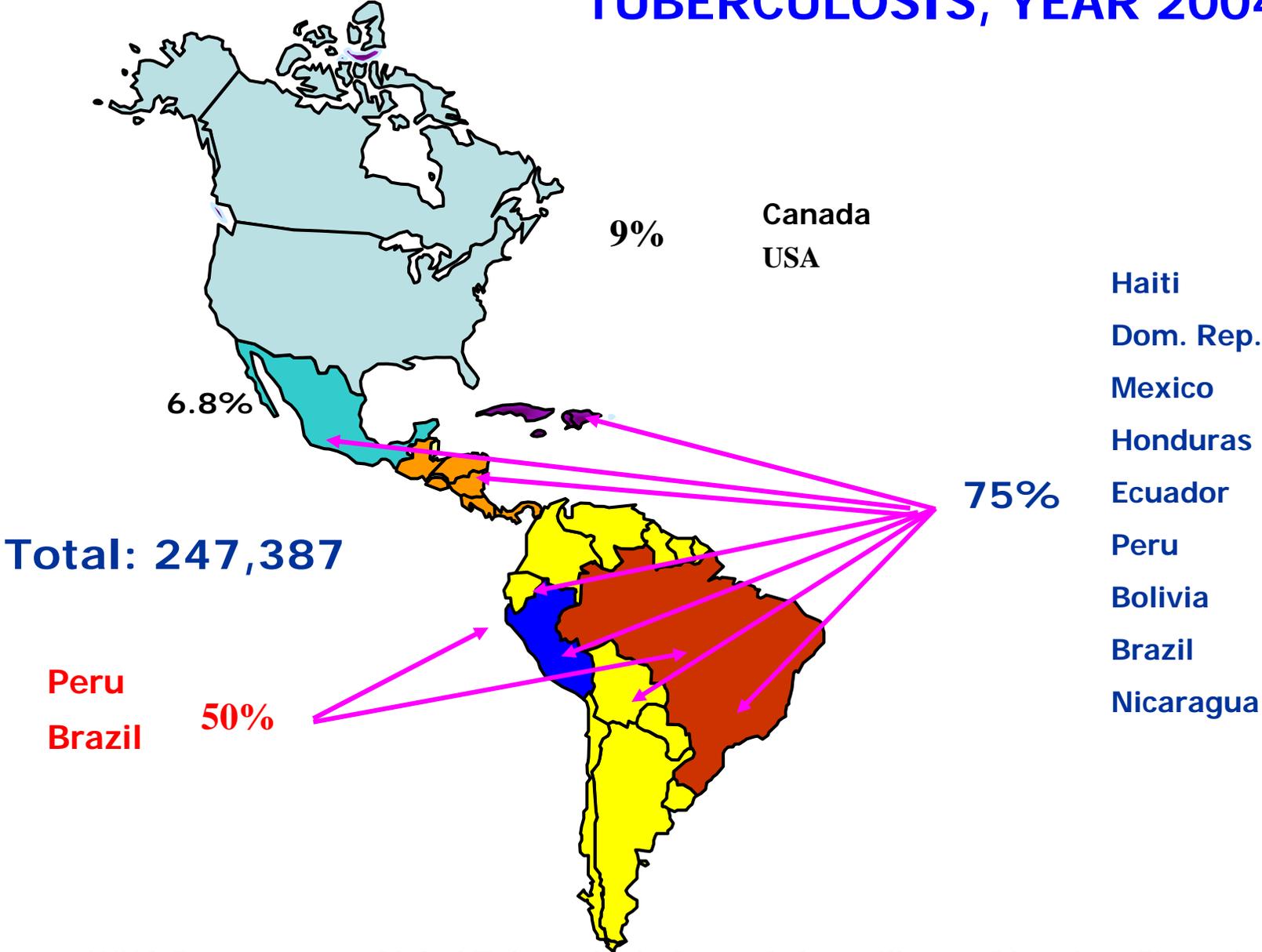


# HOW TO ENSURE POLITICAL COMMITMENT FOR MDR TB MANAGEMENT



*César Bonilla MD.*

# REGION OF THE AMERICAS TUBERCULOSIS, YEAR 2004



Source: WHO Report 2006. Global Tuberculosis Control. Surveillance, Planning, Financing

# BASIC PRINCIPLES IN MDR-TB MANAGEMENT

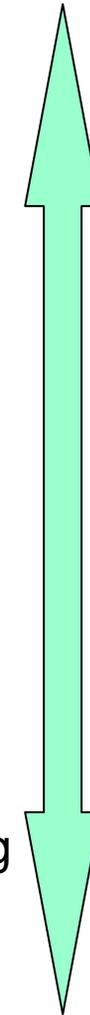
1. To establish a National TB Program that is efficient, effective and integrated into general health care services
2. To assure free access to quality medication (through application to the Green Light Committee).
3. To coordinate with the community and local governments to establish strategies that help ensure treatment adherence of the TB patient.
4. To provide free access to drug sensitivity tests.
5. To design an appropriate TB treatment regimen for the patient.



**POSITIONING THE NATIONAL TB CONTROL PROGRAM AS A FUNDAMENTAL ELEMENT  
IN ENSURING POLITICAL COMMITMENT**

# TECHNICAL EFFICIENCY IN MDR-TB MANAGEMENT

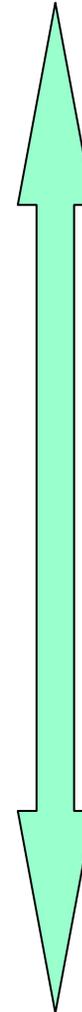
1. Clear objectives for the short, medium, and long term.
2. Clear components that improve processes
3. Consistency in application of the DOTS strategy
4. Transparency in decision-making and in the use of resources
5. Work in a multidisciplinary team at different levels of health care.
6. Coordination and strategic partnerships that facilitate a leadership role of MDR-TB management in the health care reform process, especially in regards to decentralization.
7. Organizational aspects:
  - Laboratory conditions
  - Treatment strategy
  - Information system and data management
  - Supervision and monitoring of patient care



**Cross-sectional  
Approach:  
POLITICAL  
COMMITTMENT**

# PRODUCTS OF THE APPROPRIATE APPLICATION OF THE BASIC PRINCIPLES IN MDR-TB MANAGEMENT

1. Reliable distribution of medication.
2. Professional commitment, commitment at health care establishments, and experience in MDR-TB patient care that helps ensure treatment adherence.
3. Implementation of reliable sensitivity tests for first- and second-line drugs.
4. Availability of human and physical resources.



