



The challenge of mobilizing resources to scale up MDR-TB management

Sixth meeting of the Working Group on MDR- TB
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Issues to be addressed



- What do we need to do, right now?
- What resources do we need?
- How do we get what we need?

The challenge



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- >30 fold increase in MDR treatment provision
 - Far more difficult case management
 - Diagnosis requiring more time, culture, new techniques
 - Treatment of 3-4 times the duration
 - Toxic, less effective drugs
 - Often linked with HIV, IDU
 - In context of poor countries with weak health systems
 - Few human resources
 - Low awareness that drug resistance is a problem

What do we need to do right now?

Address key constraints



Action points of the Global XDR-TB Task Force, October 2006

- Strengthen basic TB and HIV/AIDS control, to avoid creation of MDR-TB and XDR-TB - **Honest self-appraisal by countries' NTPs and NACPs; HIV community needs to be a joint owner of the problem**
- Scale-up programmatic management of MDR-TB and XDR-TB - **Countries must plan and implement, now; faster prequalification of 2nd line drug manufacturers, registration, procurement and production**
- Strengthen laboratory services for adequate and timely diagnosis of MDR-TB and XDR-TB - **Convincing global plan needed, in collaboration with general lab services; expand good local examples eg Ethiopia, Rwanda and Zambia, culture labs and MDR training (PEPFAR), Lesotho (FIND)**

Address key constraints



- Expand MDR-TB and XDR-TB surveillance - **more detailed understanding of the scale of the problem, and clearer illustration of progress made**
- Introduce infection control, especially in high HIV prevalence settings - **convincing, clear global plan needed, in collaboration with general infection control: massive training, infrastructure investment**
- Strengthen advocacy, communication and social and financial resource mobilization - **greater strategic clarity, networking, involvement of activists at global, regional and country levels,**
- Promote research and development into new diagnostics, drugs and vaccines - **fast deployment of any successes**

Key cross-cutting issues



- Human resources – workforce supply, training, community involvement, etc
- Coordination – key role of the MDR Working Group, eg linking demand (countries and Global Fund & UNITAID) with supply (drug manufacturers)
- Financial resources

Funding required



- The advent of XDR-TB and the ensuing debate* has led to significant upwards revision of estimates for MDR scale up in the Global Plan to Stop TB, 2006-2015

*eg call for universal access to drug susceptibility testing, at the World Health Assembly, 2007

Expected outcomes of the Jan 2006 and revised version of the Global Plan



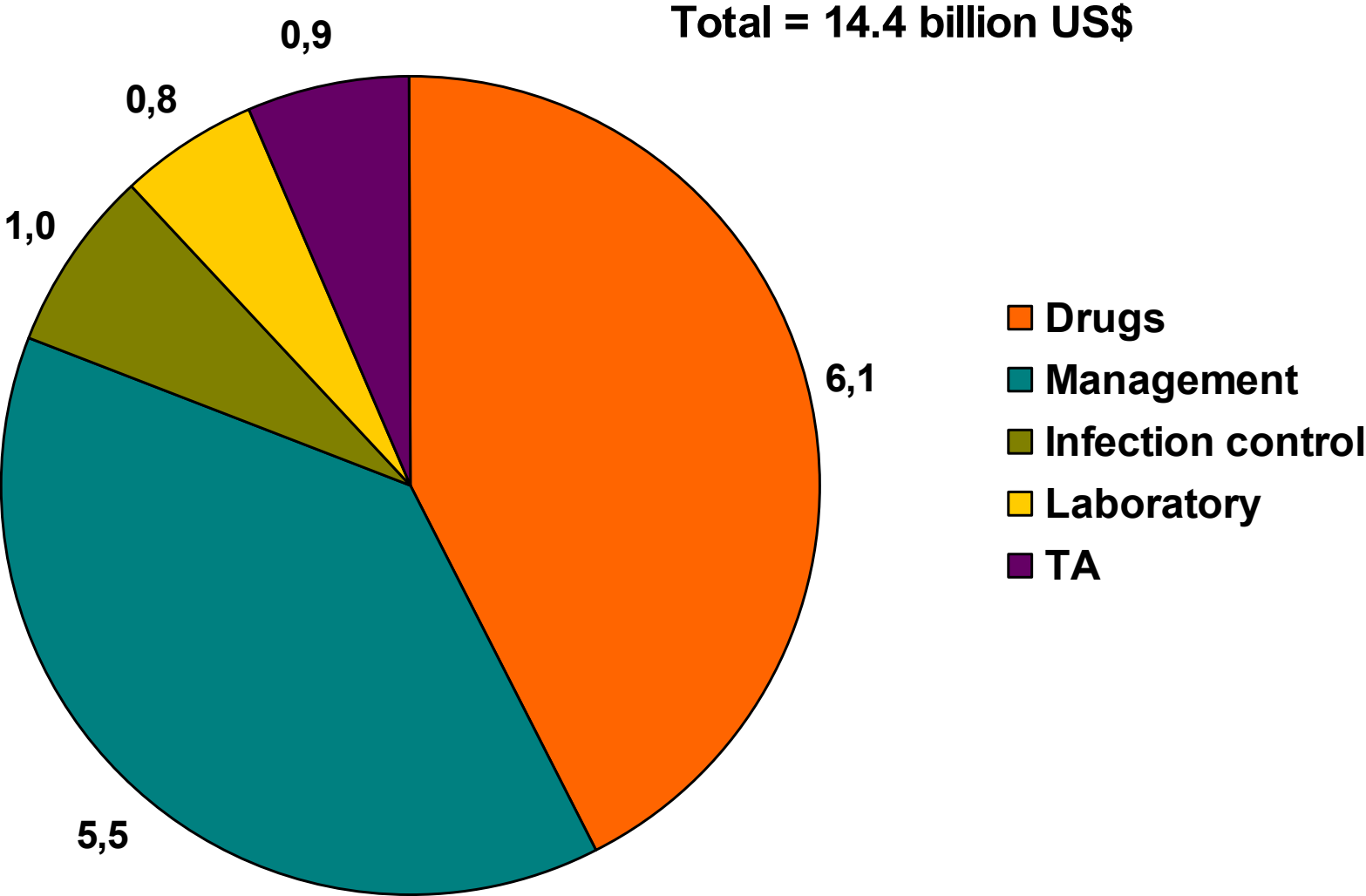
	Jan 2006 version	Proposed revised version
Cumulative number of cases receiving diagnosis and treatment, 2006-2015	778,000	1,560,000 (1,440,000 in 25 MDR-TB HBC & 120,000 in remaining countries)
% of cases receiving diagnosis and treatment of those estimated, 2006-2015	23%	61%
% of incident cases receiving diagnosis and treatment of those estimated in the year 2015	56%	80%

