Multi-Drug Resistant tuberculosis and Green Light Committee reform

Implications for the region of Europe

Vienna 16 July 2010
## The global burden of TB in 2008

<table>
<thead>
<tr>
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<th>Estimated number of cases</th>
<th>Reported number of cases</th>
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<tbody>
<tr>
<td><strong>All forms of TB</strong></td>
<td>9.4 million (range 8.9–9.9 million)</td>
<td>5.7 million (~61%)</td>
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<td>&gt; 300,000</td>
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<td>30,000</td>
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The global burden of TB in 2008 was significant, with an estimated 9.4 million cases (range 8.9–9.9 million) and a reported 5.7 million cases (~61%). HIV-associated TB accounted for 1.4 million cases (15%), while multidrug-resistant TB (MDR-TB) had an estimated 440,000 cases (0.39-0.51 million) with a reported 30,000 cases.
1995-2008: 15 years of progress through DOTS/ Stop TB Strategy

• 36 million patients cured in 1995-2008

• About 6 million deaths averted counterfactual 1995 care standards

• Case fatality rate halved from 7.6% to 4%

• Cure rate at its highest ever (87% in 2007-8)

• But….MDR-TB and XDR-TB are threatening these achievements
440,000 MDR-TB cases estimated to have emerged in 2008 (3.6% of all incident TB cases globally)

150,000 MDR-TB cases estimated to have died in 2008

Data available from 114 out of 193 countries (59%)

• 42 countries have continuous surveillance systems
• 72 countries rely on periodic surveys

Data not available from 79 countries (41% of all countries)
% MDR-TB among new TB cases, 1994-2009

Australia, Democratic Republic of the Congo, Fiji, Guam, New Caledonia, Solomon Islands and Qatar reported data on combined new and previously treated cases.
Trends of MDR-TB cases in selected settings

Orel Oblast, Russian Federation

Tomsk Oblast, Russian Federation

New MDR-TB cases

Year

Cases notified

New MDR-TB cases

Year

Cases notified
Trends of MDR-TB cases in selected settings

Estonia

New MDR-TB cases

Latvia

New MDR-TB cases
Trends of MDR-TB cases in selected settings

China, Hong Kong SAR

New MDR-TB cases

United States of America

Combined MDR-TB cases
Countries that had reported at least one XDR-TB case by end March 2010

Argentina, Canada, India, Lithuania, Peru, Slovenia, United Kingdom, Armenia, China, Iran (Islamic Rep. of), Mexico, Philippines, South Africa, Australia, Colombia, Ireland, Mozambique, Poland, Spain, Brazil, Czech Republic, Ecuador, Israel, Myanmar, Portugal, Swaziland, Bangladesh, Estonia, Japan, Namibia, Qatar, Sweden, Botswana, France, Kenya, Nepal, Republic of Korea, Tajikistan, Burkina Faso, Germany, Latvia, Namibia, Republic of Moldova, Thailand, Bangladesh, Ecuador, Italy, Myanmar, Portugal, Belgium, Estonia, France, Kenya, Netherlands, Norway, Oman, Russian Federation, United Arab Emirates, Brazil, Georgia, Latvia, Nepal, Namibia, Qatar, Sweden, Botswana, Canada, Colombia, India, Lithuania, Mexico, Mozambique, Namibia, Peru, Philippines, Russia, South Africa, Spain, Switzerland, Uzbekistan, Belgium, Estonia, France, Hungary, Latvia, Namibia, Nepal, Norway, Oman, Russia, United Arab Emirates.
100,000 treatments are estimated to be approved in 2010 by GLC, about 80,000 treatments have been approved as of April 2010.
National MDR/XDR-TB Response Plans

DR TB Response Plans in 27 High burden countries

- Developed
- Initiated
- Not initiated

0 2 4 6 8 10 12 14 16

Not initiated

Initiated

Developed

∞ 14

5 14
High-level policy changes are fundamental!
World Health Assembly, May 2009...

In addition to proper basic control..