**Cross-sectional  
Approach:  
POLITICAL  
COMMITMENT**

# STEP-BY-STEP BUILDING OF POLITICAL COMMITMENT IN MDR-TB MANAGEMENT

1. Explanation of the causes of MDR-TB.
2. TB Control:
  - Towards our intended direction.
  - DOTS strategy, the right way.
3. Magnitude of the MDR-TB problem.
4. Intervention strategies.
  - Positioning.
  - Marketing and Merchandizing.
  - Strategic partnerships with the civil society and TB patient organizations.
  - Advocacy, social mobilization, and strategic communication.
  - Technical efficiency in resource utilization.
  - Investigation: operational, epidemiological, and clinical.
5. Consolidating political commitment.

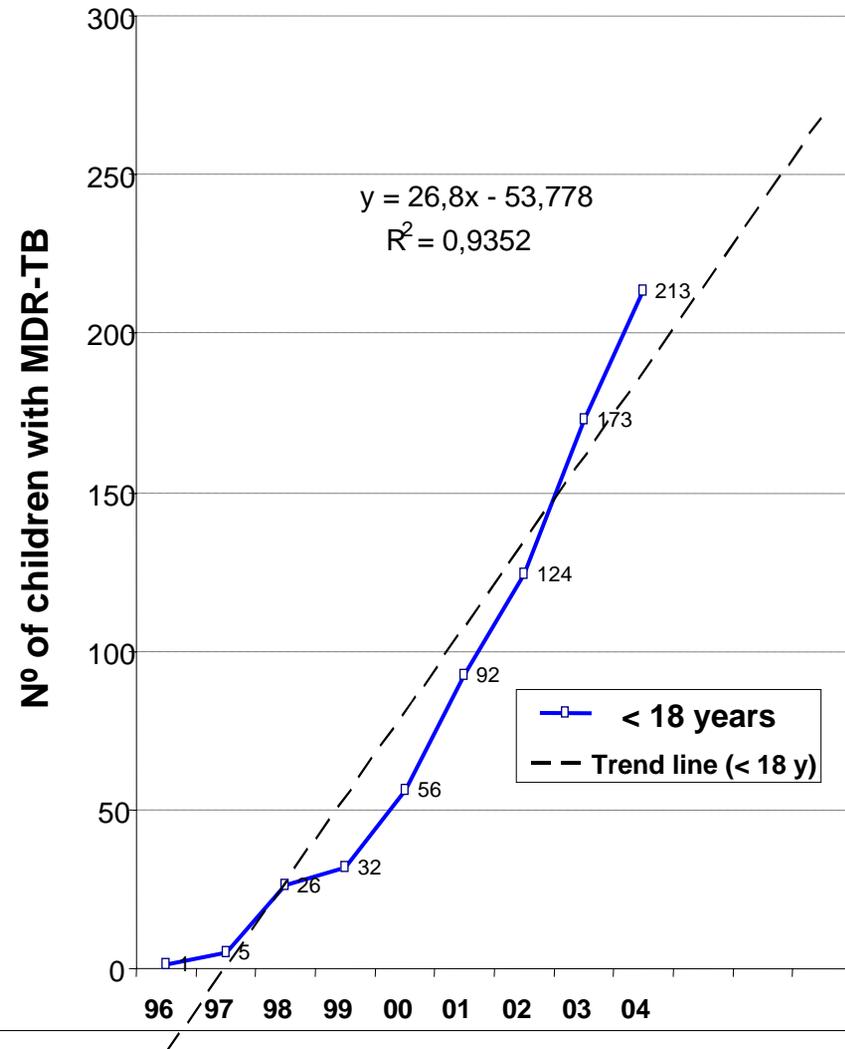
# **1.EXPLAINING THE CAUSES OF MDR-TB**

# MAGNITUDE OF THE MDR-TB PROBLEM IN PERU

The presence of MDR-TB is the result of numerous failures by the health care system over time:

1. Use of ineffective treatment regimes for MDR-TB during the 80's and 90's amplified resistance.
2. Persistent MDR-TB cases in the community without timely access to adequate treatments increased sources of infection with MDR bacilli among the population.
3. Poorly defined therapeutic policies in regards to new MDR-TB cases among contacts of documented MDR-TB cases.
4. Underestimation of the magnitude of MDR-TB resulted in inadequate diagnosis and treatment interventions.

