

***Implementation and scale-up of the Xpert MTB/RIF system for rapid diagnosis
of tuberculosis and multidrug-resistance
GLOBAL CONSULTATION***

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International Conference Centre Geneva, Switzerland

**From diagnosis to treatment &
care:
the missing links**

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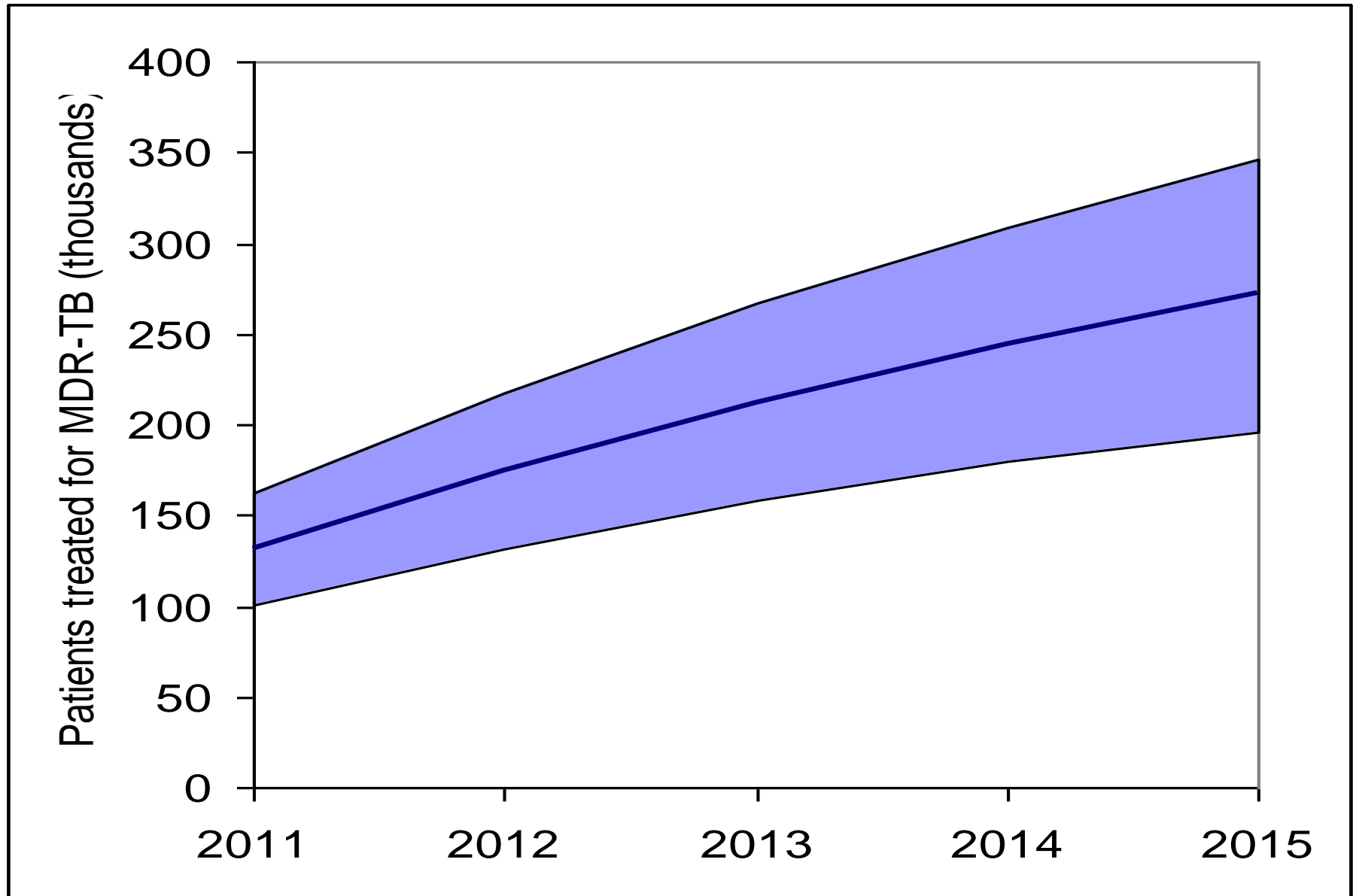
Cases of MDR-TB estimated, notified, and enrolled on treatment, 2009 (WHO TB Control Report, 2010)