1. Remove financial barriers (UHC)
2. Ensure well trained and sufficient human resources
3. Establish a network of labs where rapid tests are also available
4. Ensure availability of quality drugs
5. Regulate the use of all anti-TB drugs
6. Introduce infection control
7. Establish proper surveillance
8. Promote Research & Development
9. Mobilize resources domestically and internationally

Document WHA 62.15, 2009
"MDR-TB scale-up"

Revisiting the Global Architecture

The Workshop
Background

- Only a tiny proportion of MDR-TB cases is properly treated
  - In 2008, countries notified 29,000 (7.2%) patients out of 440,000 estimated incident cases
  - About 10,000 new patients were enrolled under WHO/GLC standards in 2009
  - 68% increase of enrolment from the previous year (small numbers)
  - Cumulative number of treated patients under GLC mechanism is around 30,000 since 2000

- HIV is multiplying cases with a high mortality (and that therefore remain undetected)

- MDR-TB rates can be reduced with existing tools

- But the national and international response to MDR-TB is weak

- Although properly managed patients are increasing, the overall effect is far too small

- Aiming at very good standards is a necessity but leaving the large majority of MDR-TB patients (> 90%) to inadequate practices will have no impact on the M/XDR-TB situation and will not protect 2d line drugs
MDR-TB in Europe

Estimated MDR-TB: ~60,000

Estimated treated: 30,000-40,000 ??

Treated with GLC: ~15,000
Objectives

1. Objectives and Strategy for scale-up of MDR-TB management *(what is required for countries to scale-up and main barriers to scale-up)*

2. Architecture *(what international support model is required and what does this imply for changes to the existing support model)*

3. Next steps *(for a new effective support model fully functional by the end of 2010)*
Objective 1. Main barriers to scale-up

Country level

- Political commitment
- Funds
- M&E

Diagnosis, incl.
- Diagnostic capacity scale-up
- Better diagnostics

Drugs, incl.
- Drug procurement capacity (some countries)
- Use of unknown quality drugs

Delivery of care, incl.
- Delivery capacity scale-up: HR constraints
- Community
- Practices and capacity of hospitals and private providers unknown

Global level

- Advocacy
- Funding support
- Normative guidance
- Technical assistance: “advice, recommendations, short missions”
- Technical “accompaniment”: medium- to long-term on-the-ground support

Global coordination

- Weak push-pull mechanisms & structure at interface
- Poor coordination of global players

Some countries

- Diagnostic capacity scale-up
- Better diagnostics

Some countries

- Drug procurement capacity (some countries)
- Use of unknown quality drugs

Do we agree with this?
How would we modify it to improve it?

Effective global drug market: quality, cost, speed

Ineffective global drug market and support for other tools
Aims of the new model under development

• Better response to needs of the countries by improving practices for MDR-TB diagnostic and treatment throughout the country (not only GLC)

• Increase country political commitment –including country-specific political analysis and action planning; expanded country ownership and accountability

• Harmonize M&E and technical support, towards more support and "rating" performance on MDR-TB scale-up
What is going to change

- MDR-TB diagnosis, treatment and recording and reporting should be part of regular TB control programme
- All cases treated for MDR-TB (GLC and non GLC) to be reported and treatment outcomes reported
- Progressive harmonization of practices to reach international standards for TB care (WHO guidelines)
- Simplification of global monitoring and analysis of what countries need to reach international standards for the management of MDR-TB in non GLC sites
Objective 3. Next Steps towards a new effective support model by the end of 2010

3 Task Forces established:

1) MDR-TB scale-up support function (Paul Nunn and Agnes Gebhard)

2) Tool supply and procurement function (Thomas Moore and Myriam Henkens)

3) New mechanisms and tools for reviewing, evaluating, monitoring and supporting MDR-TB control scale-up (Ernesto Jaramillo and Salmaan Keshavjee)
Task Forces are working on different elements and will be harmonized.

A wide consultation with countries and partners on the new approach is in the plan later this year to get inputs on the new architecture.