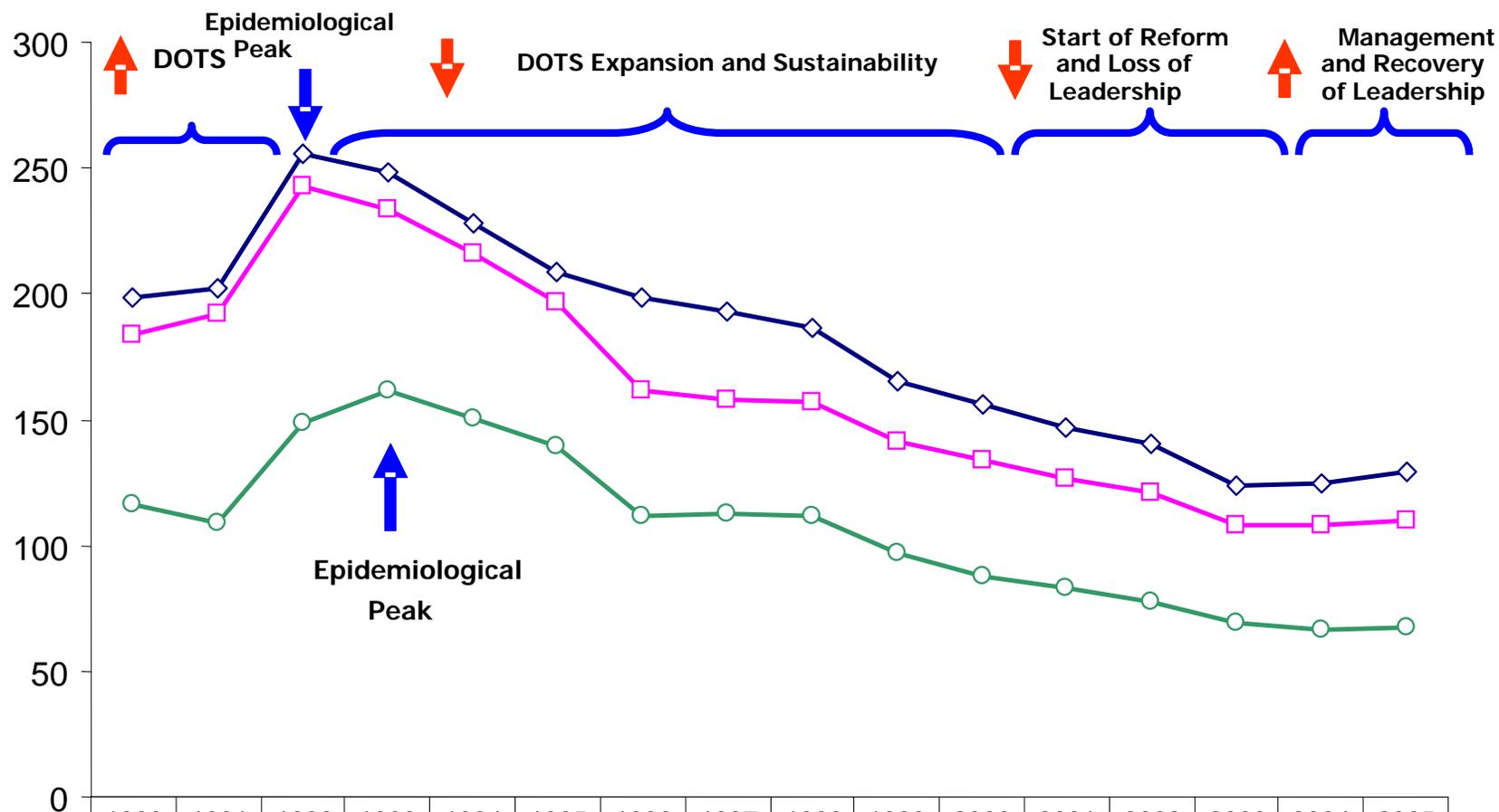
**CHILDREN < 18 YEARS OLD WITH MDR-TB THAT HAVE ACCESS TO STANDARD AND INDIV. RETREATMENT, THREE-YEAR TREND LINE PERU 1996-2004**