	Estimated cases of MDR-TB among notified cases of pulmonary TB, 2009 ²	Notified cases of MDR TB (in 2009)**	Cases of MDR-TB enrolled on treatment, 2009 (includes GLC and non-GLC patients) ²
China	59,000	1,200	458
Ethiopia	1,800	233	88
India	66,000	1,660	1,136
Kazakhstan	6,500	3,644	135
Myanmar	4,400	815	64
Nigeria	1,900	28	0
Philippines	6,800	1,073	491
Moldova	1,300	924	586
South Africa ⁵	6,600	7,343	4,143
Tajikistan	900	319	52
Uzbekistan	2,600	654	464
Viet Nam	3,100	217	307
All 27 high MDR-TB cos.	220,110	26,276	18,982 (8.6%)

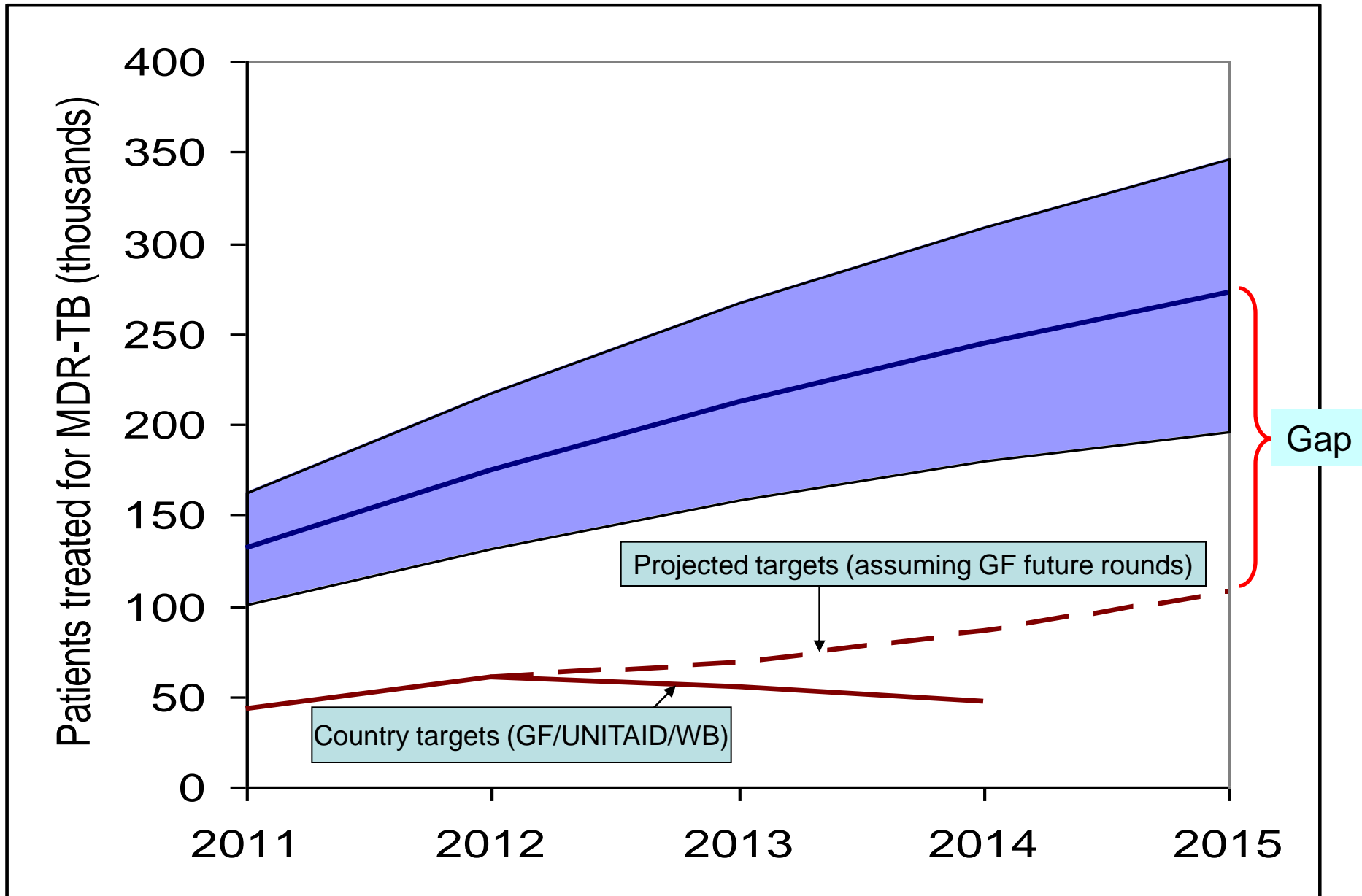
- Not enough patients are being diagnosed
- Of those diagnosed, not enough (72%) are started on treatment

