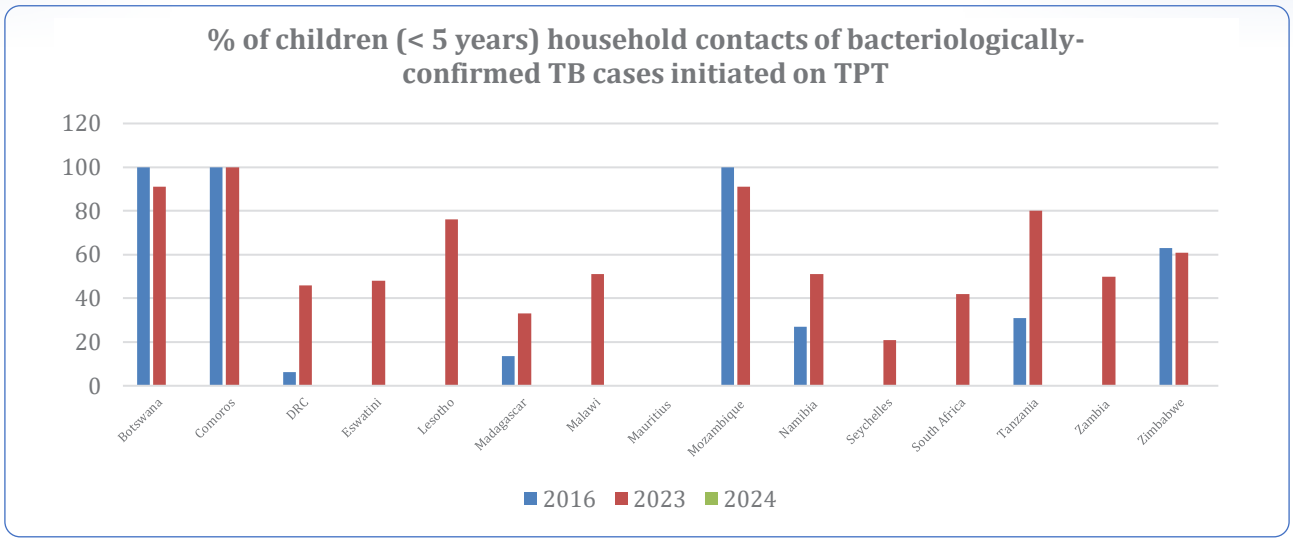
TPT for Children (<5) household contacts of bacteriologically confirmed TB cases

TPT Coverage Among Child Contacts (<5 Years)

According to WHO guidelines, all children under five years of age who are household contacts of TB patients should receive Tuberculosis Preventive Therapy (TPT). All SADC Member States prioritize this high-risk group in the programmatic management of TPT. However, data indicate that TPT coverage among child contacts remains suboptimal across the region.

Only Comoros has achieved the target for this indicator, while approximately 50% of Member States have surpassed the 50% coverage threshold. Encouraging upward trends are observed in Eswatini, Lesotho, Malawi, South Africa, and Zambia, where coverage among eligible children reached at least 70% by 2023. In contrast, progress in some countries has stagnated (e.g., Eswatini) or declined (e.g., Zimbabwe, Malawi, and Mozambique), signaling programmatic challenges that require urgent attention.

Figure 7: Percentage of Children (<5years) Household contacts of bacteriologically confirmed TB cases initiated on Preventive treatment, 2024



TB HIV Collaborative Activities

TB/HIV Co-infection and Collaborative Interventions

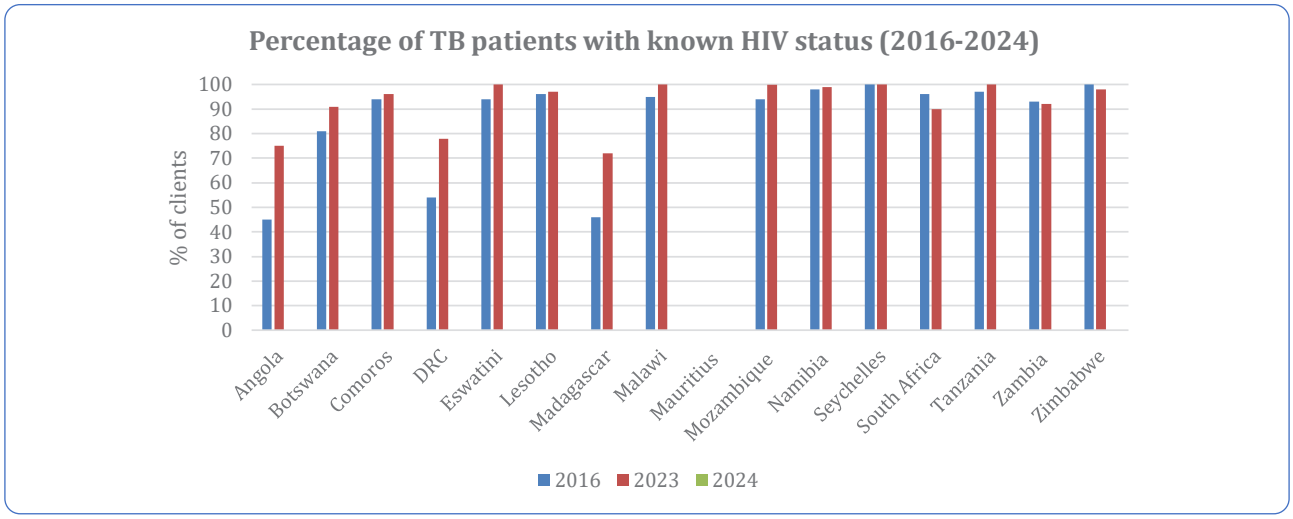
Despite ongoing HIV prevention efforts, the HIV burden in the SADC region remains substantial, with an estimated 13.4 million people living with HIV (PLHIV). All Member States have adopted the WHO Framework for TB/HIV Collaboration to strengthen the delivery of integrated TB and HIV services—an essential approach for addressing the dual burden of these diseases. Enhancing TB-HIV data collection and reporting continues to be a priority for regional TB prevention and care initiatives.

The TB/HIV cascade comprises three critical stages:

1. HIV testing for all TB patients to ensure status awareness.
2. Determination of TB-HIV co-infection rates, measured by the proportion of TB patients testing HIV-positive.
3. Initiation of antiretroviral therapy (ART) for HIV-positive TB patients to prevent TB progression and improve survival outcomes.

Figure 8 illustrates the extent of HIV testing among TB patients across the SADC region. Progress has been notable, with 9 out of 16 Member States achieving universal HIV testing for TB patients. Although Angola, Botswana, DRC, Madagascar, and South Africa remain below universal coverage, all have demonstrated consistent improvement, as evidenced by 2024 performance compared to 2016.