## **2. TB CONTROL IN PERU:**

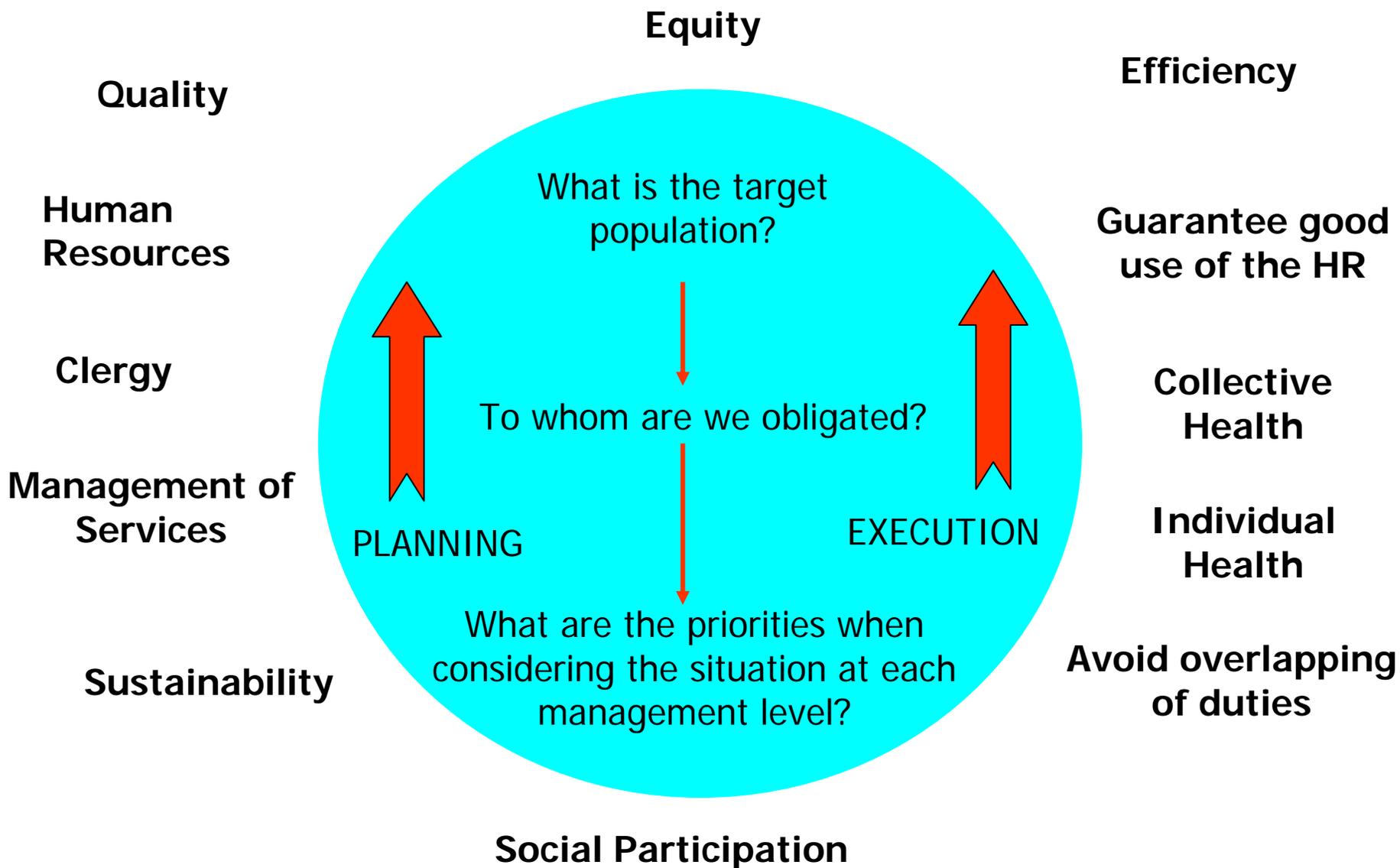
- **TOWARDS OUR INTENDED DIRECTION**
  - **DOTS STRATEGY THE RIGHT WAY**

# TB MORBIDITY AND INCIDENCE RATES IN PERU, 1990-2005

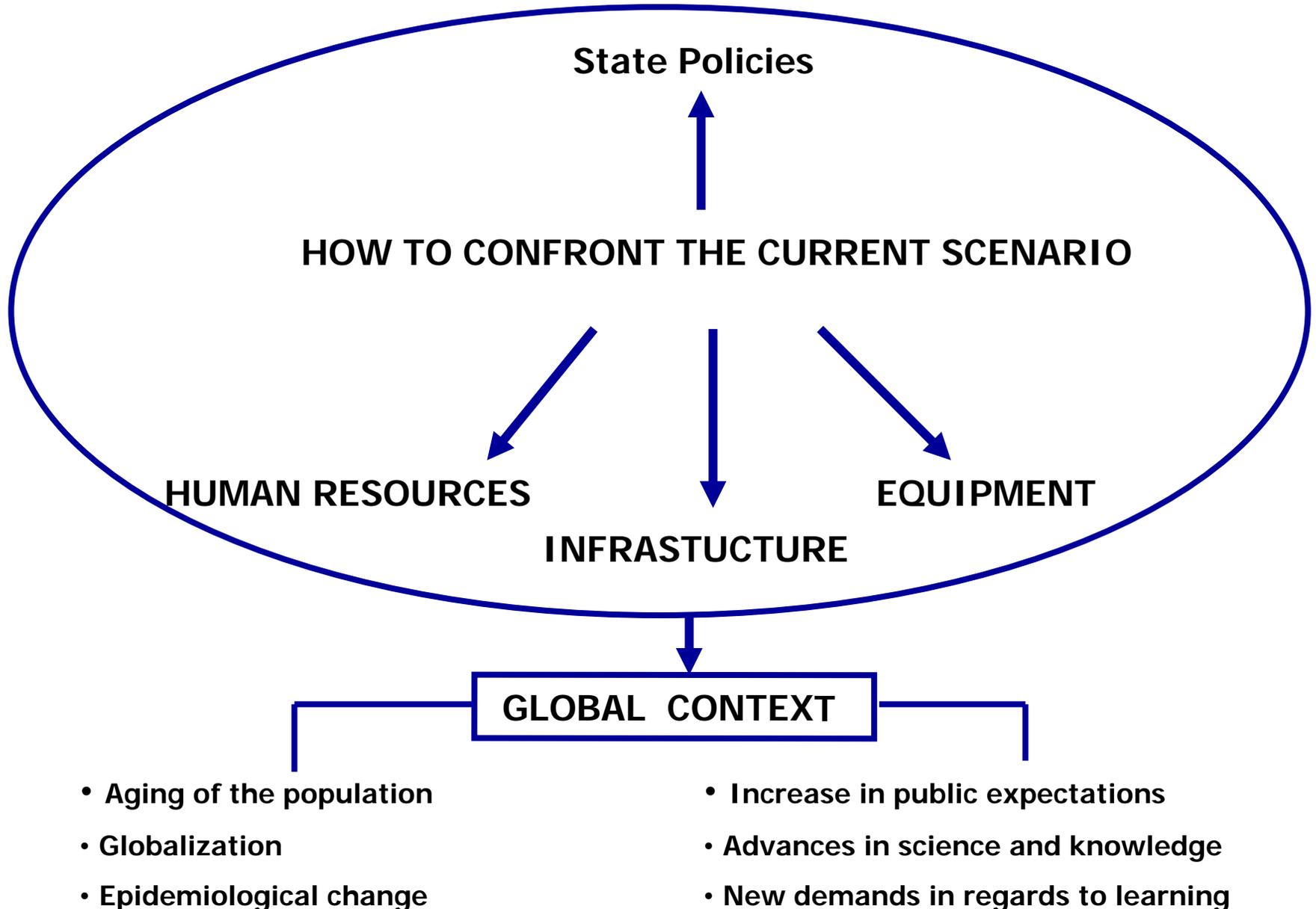


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
◆ MORBIDITY	198,6	202,3	256,1	248,6	227,9	208,7	198,1	193,1	186,4	165,4	155,6	146,7	140,3	123,8	124,4	129,0
□ TB INCID.	183,3	192	243,2	233,5	215,7	196,7	161,5	158,2	156,6	141,4	133,6	126,8	121,2	107,7	107,7	109,7
○ BK+ INCID.	116,1	109,2	148,7	161,1	150,5	139,3	111,9	112,8	111,7	97,1	87,9	83,1	77,4	68,8	66,4	67,1