- 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?

Global plan for MDR-TB treatment (2011-2015)



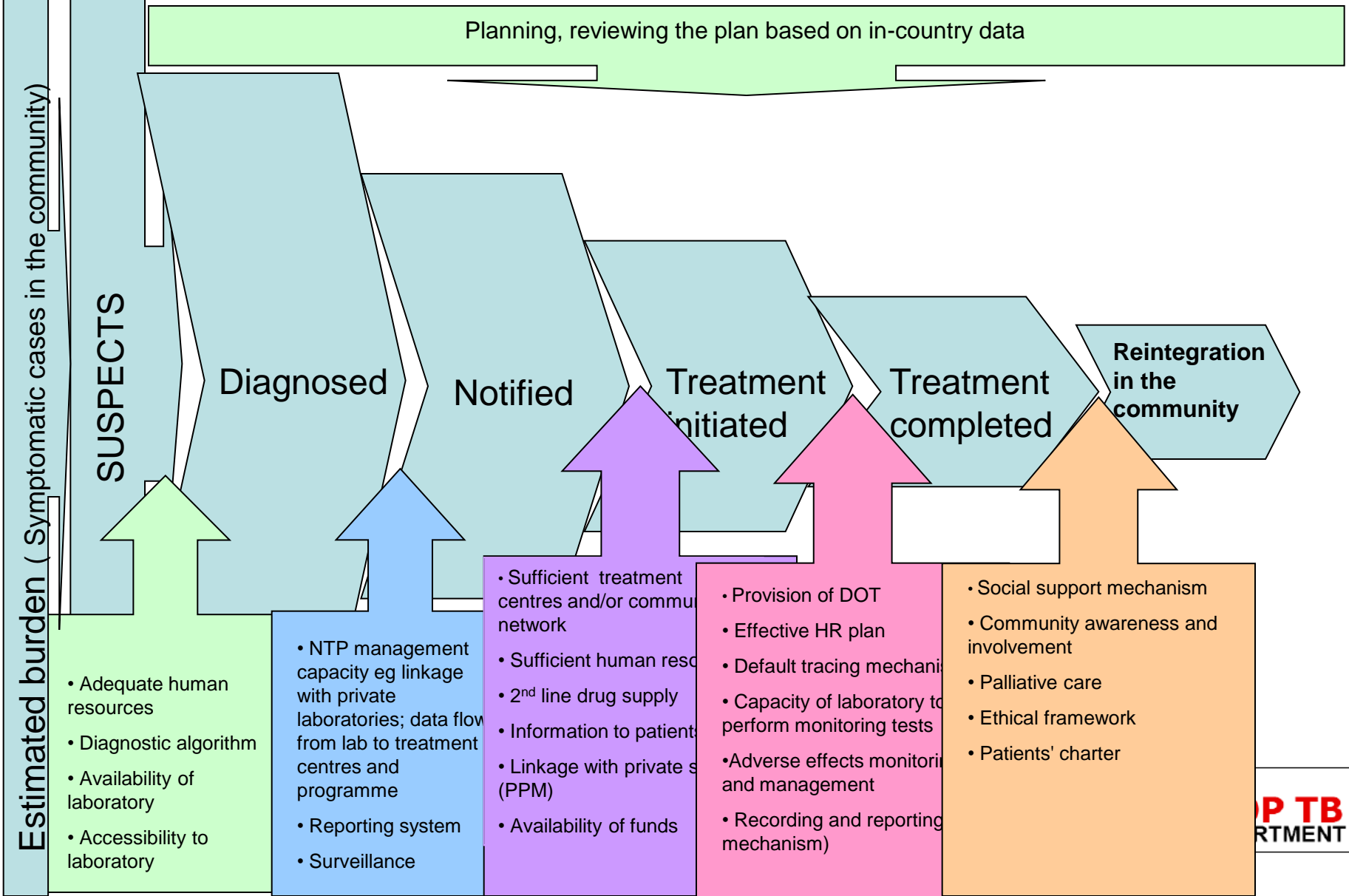
Current and projected targets



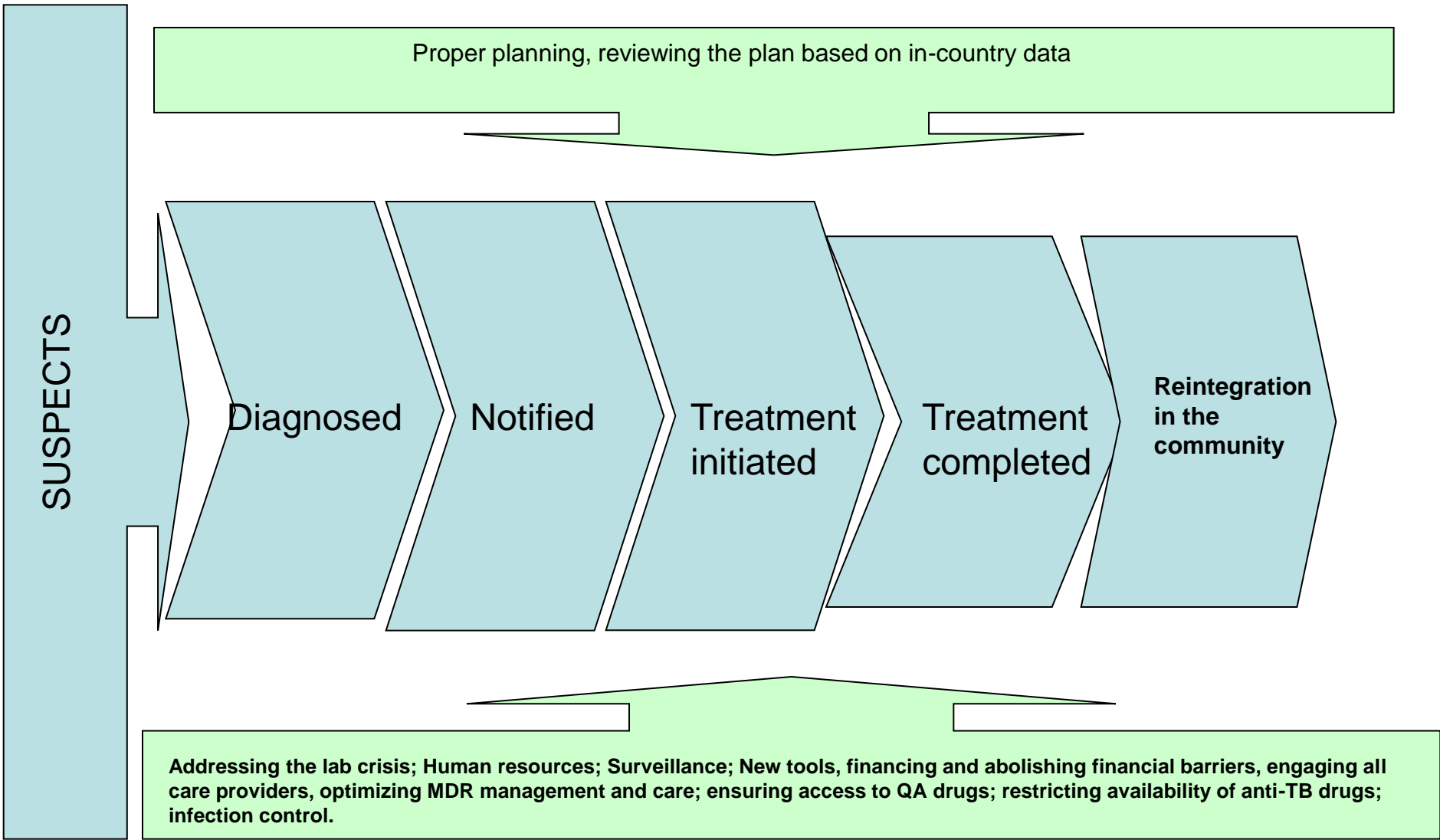