Figure 8: Percentage of TB patients with known HIV status, 2024

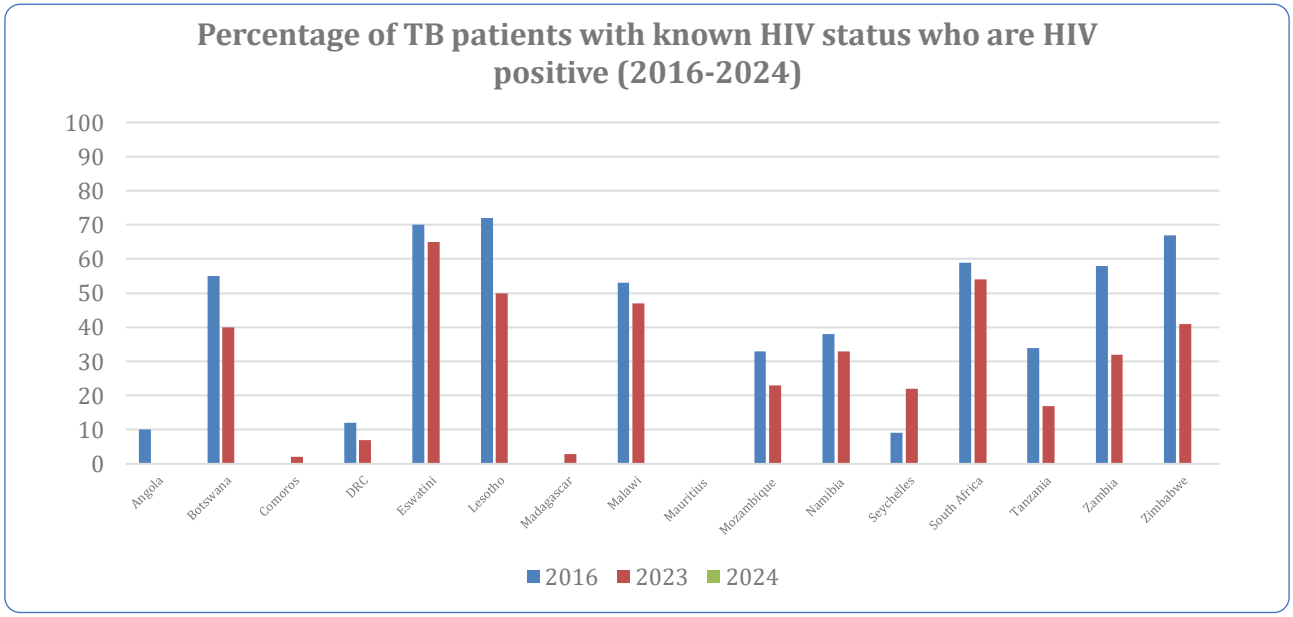


TB/HIV Co-infection Burden in the SADC Region

The SADC region bears a disproportionate share of the global HIV/AIDS epidemic, with its 16 Member States collectively hosting the largest population of individuals living with HIV. Given that HIV is a major comorbidity among TB patients, effective HIV management is critical for reducing TB-related mortality and improving treatment outcomes.

Figure 9 illustrates the extent of TB/HIV co-infection across SADC Member States. The region continues to face high TB/HIV co-infection rates, posing a significant challenge to TB prevention and care efforts. Currently, 11 SADC Member States are classified among the global top 30 high TB/HIV burden countries. Encouragingly, all Member States—except Madagascar and Seychelles—have achieved measurable reductions in HIV burden compared to the 2016 baseline. Countries such as Botswana, Lesotho, Zambia, and Zimbabwe recorded reductions exceeding 20% between 2016 and 2024.

Figure 9: Percentage of patients with known HIV status who are HIV positive, 2024



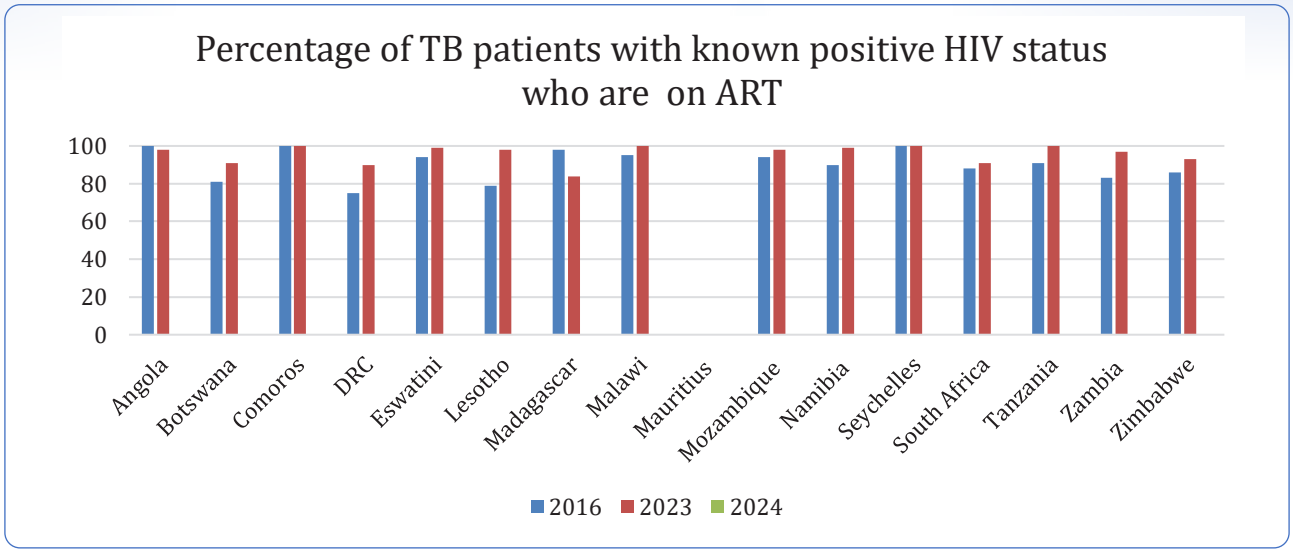
Despite these gains, five Member States still report TB/HIV co-infection rates above 50%, namely Eswatini, Lesotho, South Africa, and Zimbabwe. These persistently high rates underscore the need for intensified integrated TB/HIV interventions, including universal HIV testing for TB patients, early ART initiation, and strengthened programmatic collaboration.

Access to Antiretroviral Therapy (ART) Among TB/HIV Patients

Prompt initiation of antiretroviral therapy (ART) for TB patients testing HIV-positive is a critical intervention for reducing morbidity and mortality associated with TB/HIV co-infection. Through strengthened collaborative activities, SADC Member States have significantly expanded access to ART for TB patients.

By 2023, nine Member States achieved universal ART coverage for TB patients living with HIV, while an additional five countries surpassed the 90% coverage threshold. Madagascar remains below 90% coverage; however, notable progress has been observed, with ART uptake increasing from 41% in 2020 to 84% in 2023.

Figure 10: Percentage of TB patients with known HIV positive status who are on ART, 2024



TB Treatment Outcomes

Treatment success rates (new and relapsed cases)

Treatment Success Rates in SADC Member States

Figure 11 presents the comparison of treatment success rates for all notified TB cases in 2024 against the 2015 baseline. The SADC Strategic Plan for Tuberculosis Control (2020–2024) set a target of 90% treatment success across Member States. Four countries achieved this benchmark in 2024:

