

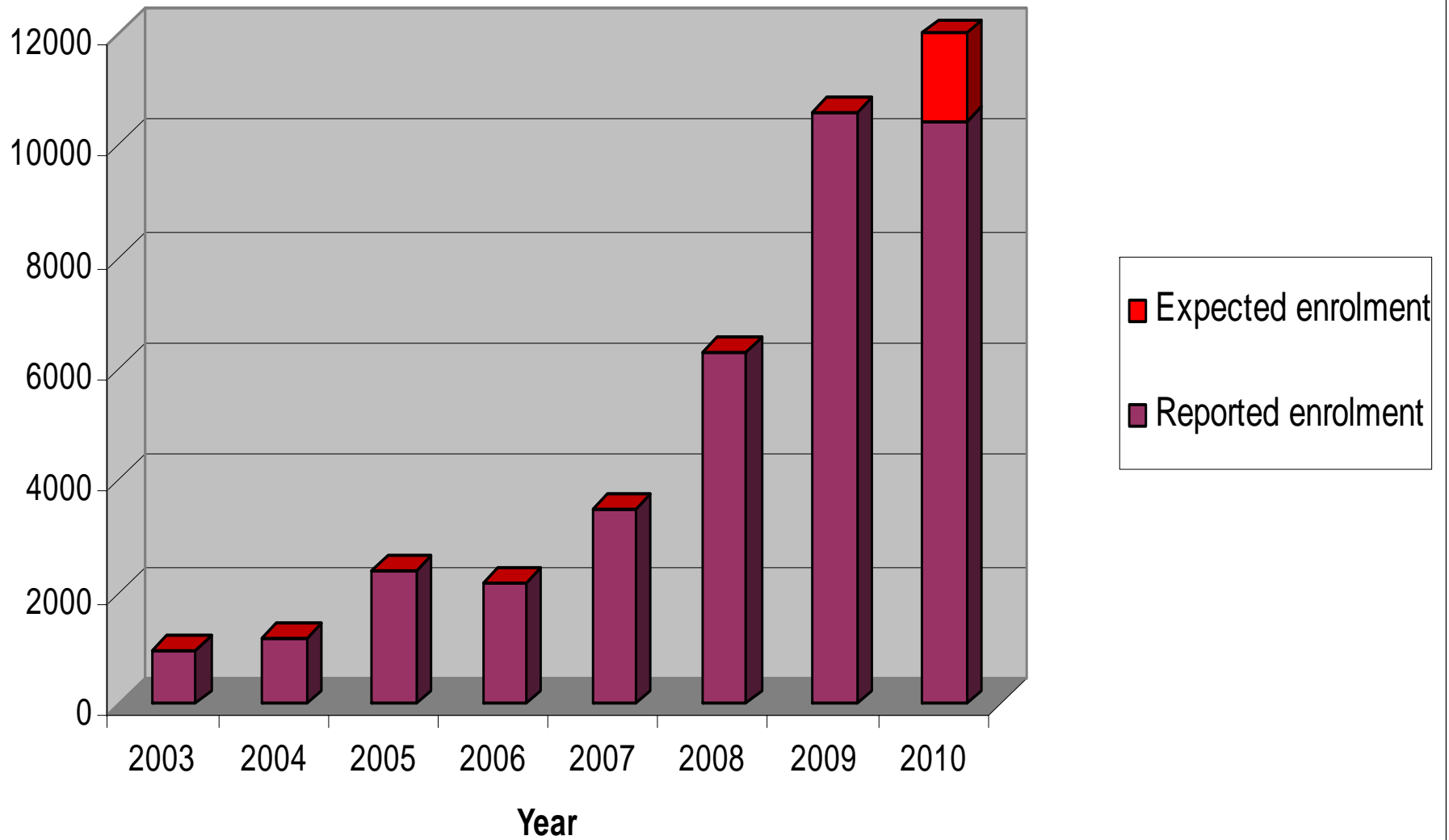
LIGUE PULMONAIRE SUISSE
20th Tuberculosis Symposium, Münchenwiler – 2010