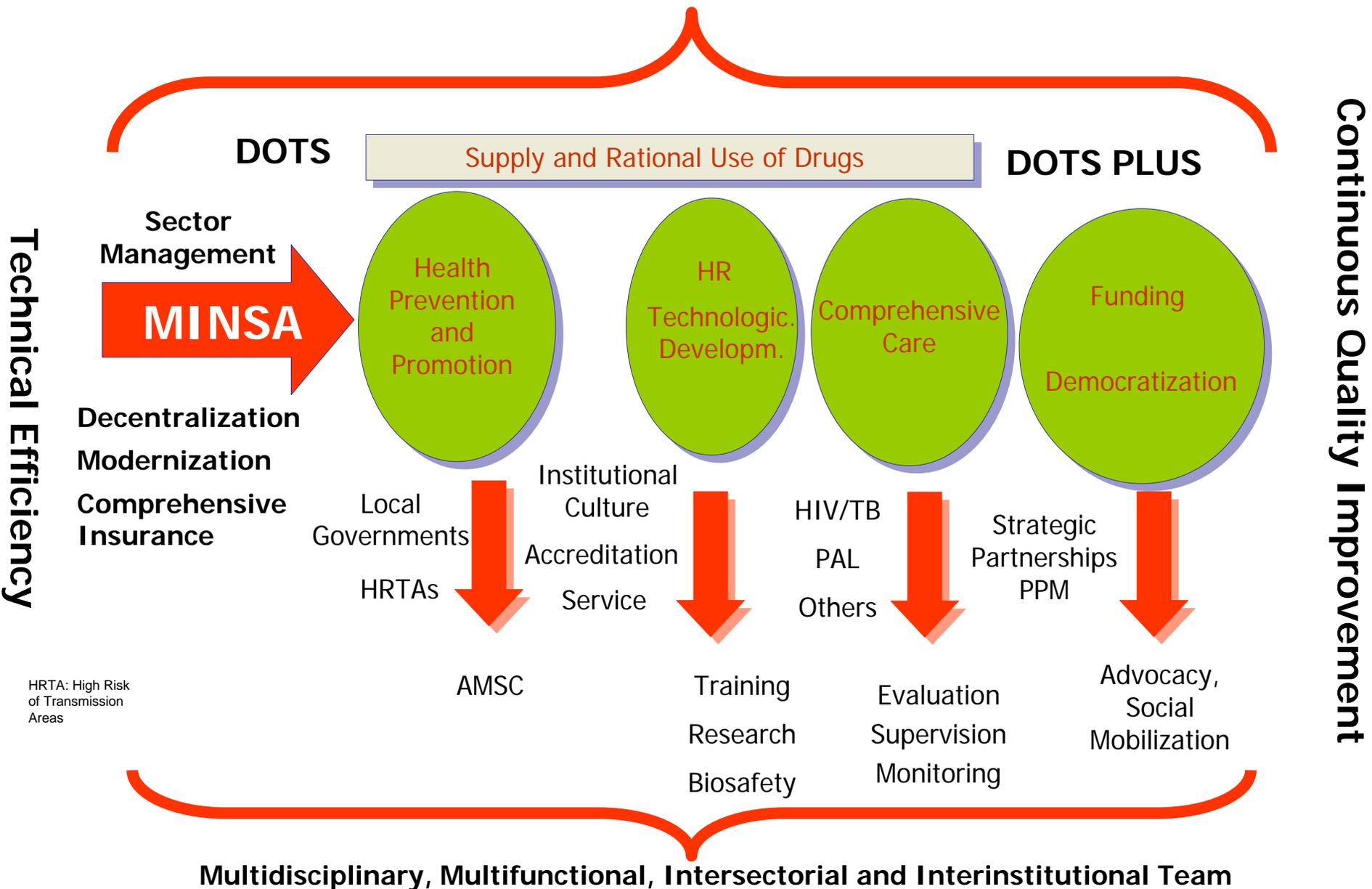
# WHAT ARE WE LOOKING FOR IN MODERN PUBLIC HEALTH?

