From diagnosis to treatment & care: the missing links

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Contents

- Current status
- Global Plan 2011-2015 targets and gaps
- Links within the patient flow system
- Links essential for MDR-TB control
- What is required to address the missing links
Cases of MDR-TB estimated, notified, and enrolled on treatment, 2009 (WHO TB Control Report, 2010)

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated cases of MDR-TB among notified cases of pulmonary TB, 2009²</th>
<th>Notified cases of MDR TB (in 2009)**</th>
<th>Cases of MDR-TB enrolled on treatment, 2009 (includes GLC and non-GLC patients)²</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>59,000</td>
<td>1,200</td>
<td>458</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>1,800</td>
<td>233</td>
<td>88</td>
</tr>
<tr>
<td>India</td>
<td>66,000</td>
<td>1,660</td>
<td>1,136</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>6,500</td>
<td>3,644</td>
<td>135</td>
</tr>
<tr>
<td>Myanmar</td>
<td>4,400</td>
<td>815</td>
<td>64</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1,900</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>Philippines</td>
<td>6,800</td>
<td>1,073</td>
<td>491</td>
</tr>
<tr>
<td>Moldova</td>
<td>1,300</td>
<td>924</td>
<td>586</td>
</tr>
<tr>
<td>South Africa</td>
<td>6,600</td>
<td>7,343</td>
<td>4,143</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>900</td>
<td>319</td>
<td>52</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>2,600</td>
<td>654</td>
<td>464</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>3,100</td>
<td>217</td>
<td>307</td>
</tr>
<tr>
<td>All 27 high MDR-TB cos.</td>
<td>220,110</td>
<td>26,276</td>
<td>18,982 (8.6%)</td>
</tr>
</tbody>
</table>
- Not enough patients are being diagnosed
- Of those diagnosed, not enough (72%) are started on treatment
What is being discussed at this meeting is a revolution in diagnosis of MDR-TB

How do we make sure that treatment keeps pace with diagnosis?
Current and projected targets

Projected targets (assuming GF future rounds)

Country targets (GF/UNITAID/WB)

Gap
Diagnostics and treatment gaps

- EXPAND TB Project aims to enhance diagnostics capacity in 27 countries with a target of 130,000 diagnoses of MDR-TB, 2010-2013
- GF and UNITAID, up to and including R9, are committed to over 250,000 MDR-TB treatments, 2009-2013
- By 2015, gap of around 170,000 treatments annually between Global Plan and (conservative) projections
OPERATIONAL FLOW- LINKS

Planning, reviewing the plan based on in-country data

- Adequate human resources
- Diagnostic algorithm
- Availability of laboratory
- Accessibility to laboratory

- NTP management capacity eg linkage with private laboratories; data flow from lab to treatment centres and programme
- Reporting system
- Surveillance

- Sufficient treatment centres and/or community network
- Sufficient human resources
- 2nd line drug supply
- Information to patients
- Linkage with private sector (PPM)
- Availability of funds

- Provision of DOT
- Effective HR plan
- Default tracing mechanism
- Capacity of laboratory to perform monitoring tests
- Adverse effects monitoring and management
- Recording and reporting mechanism

- Social support mechanism
- Community awareness and involvement
- Palliative care
- Ethical framework
- Patients' charter

Reintegration in the community

Estimated burden (Symptomatic cases in the community)
IDEAL SCENARIO

Proper planning, reviewing the plan based on in-country data

Addressing the lab crisis; Human resources; Surveillance; New tools, financing and abolishing financial barriers, engaging all care providers, optimizing MDR management and care; ensuring access to QA drugs; restricting availability of anti-TB drugs; infection control.
Bottlenecks to MDR-TB control

Access to rapid diagnosis
Bottlenecks to MDR-TB control

Access to rapid diagnosis

- Provision of Xpert MTB/Rif
- Building lab infrastructure
- Lab biosafety
- Supply chain management
- Price negotiations
- Training
- etc
- etc
National examples

A  CDC and public hospital services not systematically linked
    Delays in clearances for drug importation and customs
    Awaiting financial commitment from the MoF
    Services for MDR-TB not covered under health insurance schemes

B  Limited human resource capacity for MDR management
    MDR services limited to specific geographic area (capital)
    Strict regulations for drug procurement – delays in contract with procurement agent (IDA)
    Delayed fund disbursement from GF

C  Limited human resources for pre-implementation assessments
    Delays in procurement of second line drugs (both World Bank credit agreement & GLC/GDF/IDA mechanism)
    Delays in fund negotiation (MoU with UNITAID)
    Limited laboratory capacity for diagnosis & monitoring of MDR-TB
Bottlenecks to MDR-TB control

Access to rapid diagnosis

- Human resources
- Surveillance and monitoring
- Removal of financial barriers
- Access to quality assured drugs
- Engaging all care providers
- Optimizing MDR-TB care
- Infection control
- Technical assistance
- Restricting availability of anti-TB drugs etc
How should we remove these bottlenecks?
Global MDR-TB Initiative

**Global Level**
- Policy development
- Global guidance on diagnosis
- Quality assured drugs
- Technical assistance
- Programmatic management
- Clinical management
- New technologies
- Advocacy

**National Level**
- Policy reform
- New national norms, standards and guidelines for diagnosis and treatment
- Innovative approaches to scale up
- National level implementation and scale up

**Partners**
- Ministries of Health
- Ministries of Finance
- Development agencies
- Civil society
- Global Fund, UNITAID, World Bank
- Pharmaceutical industry
- Research Institutions
- WHO

Information, needs Policy guidance
Leadership needed at all levels

New approaches for MDR-TB control

- From proof-of-concept to field effectiveness

Policy development

- Core WHO mandate
- Systematic process for evidence synthesis

National policy reform

- Global guidance and support
- Core government responsibility

Policy transfer

- Facilitated by norms, standards, tools
- Innovative models for capacity development

Implementation and scale-up

- MOH commitment to ensure sustainability
- Donor commitment to ensure funding
- Society mobilisation to ensure demand
Conclusions

- Accelerated scaling up of treatment and care needs to be addressed now
- At national scale, with careful attention to all necessary links between diagnosis and treatment
- At global level, resources need to be re-assigned to MDR-TB
- Partners should decide their roles
- Serious funding commitment needed