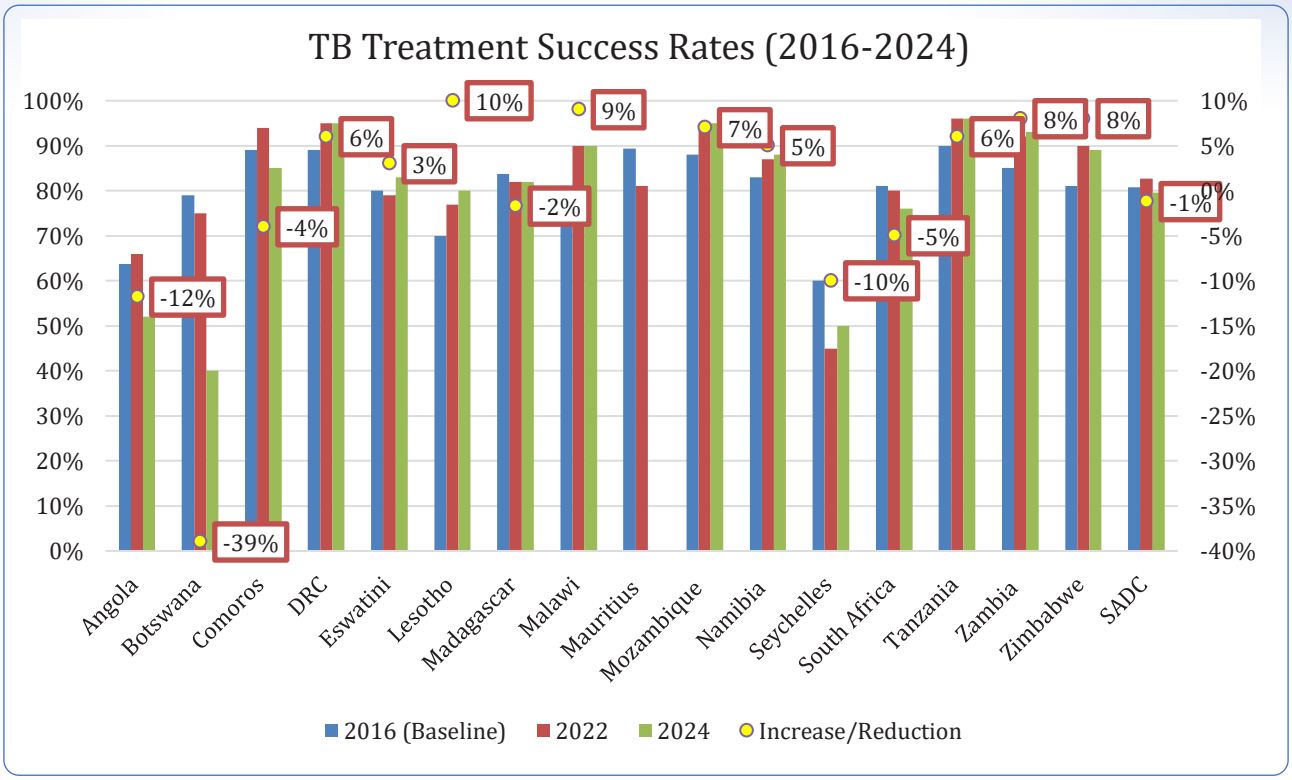
- Democratic Republic of Congo (95%)
- Malawi (90%)
- Tanzania (96%)
- Zambia (93%)

Conversely, five countries recorded declines in treatment success relative to 2015:

- Angola (-12%)
- Botswana (-39%)
- Comoros (-4%)
- Madagascar (-2%)
- South Africa (-5%)

The most substantial improvements were observed in Lesotho (+10%) and Malawi (+9%), while other countries reported moderate gains ranging from +2% (Eswatini) to +8% (Zambia and Zimbabwe). A treatment success rate below 80% is considered suboptimal and indicates the need for enhanced quality of TB care and programmatic interventions.

Figure 11: Treatment Success rate (new and relapse)



Treatment success rate among HIV positive cases

Treatment Success Among HIV-Positive TB Cases

Table 4 presents trends in treatment success rates among HIV-positive TB cases across the SADC region.

Consistent with global patterns, treatment success among HIV-positive individuals remains lower than among HIV-negative individuals, a trend that persisted in 2023. Exceptions were observed in Comoros and Seychelles, where success rates were higher among HIV-positive patients. Of the 13 countries reporting treatment outcome data for HIV-positive individuals, more than half (7 countries) recorded improvements in 2023 compared to the 2015 baseline, while 2 countries reported static performance.

Conversely, 2 countries experienced a decline in treatment success rates between 2016 and 2023. Encouragingly, 10 out of 14 reporting countries achieved treatment success rates above 80%, surpassing the average treatment success for all TB cases in Africa.

Table 4: Treatment success rate for HIV positive TB patients, direction of change 2016-2024

Country	2016	2017	2018	2019	2020	2021	2022	2023	2024
Angola									86
Botswana	78	80	80	77	70	75	75	37	62
Comoros	100	100	100	100	100	100	100	100	100
DRC	77	60	78	79	63	74	88	89	90
Eswatini	85	85	90	85	85	79	79	83	90
Lesotho	69	77	74	75	75	76	76	80	88
Madagascar			81	68	74	66	70		76
Malawi	81	80	84	86	86	87	87	89	92
Mauritius	68	66	60	64	75				92
Mozambique	86	87	85	89	88	89	91	92	94
Namibia	79	80	82	81	82	83	81	85	92

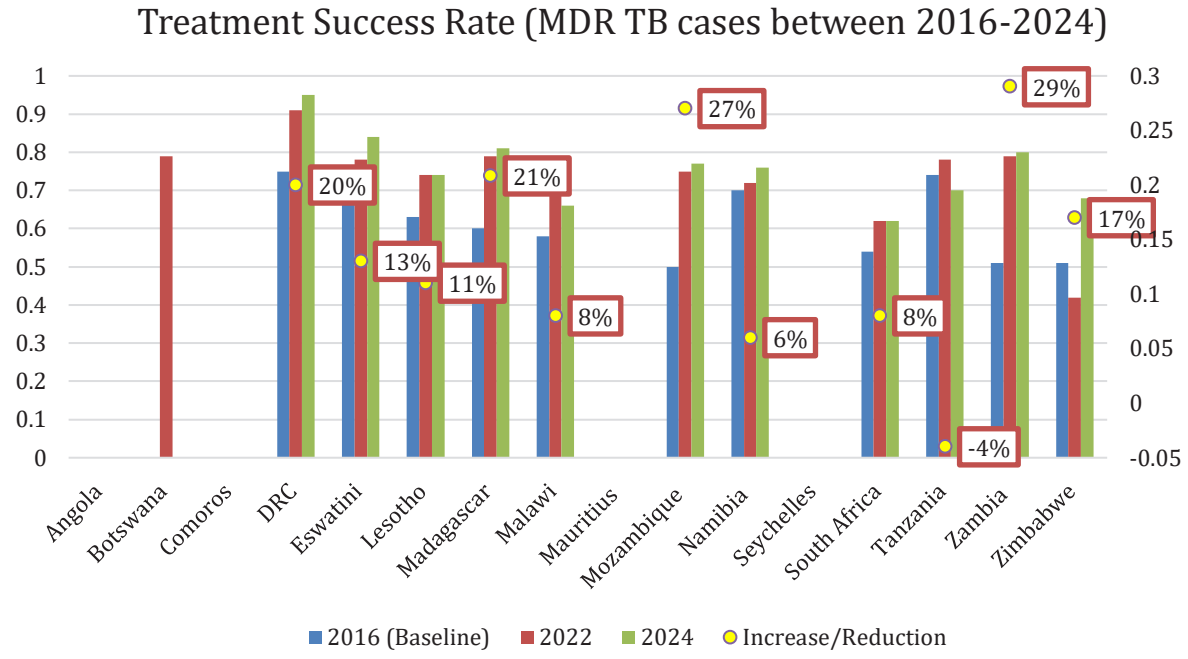
Seychelles	0	0	0	0	100	100	0	67	88
South Africa	80	80	75	79	78	78	78	76	82
Tanzania	83	85	80	89	90	92	93	93	96
Zambia	87	86	86	89	88	90	90	93	94
Zimbabwe	79	78	82	82	84	84	83	86	92

MDR/RR TB Treatment Success Rate

Treatment Success for MDR/RR-TB in the SADC Region

The treatment success rate for multidrug-resistant and rifampicin-resistant tuberculosis (MDR/RR-TB) has shown consistent improvement across SADC Member States reporting this condition since 2016.

Figure 12: Treatment success rate (MDR/RR TB cases), 2016-2024



At the continental level, the SADC region outperforms the broader African average, achieving a 76% treatment success rate compared to 71% for Africa. At the country level, seven Member States report treatment success rates exceeding the 71% continental benchmark.