**Fighting TB over the last 20
years: did we fail?**
No, probably not....

Paul Nunn, WHO, Geneva



Green Light Committee annual enrolment



Preventing drug resistance

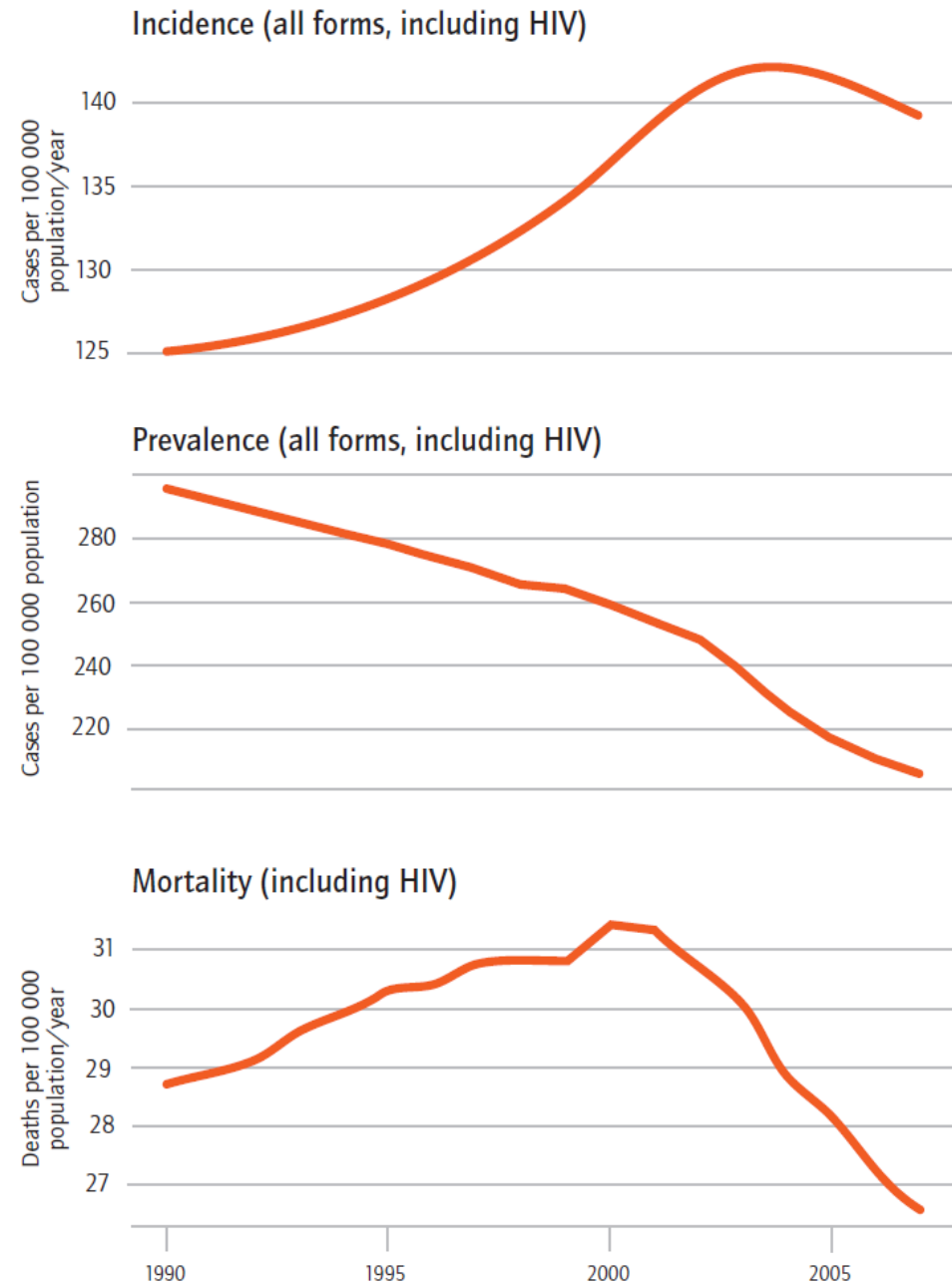
- Verdict – Probably failing
- Reasons for failure:
 - Insufficient quality of basic TB care
 - Management of MDR-TB is difficult, complex, & expensive
 - DOTS obsession, started management of MDR-TB too late?
 - Diagnostic tools too slow, until just now
 - Private sector creating it
 - Nosocomial transmission

No TB control programme can treat MDR-TB as fast as a bad programme can create it

Reducing the size of the problem...