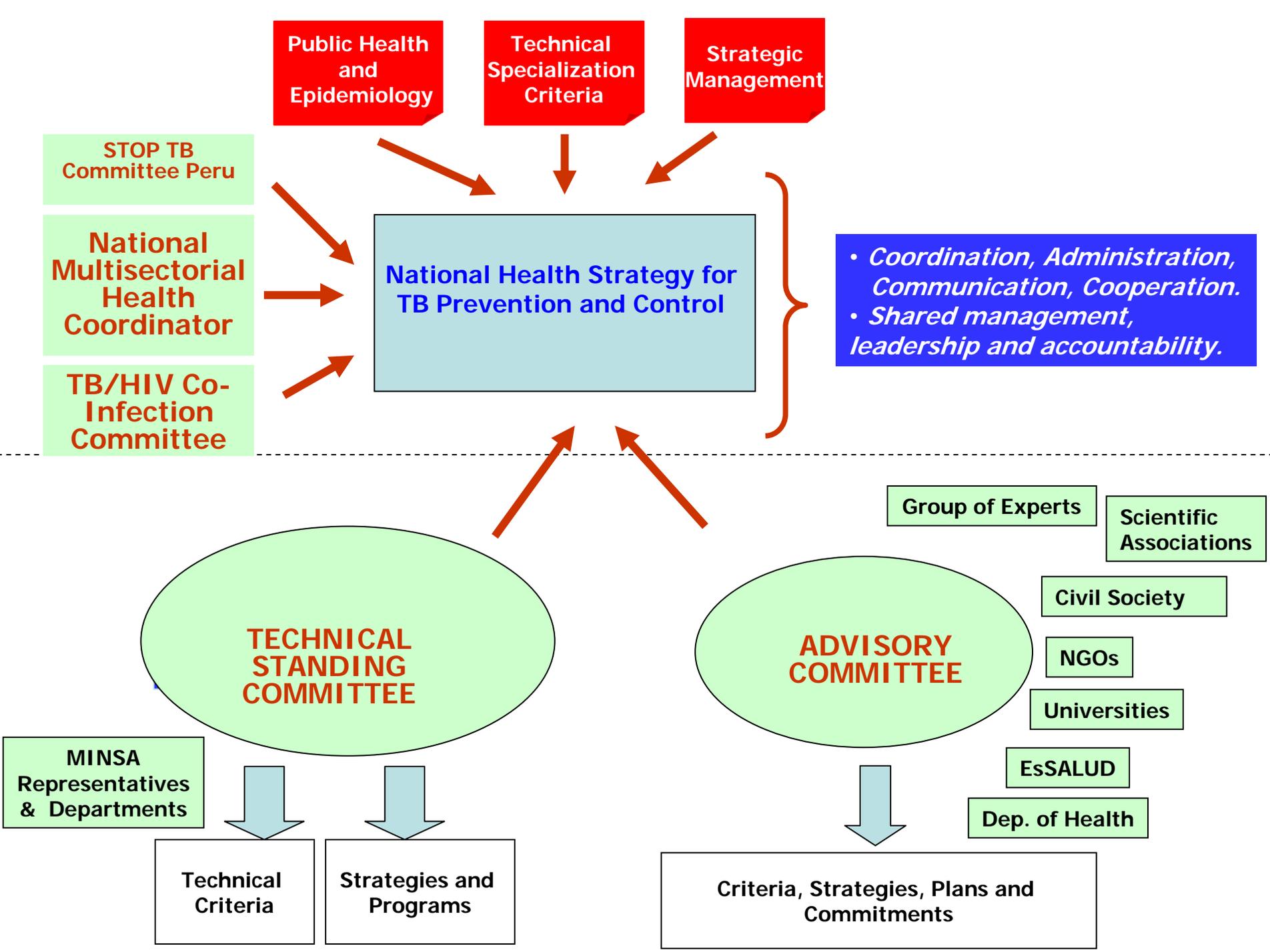


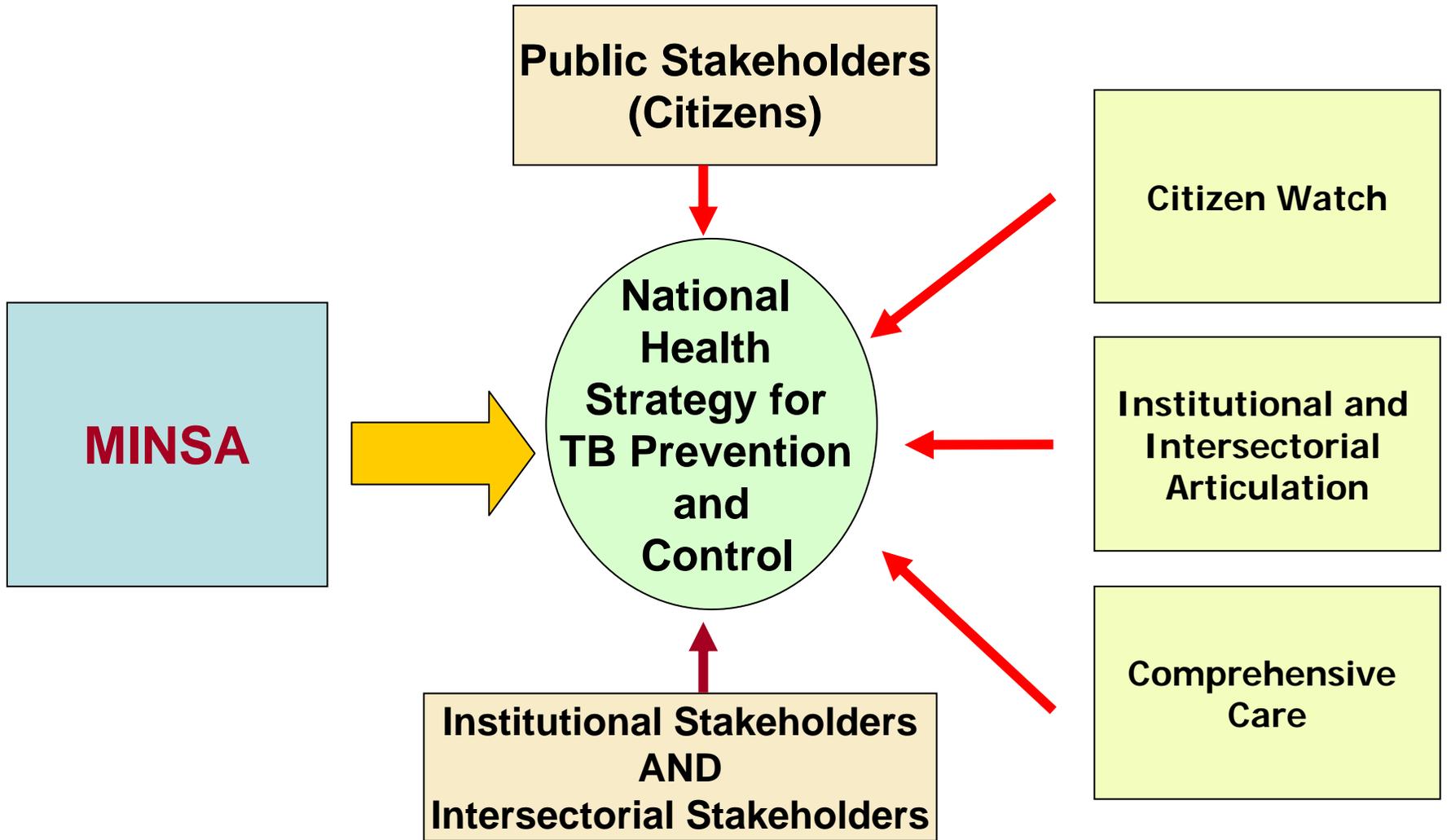
# PUBLIC HEALTH AND TB CONTROL PROGRAMS



# POLICY GUIDELINES FOR THE HEALTH CARE SECTOR AND THE NATIONAL HEALTH STRATEGY FOR TB PREVENTION AND CONTROL







# TB CONTROL ATTITUDES AND COMMITMENTS

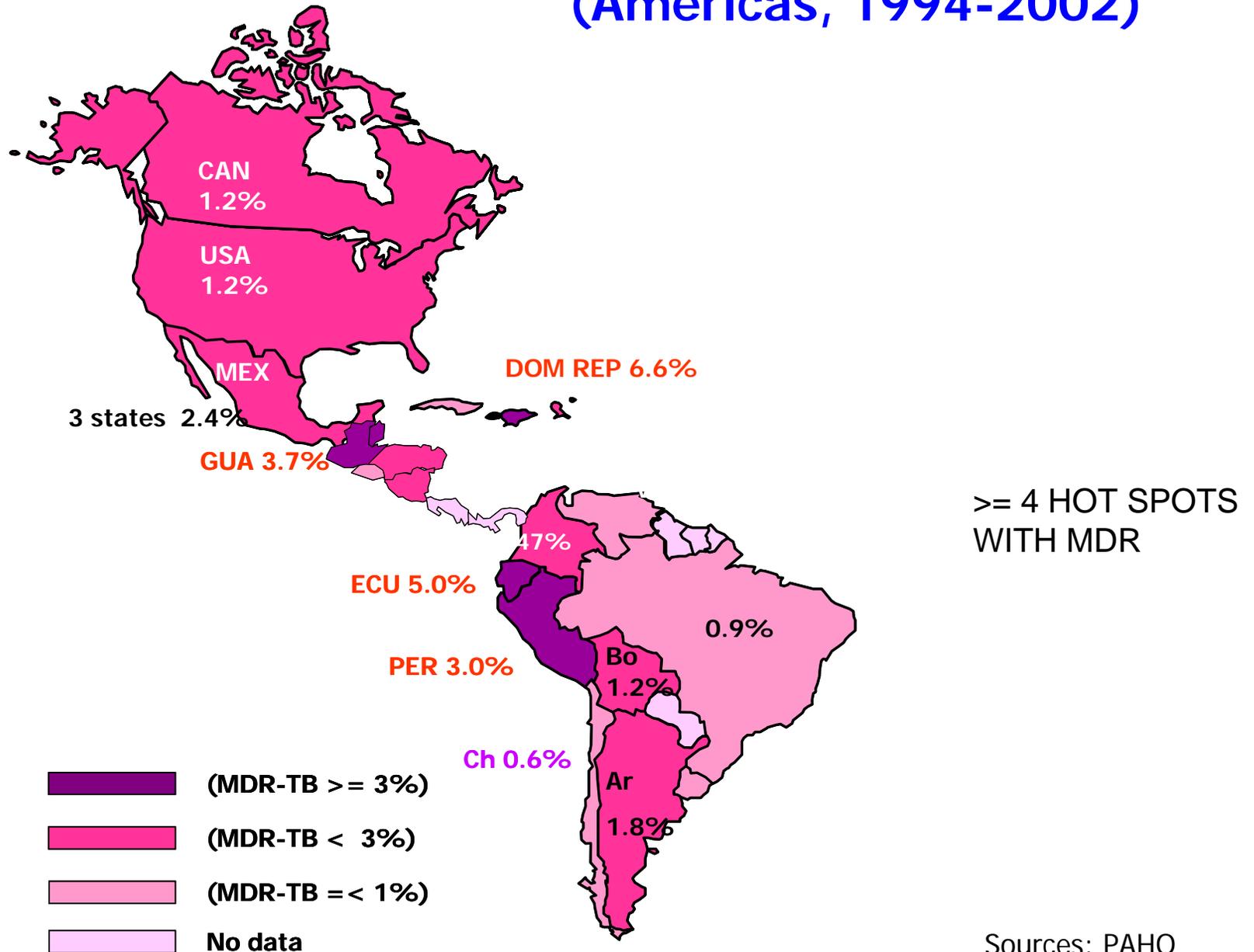
1. Promotion of a health culture in the context of TB control, considering the impact of TB on the person and the society.
2. Personal dignity & bioethical behavior.
3. Promotion & social participation as an expression of active citizenship.
4. Evidence-based information to guide social, technical & political interventions.