Among those demonstrating the most substantial gains between 2015 and 2023, four countries—Zambia (29%), Mozambique (27%), Madagascar (21%), and the Democratic Republic of the Congo (20%)—recorded increases of 20 percentage points or more. Furthermore, 10 out of 11 countries reporting MDR/RR-TB outcomes documented improvements in treatment success over the same period.

Pillar

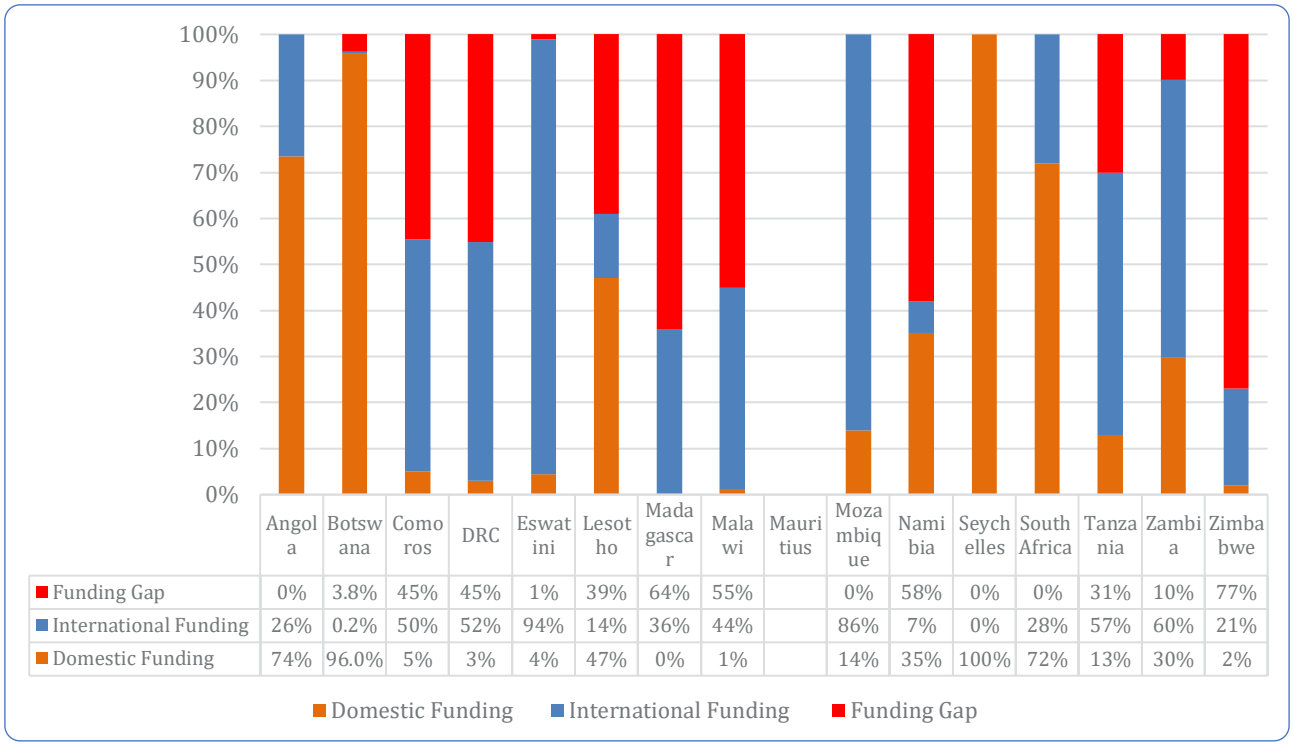
02

Bold Policies and Supportive Systems

This section covers TB policies and supportive systems in SADC Region.

Financing for TB Prevention, Diagnostics, Treatment and Programme Coordination Financing for TB Prevention, Diagnostics, Treatment and Programme Coordination

Figure 13: TB Funding and Funding Gap in SADC Member States, 2024



	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Funding Gap	0%	3.8%	45%	45%	1%	39%	64%	55%		0%	58%	0%	0%	31%	10%	77%
International Funding	26%	0.2%	50%	52%	94%	14%	36%	44%		86%	7%	0%	28%	57%	60%	21%
Domestic Funding	74%	96.0%	5%	3%	4%	47%	0%	1%		14%	35%	100%	72%	13%	30%	2%

Strategic Overview of National TB Programmes

Sustained reductions in the tuberculosis (TB) burden require adequate and predictable financing over extended periods. National TB Programmes (NTPs) operate under comprehensive, costed strategic plans that encompass TB prevention, case detection (diagnostics), patient management, and programme coordination. However, financial gaps remain a critical challenge, as they compromise service delivery, coverage, quality, and ultimately, key impact indicators.

Funding for TB programmes is derived from domestic sources—including national governments and private sector contributions—and international partners, such as the Global Fund, World Bank, CDC, USAID, among others. Innovative financing mechanisms are urgently needed to close these gaps and ensure uninterrupted implementation of priority interventions.

2024 Financial Analysis

The 2024 financial landscape reveals significant disparities in TB programme funding across SADC Member States:

- **High Domestic Financing:** Angola, Botswana, Namibia, Seychelles, and South Africa demonstrate substantial reliance on domestic resources.
- **No Funding Gaps:** Angola, Seychelles, and Mozambique have fully funded their costed priority needs through combined domestic and international sources.
- **Significant Funding Gaps:** Malawi, Namibia, and Zimbabwe report over 50% of priority needs unfunded, posing a major risk to programme performance.

Overall, funding adequacy varies widely, with some programmes largely underfunded, others partially

funded, and a few adequately funded. Data gaps persist for Mauritius, and only 7 of 16 Member States (44%) report an NSP budget funding gap of less than 5%, underscoring the need for resource mobilization and financial sustainability strategies.

Global Funding Shock:

Funding Cuts Threaten Decades of Progress in the Global TB Response

The tools and strategies required to achieve further and more equitable progress against TB exist, and numerous country examples demonstrate their effectiveness. However, this progress is now at risk in a rapidly changing global context. Many donor countries are retreating from the solidarity that once underpinned the global TB response, even as the epidemic remains one of the deadliest in modern history.

Funding cuts and freezes introduced in 2025 have placed the global disease response in jeopardy.

Sustained Treatment Needs Amid Funding Losses

Without urgent corrective action, interruptions in treatment services—caused by stockouts of medicines, shortages of essential drugs, or health workforce gaps—will undermine health systems and population health outcomes. Requiring patients to make repeated clinic visits for test results, treatment initiation, or medication refills increases the risk of treatment discontinuation and onward transmission of HIV and tuberculosis, further straining already overburdened health systems.

Projected Impact of Service Disruptions

The consequences of these funding cuts are likely to be severe. Treatment interruptions will lead to increased TB and HIV-related morbidity and mortality, higher transmission rates, and long-term human and economic costs. UNAIDS modelling indicates that if programmes previously supported by PEPFAR are halted, the world could see over 1 million additional TB/HIV-related deaths by 2030 .

Beyond Medicines: The Broader Role of Donor Funding: Donor contributions finance more than the procurement of medicines and diagnostics. They also support:

- Health workforce remuneration and training
- Information systems and data management
- Research and innovation
- Supply chain and logistics systems
- Community-led programmes that ensure equity and person-centered care

PEPFAR alone previously supported remuneration for at least 340,000 health workers , but the current status of these positions is uncertain. Funding losses are also disrupting data collection and monitoring systems, limiting the ability to track service interruptions and respond effectively.