Diagnostics and treatment gaps

- 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

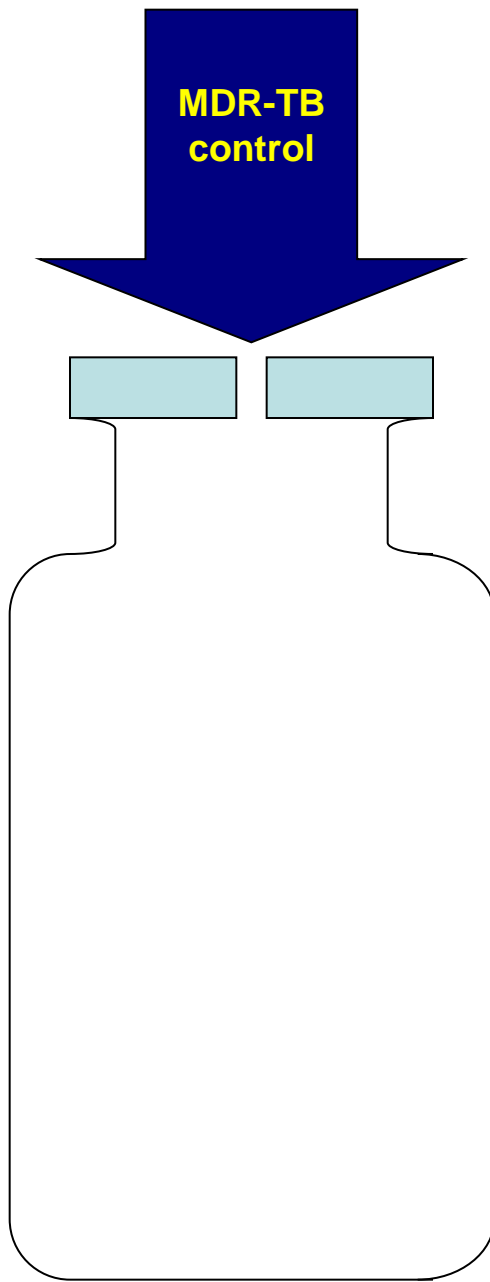
OPERATIONAL FLOW- LINKS



IDEAL SCENARIO



Bottlenecks to MDR-TB control