Budget requirements of the Jan 2006 and revised version of the Global Plan



	Jan 2006 version	Proposed revised version
Range of cost per patient treated (US\$)	MDR-TB: 1,979-8,196	MDR-TB: 1,979-8,196 XDR-TB: 6,843-15,579
Total cost for 10 years (billion US\$)	5.8	14.4 (13.5 in 25 MDR-TB HBC & 0.9 in remaining countries)

Costs to manage MDR and XDR-TB cases: 25 MDR-TB priority countries, 2007-2015



Funding strategies



- The STOP TB strategy and the Global Plan are the framework for resource mobilization
- The goal therefore is \$65 billion for the Global Plan of which \$14 billion for MDR and XDR TB control
- XDR and MDR are key levers for raising resources for TB control in general as well as specifically for the management of drug resistance

Funding sources and strategies



- Governments – general health services, NTPs, NACPs, through -
 - National Health Sector Plans, Sector-wide approaches (SWAPS), Poverty reduction strategies (PRSPs), HIV funding support etc
- Global Fund – TB, HIV and health systems, through -
 - Countries, mechanisms such as the Green Light Committee
- Bilateral development and health agencies, through bilateral and multilateral funding streams -
 - US Government: USAID; Office of the Global AIDS Coordinator (OGAC), Presidential Emergency Plan for AIDS Relief (PEPFAR); UK Department for International Development; etc

Funding sources and strategies



- World Bank –
Multi-country AIDS programmes (MAPs), Treatment of AIDS programmes (TAPs); SWAPs, PRSPs
- Unitaid –
Bulk purchase of second line drugs through GLC in coordination with Global Fund
- European Union –
Eg European Neighbourhood, Africa-Caribbean programme (ACP) and research platforms
- Foundations –
 - Specific issues, eg Bill and Melinda Gates Foundation (discovery, development, delivery); OSI (community/civil society) etc
- Corporate sector –
 - Transfer of technology eg Eli Lilly; workplace health programmes; corporate giving

Key agencies with roles and responsibilities



- Stop TB Co-ordinating Board

Strategic direction

- MDR Working Group, drug resistance team at WHO and Stop TB Partnership secretariat, advocacy teams

Planning, convening, collaborating with other TB efforts, technical assistance, direct resource mobilization

- Green Light Committee

Increase throughput

- National advocates eg RESULTS

Approaching parliamentarians – eg EU, India, UK, US

- Countries

Develop costed plans, with technical assistance, if necessary

- Faith-based organisations, non-governmental agencies

Development of TB programmes

- Etc, etc



THE
STOP TB
DEPARTMENT

- "Let a thousand flowers bloom"

Mao Tse Tung, c. 1965

Conclusions



- Enormous challenge
- Success in TB control demands success in controlling MDR-TB
- We know what to do
- If we don't do it, nobody else will

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