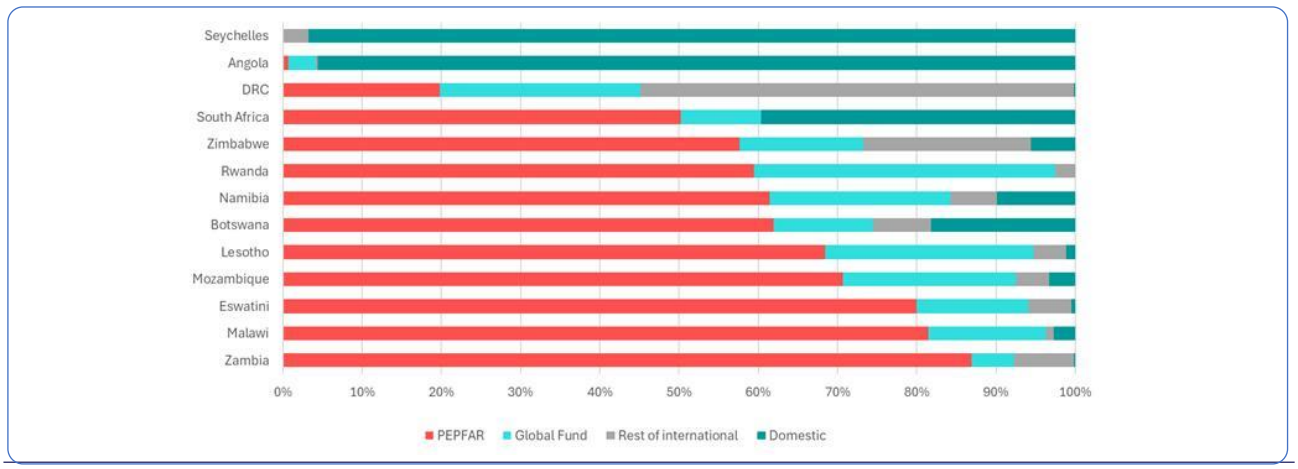
Impact of Funding Cuts

The PEPFAR annual budget (2024) for SADC Member States allocates nearly half (46%) to Care and Treatment, which includes antiretroviral therapy, TB treatment, diagnostics, and clinical services for people living with HIV (PLHIV). Prevention receives 18%, while testing services and socio-economic support (such as OVCs and DREAMS) each receives 6%.

Although treatment funding is safeguarded under the PEPFAR "Waiver for life-saving services", over $400 million in prevention funding is at significant risk (except in Angola and DRC, prevention contributions from PEPFAR were very significant, over 50% in most Member States). Without sustained investment in prevention, the region will not achieve the goal of ending AIDS as a public health threat by 2030.

The figure 14 below shows the majority of SADC countries' HIV PREVENTION activities were heavily dependent on PEPFAR funds. Other than Angola and DRC, PEPFAR contributed more than 50% of all prevention funding. Prevention component of PEPFAR budgets did not receive any waiver or indication of continuing.

Figure 14: Funding for SADC HIV prevention services



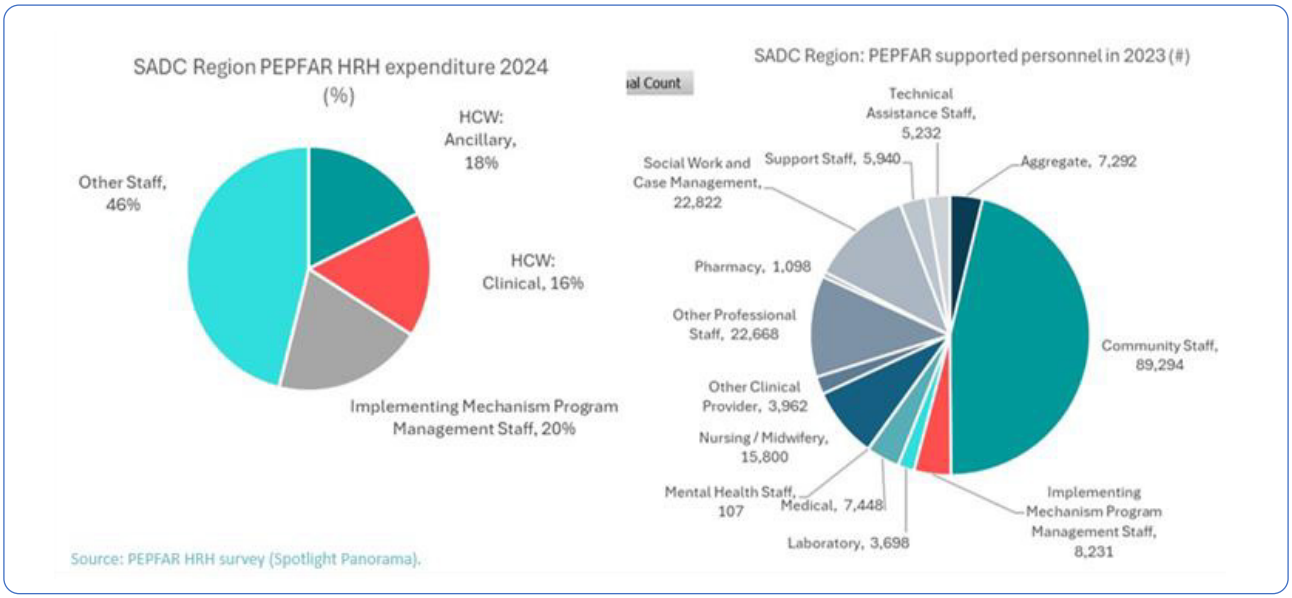
Impact on Human Resources:

Almost 50% of PEPFARs budget in the Member States was going to salaries of health care workers and other staff; only 8% for pharmaceuticals (which includes ARVs and other), and 13% on other commodities. All other operational type costs lumped together made up 32%.

PEPFAR supported almost 200,000 workers across the Member States (paid for fully or partially). The total full-time equivalents were 132,000. 34% were Health Care Workers, clinical and non-clinical. In addition, 90,000 community level staff in the SADC region were supported by PEPFAR (paid for fully).

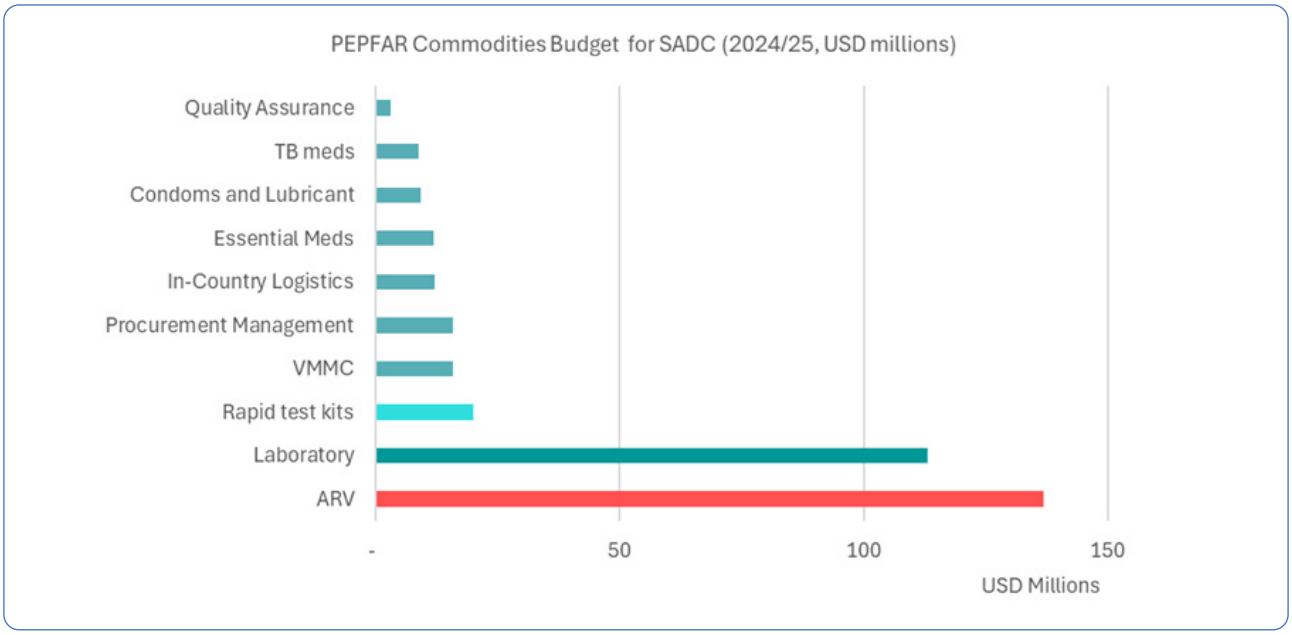
Impact on Commodities:

Figure 15: PEPFAR funding breakdown by HCW cadre (2024)



Within the PEPFAR commodity plans for the SADC countries (detailed in their COP24) for 2024/25, almost USD 150 million was for ARVs (including ARVs for PrEP), USD 120m for laboratory reagents.