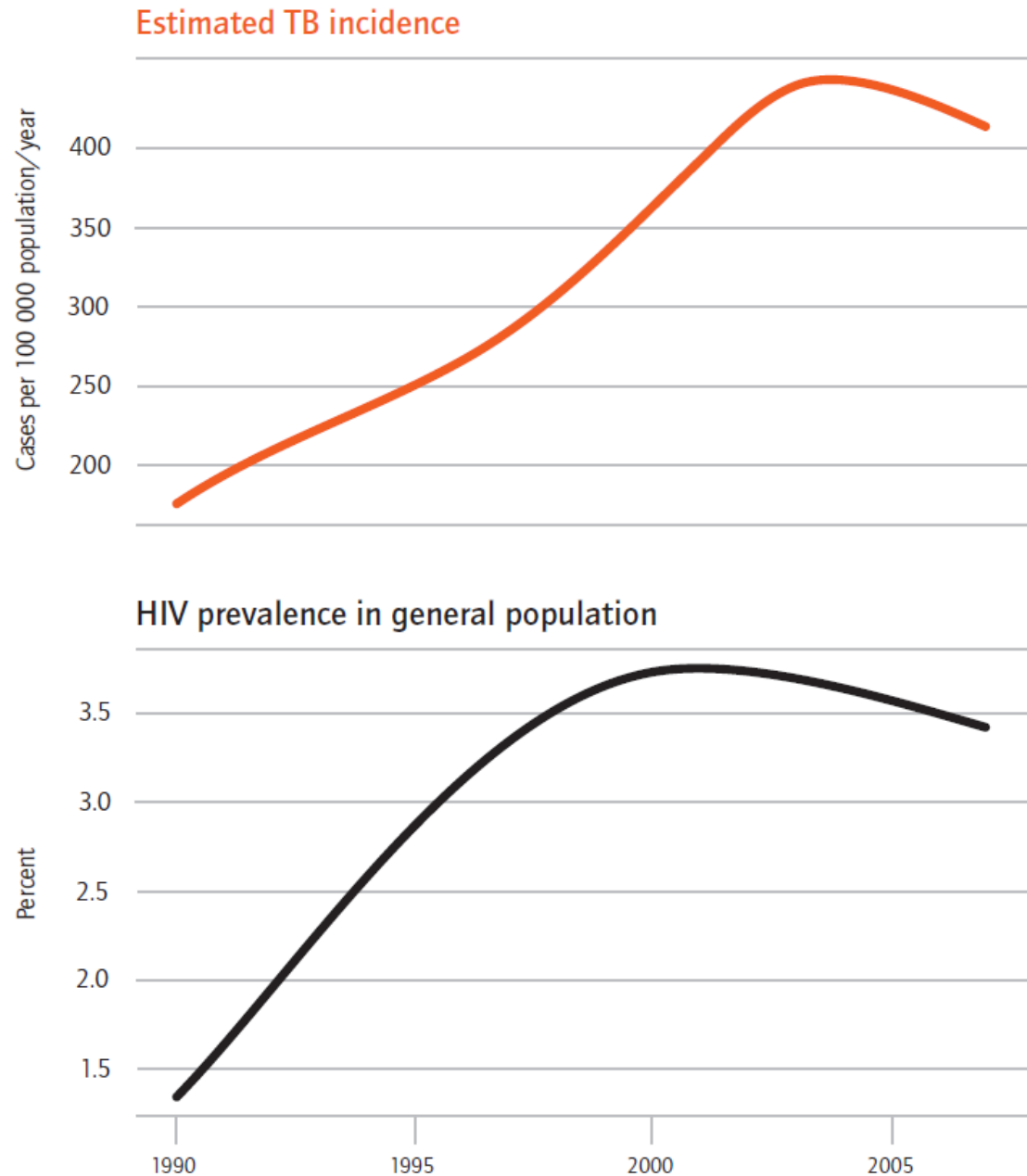


Global rates of TB incidence, prevalence and mortality, including in people with HIV, 1990-2007