# NEW PARADIGMS

1. Promoting TB and MDR-TB control while preserving human dignity, bioethics, and human rights within a healthy citizen context.
2. Comprehensive and integrated health care to enhance TB and MDR-TB control actions.
3. Promoting advocacy and guiding public policy through intersectoriality, interinstitutionality and development of strategic partnerships for TB and MDR-TB control.
4. Organizing and providing care to people with TB and MDR-TB through multidisciplinary teams comprised of a healthcare team, civil society representatives, and associations of people living with TB.
5. Strategic communication.

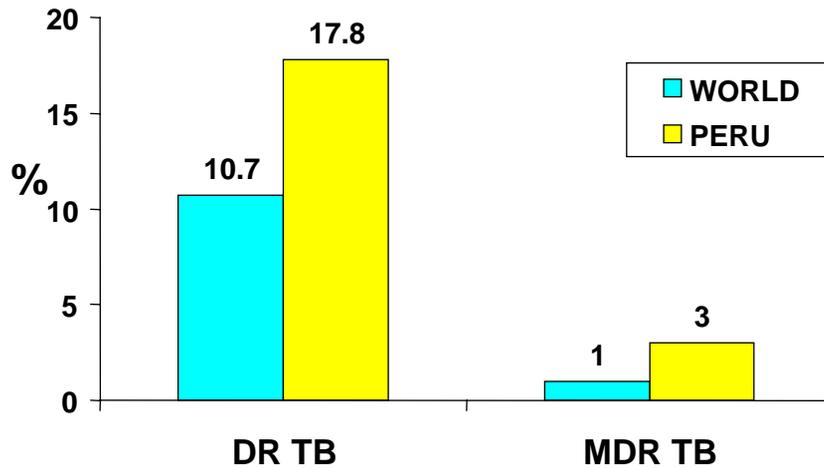
## **4. MAGNITUDE OF THE MDR-TB PROBLEM**