Figure 16: PEPFAR funding breakdown by commodities



The Way Forward

The immediate priority is to protect and sustain HIV programmes in the face of severe funding constraints and human rights setbacks. This includes:

- Securing emergency financing to prevent treatment interruptions and stockouts
- Safeguarding community systems as integral components of HIV/TB responses
- Leveraging innovations, such as long-acting prevention tools, to maximize impact in diverse contexts
- Strengthening accountability and data systems to monitor service continuity and equity

Without urgent action, the global TB response risks losing decades of progress, with devastating consequences for public health and human rights.

Strategic Recommendations:

SADC Member States should:

1. Expand Fiscal Space to Fund HIV Programme including Prevention:
   - Intensify advocacy for sovereign debt restructuring and relief.
   - MOFs and parliaments should allocate emergency HIV prevention and broader health funding (about 10% more, varies by country)
2. Implement Aggressive Efficiency Gains to Free Up Resources:
   - Strengthen supply chain management, eradicate pilferage, and improve contract management to reinvest savings into prevention.
3. Strengthen Regional Pooled Procurement for Prevention Commodities:
   - Leverage the SADC Pooled Procurement Services to secure lower prices for PrEP, test kits, and other essential medicines.
4. Accelerate Sustainable Financing Reforms for HIV Prevention:
   - Fast-track the rollout of National Health Insurance schemes and explore health-specific levies e.g. HIV levy to create dedicated funding streams.

Recommendations for partners, TB technical groups and civil society:

For International Donors and Partners:

- End Abrupt Funding Cliffs: Ensure planned, phased, and predictable transitions.
- Shift to Catalytic and Innovative Financing: Support domestic resource mobilization and local manufacturing.
- Renew Global Solidarity to Protect Prevention Gains: A fully funded Eighth Replenishment of The Global Fund is a global health security imperative.

For TB, Civil Society and Community Organizations:

- Intensify Community-Led Monitoring and Budget Advocacy: Hold governments accountable for domestic commitments.
- Champion Innovation in TB Prevention and Treatment: Develop and advocate for lower-cost, high-impact service delivery models.
- Build Coalitions for Health Financing Reform: Create a powerful, unified voice to demand that health be prioritized.

Pillar

03

Intensified Research and Innovation

This section covers TB research and innovation in SADC Region.

TB Research Agenda in SADC Region

Strategic Research and Innovation for TB Elimination

The SADC Strategic Plan for Tuberculosis Control (2020–2024), which has been domesticated by most Member States, prioritizes intensified research and innovation to inform policy, practice, and approaches that accelerate the TB elimination agenda. In alignment with this strategic intervention, SADC established a Scientific Committee in 2024 under the umbrella of the SADC End TB Committee (SETC) to guide regional research priorities.

This report highlights one regional study conducted through the TB in the Mining Sector Project, implemented by the East, Central and Southern Africa Health Community (ECSA-HC). The study involved a Community, Rights, and Gender (CRG) assessment across six SADC countries: Angola, Botswana, Eswatini, Madagascar, Malawi, and Zimbabwe. The assessment aimed to identify and address gender and human rights barriers affecting access to TB services among key populations in the mining sector, including miners, ex-miners, their families, and surrounding communities. These populations were prioritized due to their heightened vulnerability to TB, driven by high exposure risk, limited healthcare access, and socio-economic constraints.

Key Findings

1. **Cross-Border Challenges**

   Frequent cross-border movement of miners undermines TB prevention and care due to weak cross-border health regulations, poor enforcement, and inadequate coordination between countries. This mobility disrupts continuity of TB care for miners and ex-miners.

2. **Policy Implementation Gap**

   Despite existing policies, implementation remains weak in remote mining areas due to resource shortages (e.g., mobile clinics, diagnostic kits, trained personnel), poor enforcement mechanisms, and limited health worker training.

3. **Accessibility Barriers**

   Geographic isolation and high transportation costs significantly limit miners' access to TB services, particularly in Angola, Malawi, and Madagascar. Informal miners face additional challenges due to illegal status and fear of discrimination when seeking occupational health services.

4. **Quality of Care**

   Service quality is compromised by resource constraints, inadequate infrastructure, and shortages of essential medicines and diagnostics, notably in Angola, Botswana, and Madagascar.

5. **Stigma and Discrimination**

   Stigma against TB patients—especially those with multidrug-resistant TB (MDR-TB)—remains a major barrier. Cultural misconceptions and discriminatory practices by some healthcare workers exacerbate this issue.

6. **Cultural Norms and Gender Roles**

   In Angola, Botswana, Eswatini, and Zimbabwe, cultural norms discourage men from seeking timely TB care due to perceptions of illness as weakness. Women, while more proactive in accessing health services, face increased exposure risks due to caregiving roles and limited autonomy in healthcare decision-making. Financial and transportation barriers further restrict women's access in Eswatini, Madagascar, and Zimbabwe.

Progress on Strategic TB Studies

The SADC TB Strategy emphasizes several priority studies, including TB Prevalence Surveys, Drug-Resistant TB Surveys (DRS), Patient Cost Surveys, and TB Stigma Surveys. Progress to date includes:

- **TB Prevalence Surveys:** Conducted by 9 of 16 Member States in the past decade.
- **Drug-Resistant TB Surveys:** Recently completed in Lesotho and Zambia, with Zimbabwe currently in progress.
- **Patient Cost Surveys:** Six Member States—Angola, Botswana, Comoros, Eswatini, Madagascar, Mauritius, and Seychelles—have yet to conduct these surveys.

Recently, emphasis on TB Prevalence Surveys has declined due to the widespread adoption of molecular diagnostics and advanced epidemiological modelling tools.

TB in Mining Sector

TB in Mineworkers: Epidemiological Context and Programmatic Response

Mineworkers represent a high-risk population for tuberculosis (TB) due to occupational and environmental factors, including silica dust exposure, overcrowded and poorly ventilated living conditions, and elevated

HIV prevalence within this group. The exact number of miners and ex-miners remains unknown across most SADC Member States, except for South Africa, which reported 498,765 miners in 2022. Similarly, data on artisanal and small-scale miners is largely unavailable.

The SADC Declaration on TB in the Mines recommends a comprehensive approach encompassing systematic screening of mineworkers, prompt initiation of treatment, and tracking of mineworkers' movements—particularly cross-border—to ensure treatment adherence and monitor transmission dynamics for targeted preventive interventions.

Member States have demonstrated progress in reporting TB among mineworkers, as reflected in the data presented in Table 5. A comparison of 2022 and 2023 data for reporting countries indicates a 7% increase in total TB notifications among mineworkers, suggesting that monitoring and evaluation (M&E) systems are increasingly capturing occupation-disaggregated data. Overall, TB notifications among mineworkers have shown an upward trend across most Member States, except South Africa, where notifications declined steadily from 3,799 cases in 2016 to 1,200 in 2022.