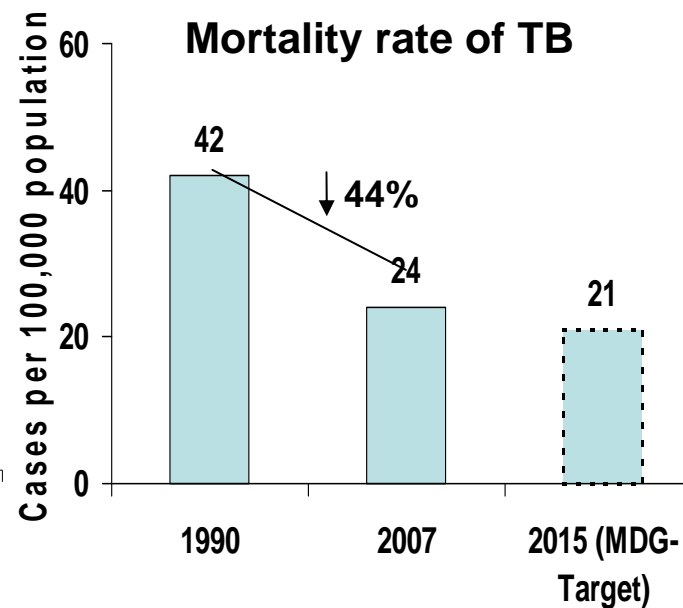
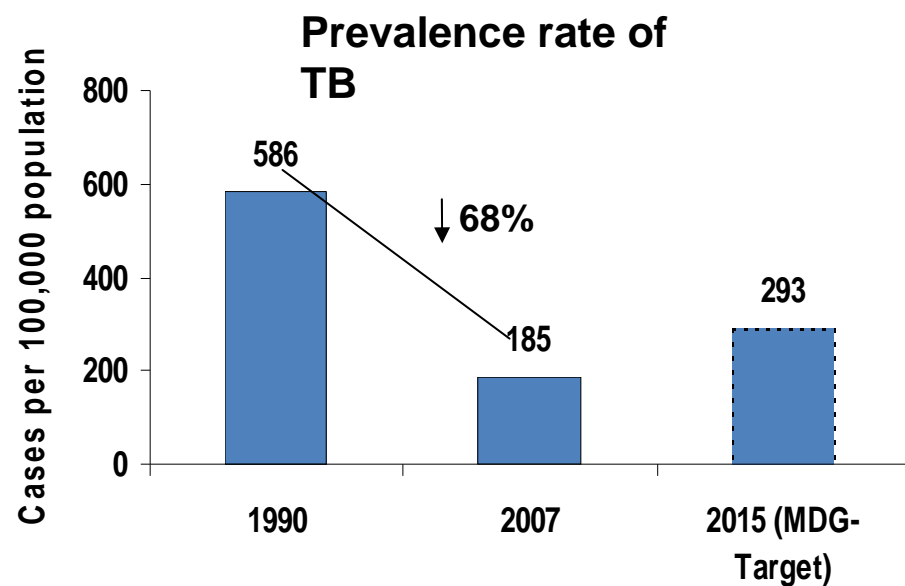