Access to rapid diagnosis

Bottlenecks to MDR-TB control

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



THE
STOP TB
DEPARTMENT

National examples

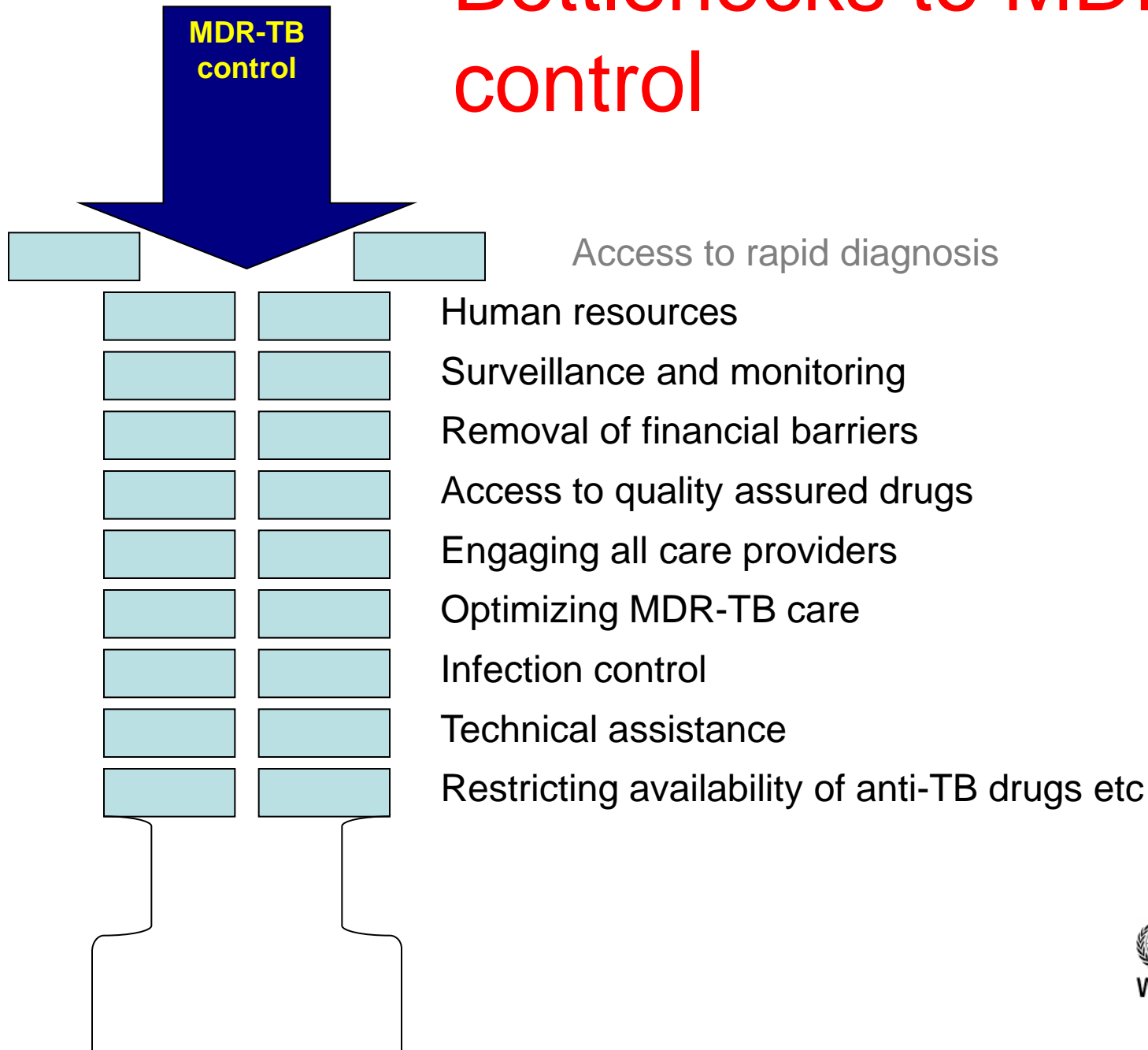
- A** CDC and public hospital services not systematically linked
Delays in clearances for drug importation and customs
Awaiting financial commitment from the MoF
Services for MDR-TB not covered under health insurance schemes