High TB case notifications were observed in Democratic Republic of the Congo (DRC) and Tanzania, followed by Lesotho, whereas Namibia and Eswatini reported the lowest figures. Variations in TB notifications among mineworkers are influenced by the scale of mining activities, as well as the extent of screening, documentation, and reporting. Implementation of the Cross-Border Referral System (CBRS) is expected to address existing data gaps and strengthen continuity of care for mobile mineworker populations.

Table 5: Miners or Ex-Miners notified with TB

Country	2022	2023	2024	% Change
Angola	ND	ND	ND	
Botswana	168	98	45	-42%
Comoros	ND	ND	ND	
DRC	9431	9839	1015	4%
Eswatini	61	81	102	33%
Lesotho	1162	1814	2781	56%
Madagascar	177	591	1081	234%
Malawi	50	150	325	200%
Mauritius	ND	ND	ND	
Mozambique	740	878	976	19%
Namibia	7	18	41	157%
Seychelles	ND	ND	ND	
South Africa	1200	ND	ND	
Tanzania	3270	3916	4701	20%
Zambia	235	229	223	-3%
Zimbabwe	454	458	462	1%
Total	16,955	18,072	19,762	7%

Occupational Health Standards for TB/HIV and Lung Diseases in Mining

To strengthen the quality-of-service delivery for TB/HIV and occupational health, the East, Central and Southern Africa Health Community (ECSA-HC), through the TIMS III Project, developed generic Mine Health and Safety Standard Operating Procedures (MHS SOPs). These SOPs provide standardized guidance for the prevention and control of tuberculosis, HIV/AIDS, silicosis, and other occupational lung diseases in mining environments.

The SOPs have been adapted or adopted by Member States with significant mining activities, including Angola, Botswana, Democratic Republic of the Congo (DRC), Mozambique, Namibia, Tanzania, South Africa, Zambia, and Zimbabwe. Despite this progress, implementation and rollout at national and enterprise levels remain slow, limiting the potential impact of these standards on occupational health outcomes.

Pillar

04

Regional Coordination of the TB Response

This section covers broader regional coordination of TB response in the region.

Implementation of the SADC TB Cross-Border Digital Referral System (CBRS)

The SADC TB Cross-Border Digital Referral System (CBRS) has undergone substantial enhancements to align with the latest WHO recommendations for the diagnosis and treatment of tuberculosis (TB) and occupational lung diseases. The upgraded system is designed for interoperability with existing national health information systems, while maintaining its core function of facilitating cross-border patient referrals within the SADC region.

A key innovation in the revised CBRS is the inclusion of in-country referral functionality, introduced to address challenges related to patients lost to follow-up, which have negatively impacted treatment outcomes in several Member States.

Significant milestones have been achieved in the rollout of the enhanced CBRS. Notably, 10 Member States—Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia, and Zimbabwe—have successfully completed User Acceptance Testing (UAT), a critical step toward full implementation. This achievement represents a pivotal advancement in strengthening TB prevention and care and continuity of care across the region.

Update on harmonised minimum standards for Prevention, Treatment and Management of TB in SADC Region

Status of Harmonized TB Diagnosis and Management Protocols in SADC

The current harmonized protocol for tuberculosis (TB) diagnosis and management in the SADC region has been in place for over a decade. These guidelines have played a pivotal role in advancing TB prevention and care efforts across Member States. Under this framework, all countries have adopted WHO-recommended molecular diagnostic tools and implemented patient-friendly formulations for both drug-susceptible TB (DS-TB) and drug-resistant TB (DR-TB).

However, a recent landscape analysis reveals substantial variability in the adoption of WHO-recommended guidelines for childhood TB and DR-TB across the region. This inconsistency is partly attributable to the outdated harmonized minimum standards, which have not kept pace with multiple revisions of global guidelines by WHO.

This situation underscores the urgent need to revise and update the SADC harmonized standards for TB prevention, diagnosis, treatment, and management to ensure alignment with current global best practices and accelerate progress toward TB elimination targets.

Update on domestication of the SADC Action Plan on TB

Progress on Domestication of the 2012 SADC TB Declaration through TIMS Project

The TIMS Project has made notable progress in supporting the adaptation and domestication of the 2012 SADC TB Declaration among Member States. Key achievements include:

- **Integration into National Plans:** TIMS interventions have been incorporated into National TB Strategic Plans (NSPs) of several Member States.
- **Disease Classification:** Tuberculosis (TB) and silicosis acquired during or after employment are now formally recognized as occupational lung diseases.
- **Legislation on Compensation:** Legal frameworks for compensation related to occupational lung diseases have been established in some Member States.
- **Funding Mechanisms:** Government and partner funding is available for interventions targeting TB, silicosis, HIV, and other occupational diseases.
- **Adoption of Mining-Sector TB Interventions:** Only 6 of 16 Member States—Eswatini, Lesotho, Namibia, South Africa, Zambia, and Zimbabwe—have integrated TB interventions for the mining sector into their NSPs. Implementation in these countries is either advanced or at full scale.
- **Legislation for Compensation:** Only 4 of 16 Member States have enacted legislation supporting compensation for occupational lung diseases.

Despite these achievements, the overall level of adoption and domestication remains low. Nevertheless, Member States have made considerable efforts to institutionalize measures for primary prevention, diagnosis, and management of occupational lung diseases associated with mining and industrial activities. Accelerated action is required to institutionalize high-impact interventions outlined in the SADC TB Declaration and close existing policy and implementation gaps.

There is legislation in place for compensation related to occupational lung diseases.

- **Funding:** Government or partner funding exists for programme interventions targeting TB, silicosis, HIV, and other occupational diseases.
- **Adoption of Interventions:** Only 6 out of 16 member states (Eswatini, Lesotho, Namibia, South Africa, Zambia, and Zimbabwe) have adopted TB interventions in the mining sector into the NSPs. The implementation status in these countries is either advanced or at full scale.
- **Legislation for Compensation:** Only 4 out of 16 member states have legislation supporting compensation for occupational lung diseases.

Overall, the level of adoption and domestication is low. However, the member states have made considerable efforts in institutionalizing measures for the primary prevention, diagnosis, and management of occupational lung diseases related to mining or industrial activities. There is a need for increased attention to accelerate the progress in institutionalizing the high-impact interventions proposed under the SADC TB declaration.

Status of Implementation of MAF-TB in SADC Region

Multisectoral Response and Legislative Framework for TB prevention and care

The SADC TB Strategy (2020–2024) and the 2012 SADC TB Declaration recognize the multisectoral response as a catalytic and central component of TB elimination efforts. This approach has been further reinforced by the WHO Multisectoral Accountability Framework for TB (MAF-TB), which promotes coordinated action across sectors to address the social, economic, and health determinants of TB.

The SADC Declaration advocates for a multisectoral response to combat the dual epidemic of TB and occupational lung diseases. As of this report, 12 of 16 Member States have developed and are actively implementing the MAF-TB framework, while Angola and Eswatini are yet to initiate development and implementation.

Legislation on TB Notification

The SADC Harmonized Standards on TB recommend that TB be classified as a notifiable disease. However, Eswatini and Lesotho have not yet mandated TB notification by law, representing a critical gap in surveillance and accountability.

Summary and Recommendations

Overall, significant progress has been achieved in adopting and implementing MAF-TB across the region. Member States are encouraged to sustain and accelerate multisectoral engagement, strengthen legislative frameworks, and ensure full compliance with TB notification standards to enhance accountability and improve TB outcomes.