...even in the presence of HIV

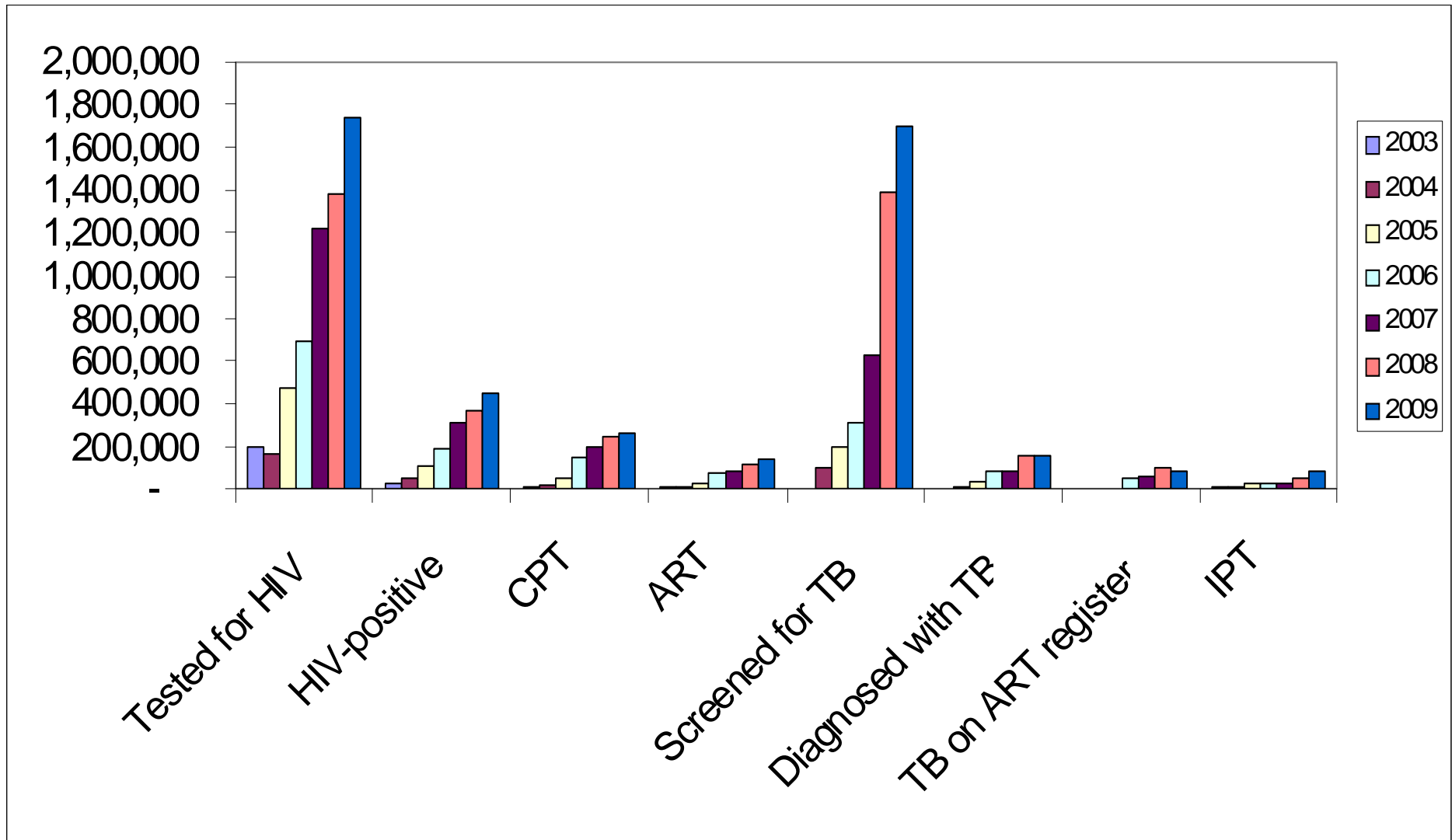
Estimated incidence of TB and prevalence of HIV for the African subregion most affected by HIV (Africa high-HIV), 1990-2007



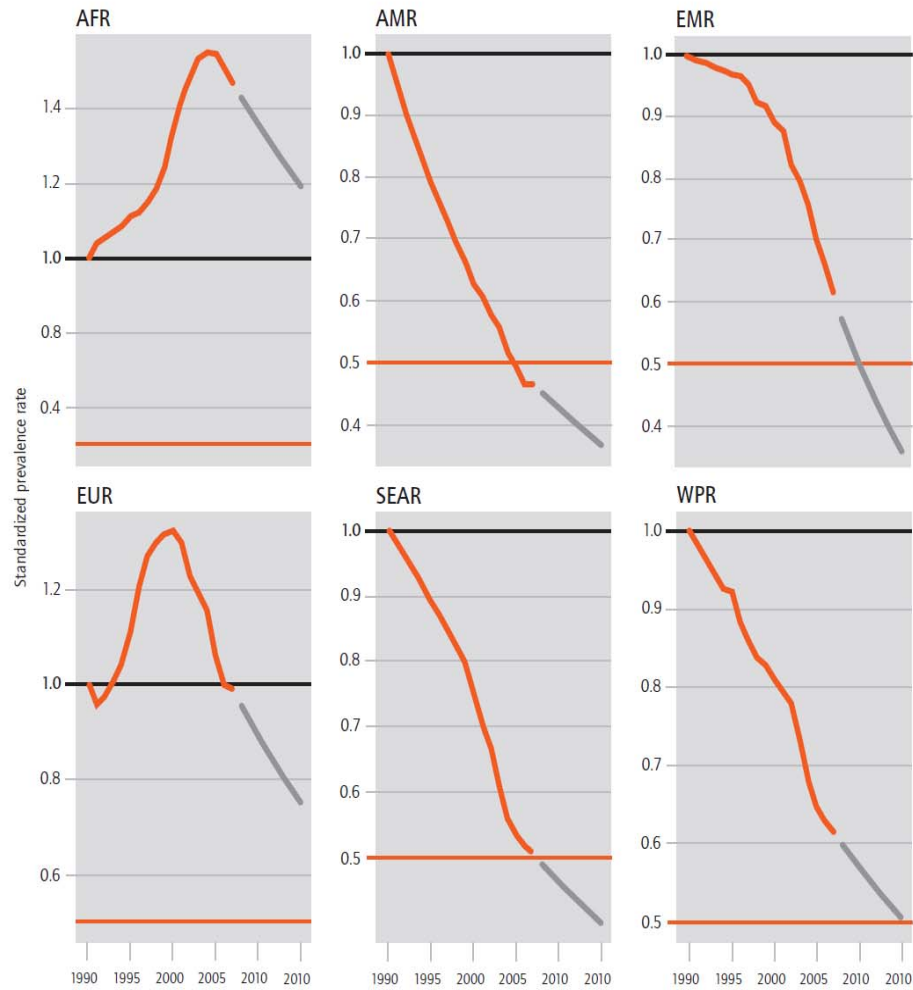
Progress towards Millennium Development Goals - India