- 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

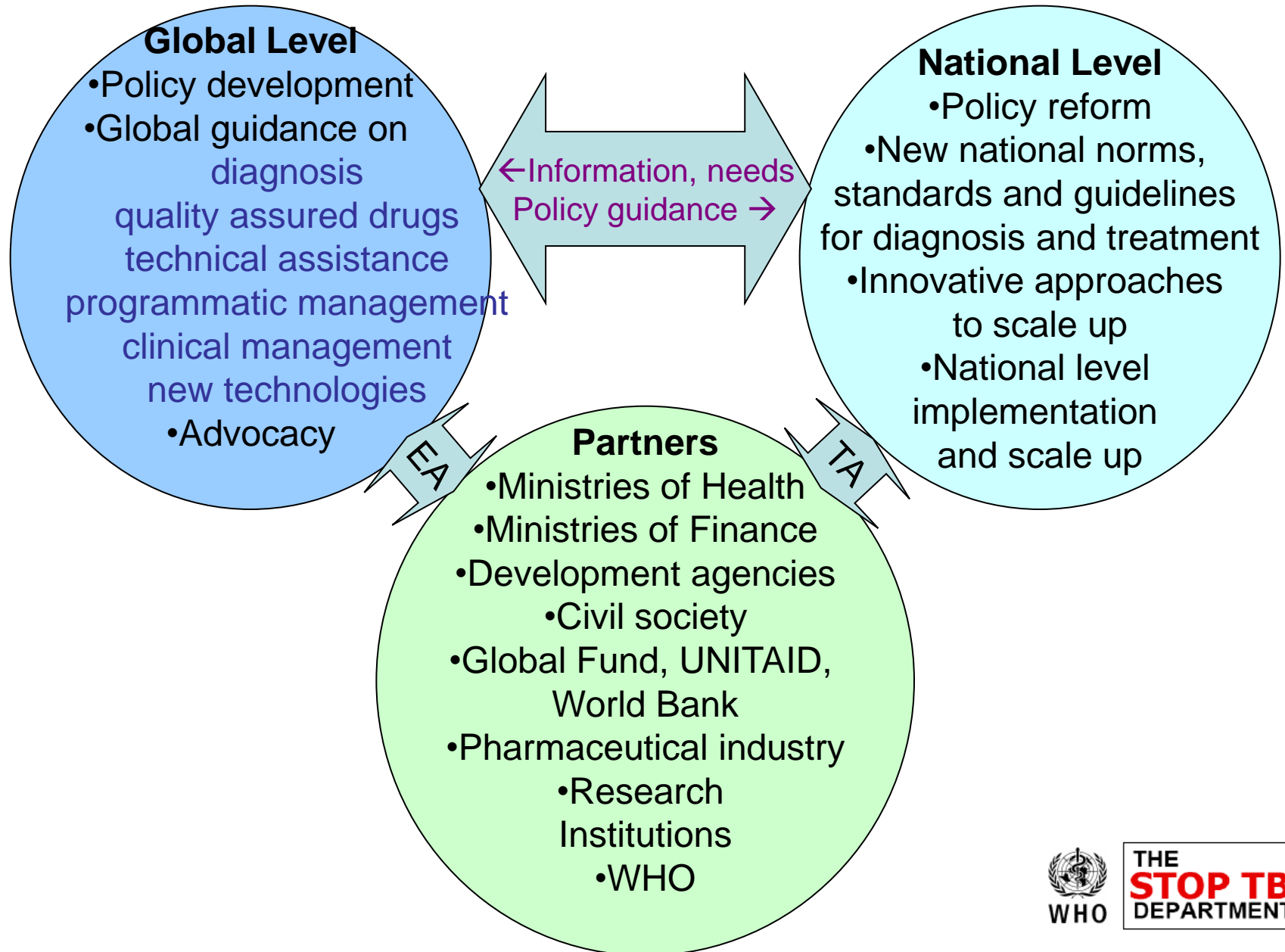


Bottlenecks to MDR-TB control

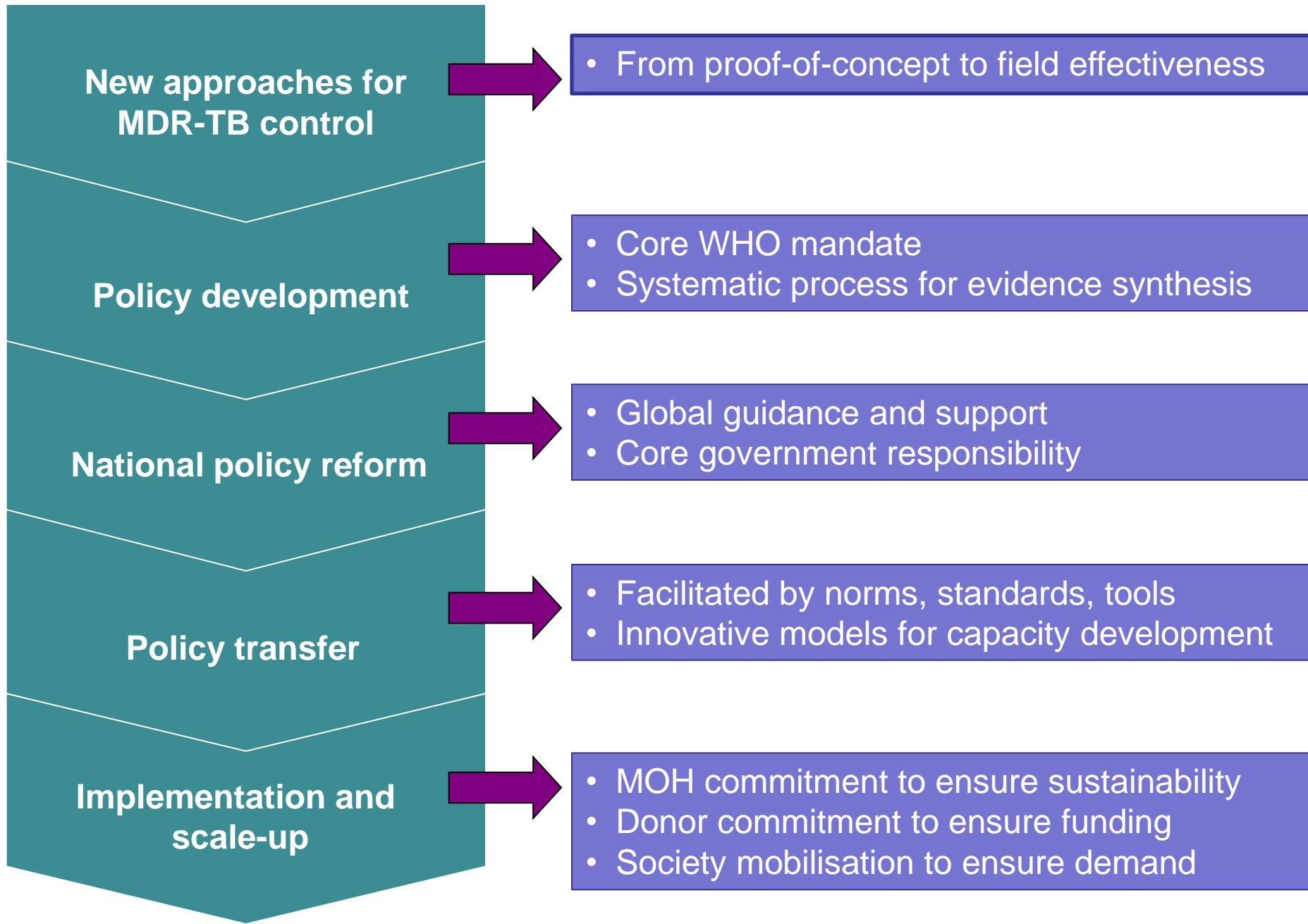


- How should we remove these bottlenecks?

Global MDR-TB Initiative



Leadership needed at all levels



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