Key Takeaways

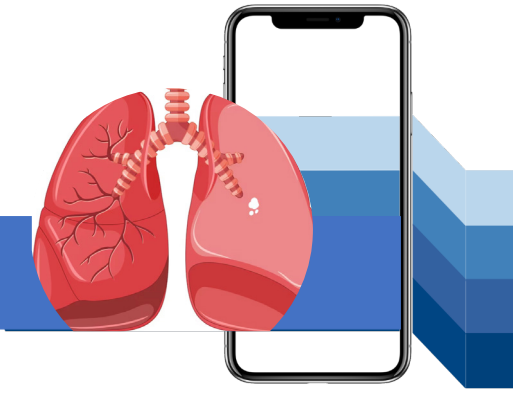
1. **SADC's Resilience in TB prevention and care:** The region continues to demonstrate resilience in the fight against TB, recording significant progress across key impact and coverage indicators.
2. **Declining TB Incidence:** TB incidence in the SADC region continues to decline, with a 37% reduction between 2023 and 2024.
3. **Mortality Reduction:** Substantial progress has been achieved in reducing TB-related mortality, with most Member States reporting improved treatment outcomes.
4. **Progress Toward SDG Milestones:** Several Member States are on track to achieve the Sustainable Development Goal (SDG) TB milestones.
5. **Persistent Funding Gaps:** The majority of Member States face funding gaps in their costed TB strategic frameworks, slowing progress toward targets.
6. **Mining Sector Response:** Significant improvements have been noted in TB response within the mining sector, including increased TB notifications among miners and ex-miners, reflecting strengthened systems.
7. **Policy Uptake:** There has been notable adoption of recommendations issued by SADC Ministers of Health in 2023.
8. **Policy Framework Updates:** Regional TB policy frameworks—including Harmonized Standards on TB Prevention, Treatment, and Management and the SADC TB Strategy—are due for revision and update.
9. **Domestication Gaps:** Despite efforts to domesticate SADC TB action plans, critical gaps remain in the adoption of catalytic interventions.
10. **Multisectoral Accountability:** Member States are at varying stages of implementing the Multisectoral Accountability Framework for TB (MAF-TB), requiring amplified efforts to accelerate progress.

Conclusion

Tuberculosis (TB) remains a major public health challenge in the Southern African Development Community (SADC) region, which continues to experience a TB burden higher than the continental average. Despite this, substantial progress has been achieved in key areas of the TB response, including prevention, diagnosis, treatment, and programmatic management. TB incidence has shown a steady decline, accompanied by a significant reduction in TB-related mortality.

The deployment of innovative diagnostic technologies has enabled earlier and more accurate case detection, while the introduction of shorter, patient-friendly treatment regimens has improved treatment outcomes and adherence. Furthermore, expanded coverage of preventive therapy for high-risk populations has contributed to the downward trend in TB incidence.

The implementation of the 2023 Health Ministers' Recommendations has been instrumental in catalyzing regional efforts, fostering stronger partnerships and cross-country collaboration, and driving more coordinated and effective TB prevention and care strategies. These achievements underscore the region's commitment to accelerating progress toward the End TB targets, while highlighting the need for sustained investment, innovation, and political will to eliminate TB as a public health threat.



Recommendations

1. **Increase Domestic Financing & Sustainability:** Boost national funding for TB programmes to reduce over-reliance on donors. Governments should allocate greater budget resources for TB prevention and care – covering frontline health worker salaries, diagnostics, and medicines. Investing domestic funds will ensure more sustainable TB efforts and allow scaling up of services (e.g. community screening) that donors may not fully cover.

2. **Scale Up TB Prevention:** Member States should prioritize TB contact investigation, expand Tuberculosis Preventive Therapy (TPT) for eligible risk groups, adopt shorter TPT regimens, and leverage digital technologies within decentralized service delivery models. Scale up TB preventive therapy (TPT) to reach those at highest risk. All SADC countries should aim to put the majority of people living with HIV on TPT and offer TPT to close contacts of infectious TB cases, in line with UNHLM targets. Additionally, address the needs of vulnerable groups – e.g. prisoners, urban poor, and people with diabetes. Targeted interventions (screening campaigns, nutritional support) in these populations can significantly cut TB incidence. Ensuring no patient faces catastrophic costs is also key: expand social support (transport vouchers, food packages) for TB patients, which improves adherence and outcomes.

3. **Strengthen TB/HIV Collaboration:** Sustain and enhance integrated TB/HIV services, including interventions addressing TB and associated comorbidities.

4. **Gender-responsive TB Care:** Guided by Community, Rights, and Gender (CRG) assessments and action plans, and the 2025 commitments on Tb and Gender, Member States should design gender-responsive interventions in the upcoming National Strategic Plans to ensure equitable access to TB services across the entire care cascade.

5. **Regional TB Research Agenda:** Through the SETC Scientific and Research Committee, establish a robust regional research framework, including systematic dissemination of study findings and best practices. Build regional research capacity to answer pressing questions and drive innovation. SADC should develop a joint regional TB research agenda, focusing on operational research to understand persistent transmission drivers (for instance, a commissioned TB transmission study could shed light on why certain communities have ongoing high incidence). Research on new tools – like shorter treatment regimens, vaccines, or digital adherence technologies – should be encouraged via partnerships with academia and international agencies. Innovations (for example, using AI to read chest X-rays, or video-observed therapy) can then be rapidly piloted and scaled in SADC contexts.

6. **Harmonize Treatment Protocols and Drug Procurement:** To improve patient outcomes and avoid interruptions, standardize TB care across the region. SADC should harmonize TB treatment guidelines, including new DR-TB regimens, so that a patient receives the same standard of care in any Member State. Additionally, establish pooled procurement mechanisms for TB medicines to prevent shortages and reduce costs. Joint purchasing and stockpile sharing through a SADC platform will help ensure steady drug supply (avoiding stock-outs due to isolated procurement delays).

7. **Strengthen Cross-Border TB prevention and care & Mining Sector Initiatives:** Enhance regional collaboration to tackle TB in mobile populations and miners. SADC should implement harmonized cross-border referral systems so that migrant TB patients (e.g. mineworkers, truck drivers) can continue treatment seamlessly across countries. Member States should also expedite compensation and support for ex-miners with TB and silicosis, per the 2012 SADC Mining Declaration. Coordinated screening of miners, sharing of health data across borders, and harmonized treatment protocols will reduce TB transmission in this high-risk group. Scale up efforts to capture and report disaggregated data on TB and other occupational lung diseases in mining and ensure optimal rollout of the Cross-Border Referral System (CBRS).

8. **Accelerate SOP and Operational Plan Implementation:** Expedite the rollout and implementation of Mine Health and Safety SOPs, the TIMS operational plan, and the CBRS across Member States.

9. **Enhance TB Detection with Modern Diagnostics and Outreach:** Expand access to rapid molecular diagnostics (e.g. GeneXpert and Truenat) for all presumptive TB cases – including in primary care and community settings. This improves early case detection and DST (drug resistance testing) coverage. Coupled with this, intensify community-based case finding, deploy mobile screening units (with X-ray and Xpert) especially in high-burden areas like urban slums, border towns, and mining communities. Finding and treating the "missing" TB cases is essential to reduce transmission. SADC governments should also integrate TB screening into HIV, maternal-child health, and primary health programmes to leverage every patient encounter for TB detection.

10. **Bolster Data Systems and Monitoring:** Improve TB surveillance and data management for informed decision-making. SADC should introduce an electronic TB reporting platform for Member States to submit standardized data. This will minimize errors and enable regional analysis of trends. Develop a SADC TB reporting template and conduct training so that all countries report on the top 10 indicators consistently. Stronger health information systems (potentially linked with WHO/UNAIDS data) will help identify gaps (e.g. low treatment success pockets) and track progress in real time. Regular regional scorecards should be reviewed by SADC ministers to maintain accountability.