Progress of implementation of TB/HIV collaborative activities 2003-2009



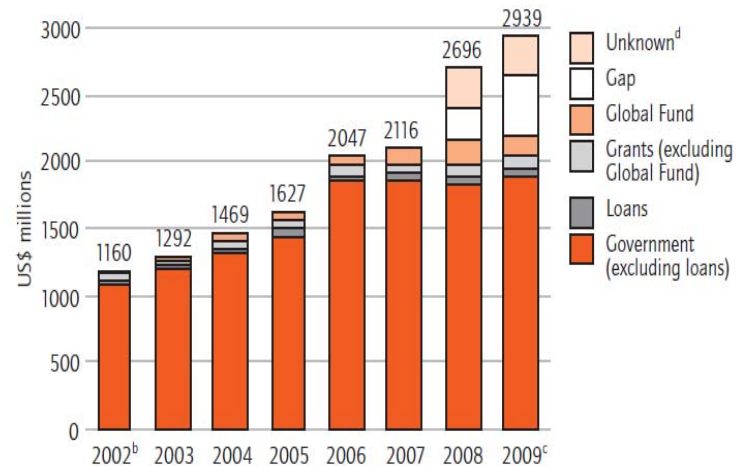
Progress towards achieving the target of halving prevalence by 2015 compared with the level of 1990, by WHO region. The y-axis displays standardized prevalence rates, with the baseline set at the 1990 level in each region (black horizontal line) and regional targets set at 50% of the 1990 level (red horizontal line). Trends for 2008–2015 are forecast using an exponential regression of estimated prevalence rates over the period 2005–2007.



Reasons for success in reducing the size of the problem

■ **FIGURE 3.8**

Total TB control costs by source of funding, high-burden countries,^a 2002–2009



^a Total TB control costs for 2002–2007 are based on expenditure data, whereas those for 2008–2009 are based on budget data.

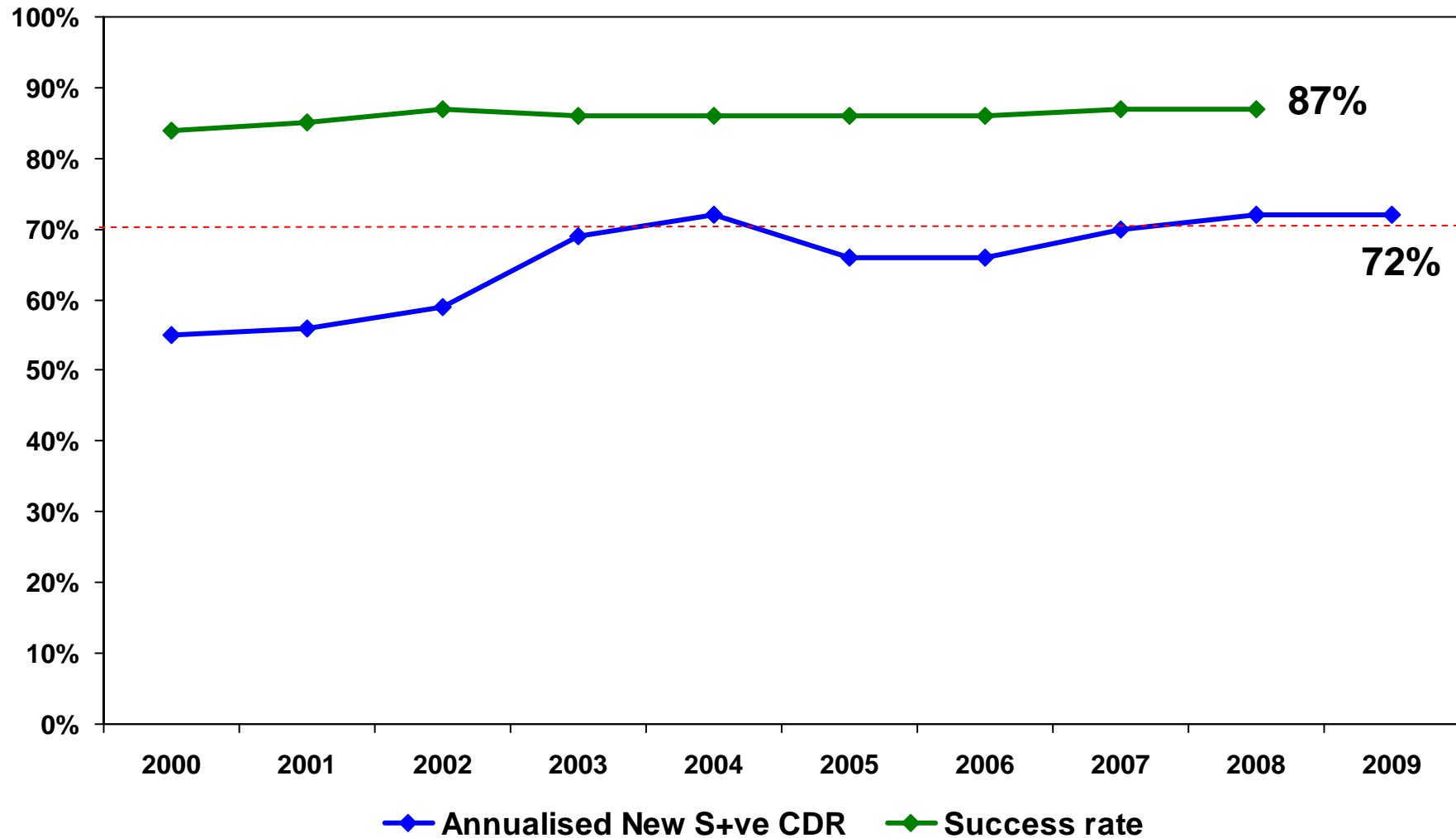
^b Estimates assume costs 2002 equal to costs 2003 for Afghanistan, Bangladesh, Mozambique, Nigeria, Uganda and Zimbabwe.

^c Estimates assume costs 2009 equal to costs 2008 for South Africa.

^d "Unknown" applies to South Africa 2008–2009.

- Standardised approach, even with Stop TB strategy
- Expanding the partners addressing TB (Amsterdam Ministerial meeting, and Cairo, DOTS expansion meeting, 2000)
- Increased technical assistance
- Increased funding – Global Fund for AIDS TB and Malaria
- Political response in big countries

New Smear-Positive Case Detection Rate and Treatment Success Rate in DOTS Areas, India, 2000-2009*



- Population projected from 2001 census
- Estimated no. of NSP cases - 75/100,000 population per year (based on recent ARTI report)

Targets

- "70% sputum smear positive case detection and 85% cure rate among those detected " (WHO – 2000, postponed to 2005)
- Millennium Development Goals:
 - Reduce incidence by 2015
- Stop TB Partnership goals:
 - Halving mortality and prevalence by 2015
- Case detection – failed (63% in 2008)
- Cure rate – succeeded (86% in 2008)
- MDG – succeeded 2004 (assuming no reversal before 2015)
- Likely success – except Africa (HIV) and Europe (MDR), and non-responsive governments in both

Conclusions

- Tremendous progress over the past several decades
- Must do better with current tools, eg faster diagnosis (expand Xpert) and ARVs
- Need new tools and strategies to control TB – most of the “easy work” has already been done – drugs and vaccines in the pipeline
- Core business + Health sector policies + research + determinants
- More attention to the human behavioural aspects of managing TB control: persistence, patient-centeredness, zealous adherence to technical rigour and programme excellence

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