# INITIAL RESISTANCE OF MDR-TB (Americas, 1994-2002)

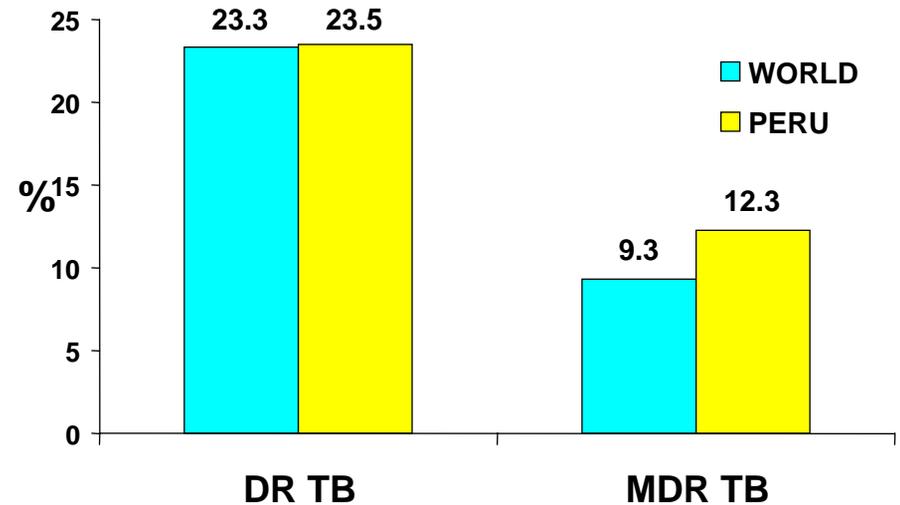


Sources: PAHO

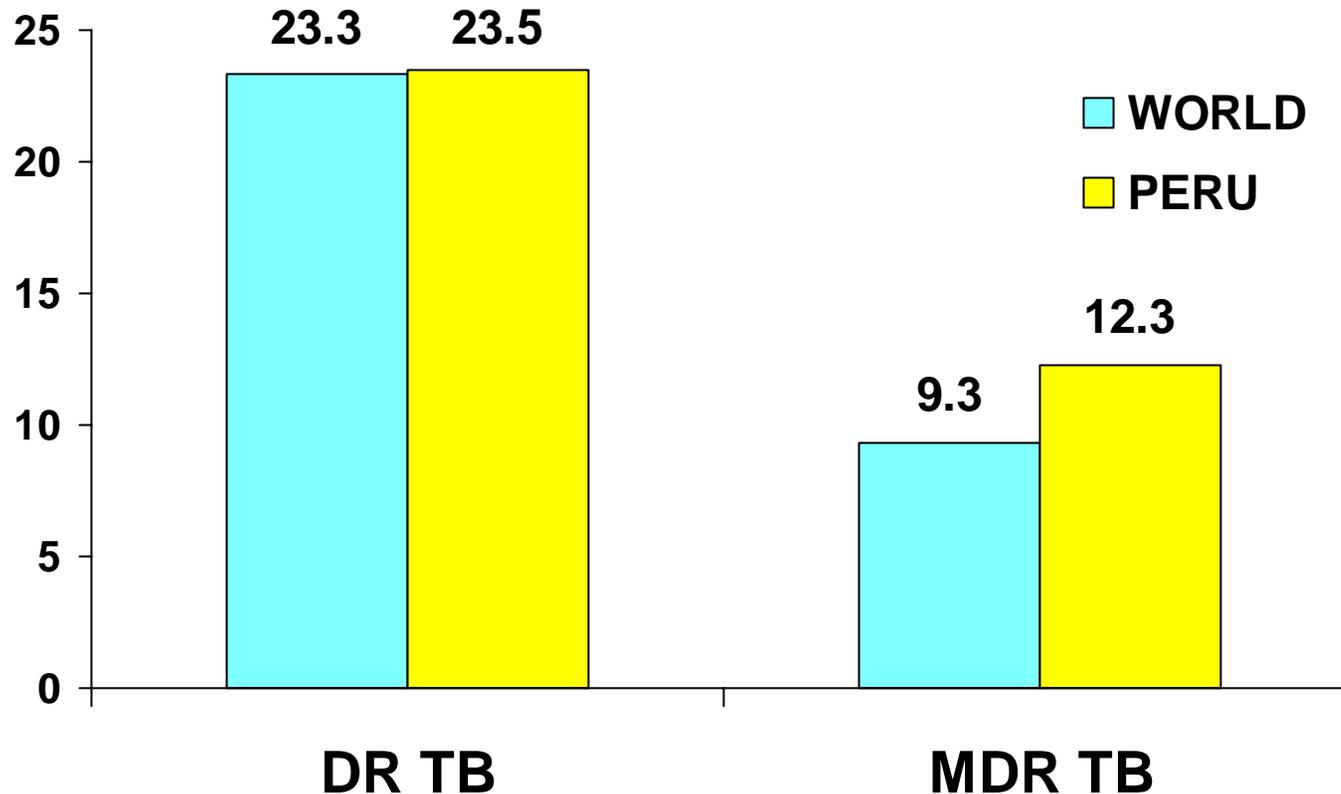
### DRUG-RESISTANT TB IN NEW PATIENTS, WHO/UICter 1999



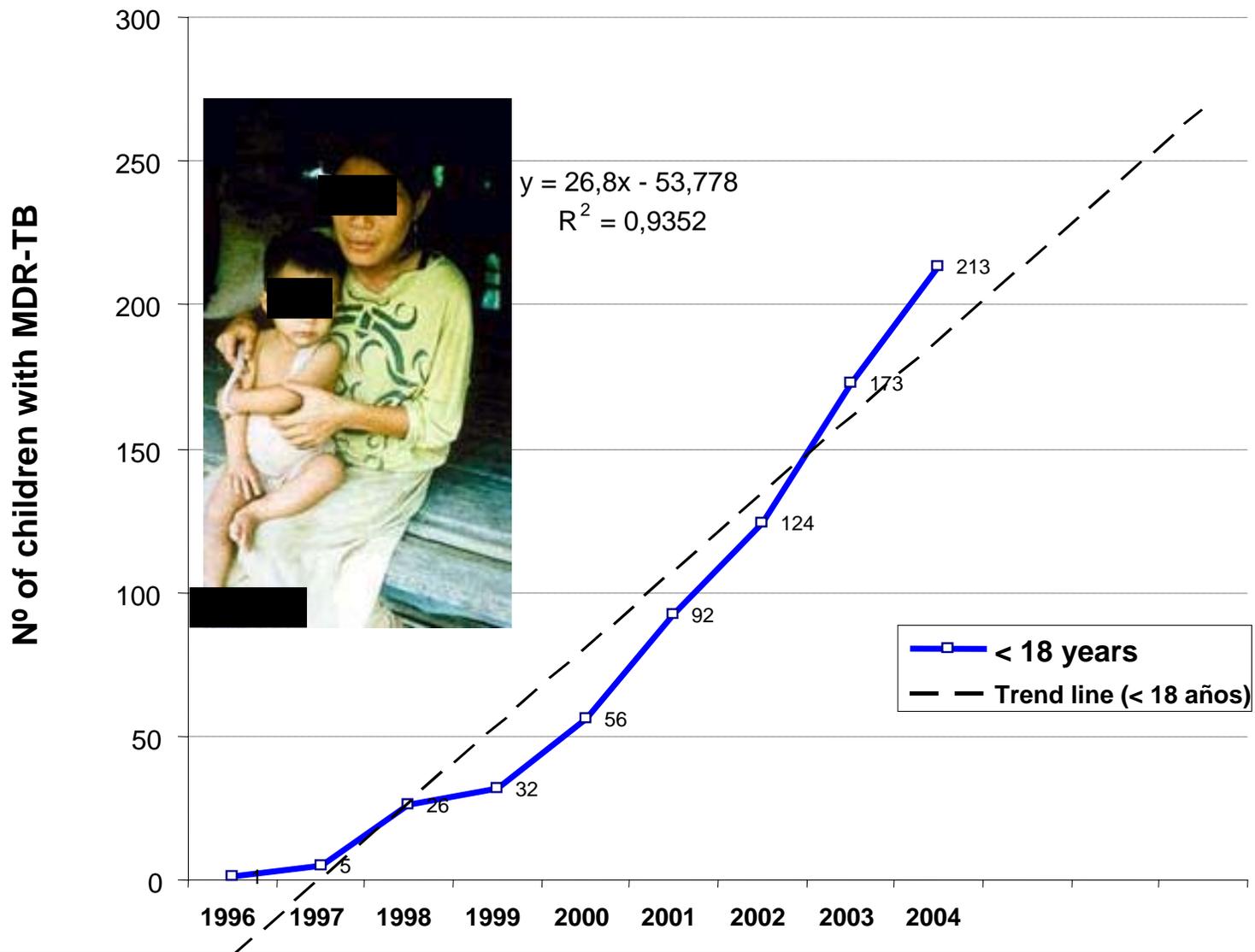
### DRUG-RESISTANT TB IN PREVIOUSLY TREATED PATIENTS, WHO/UICter 1999



# DRUG-RESISTANT TB IN PREVIOUSLY TREATED PATIENTS, WHO/UICITER 1999

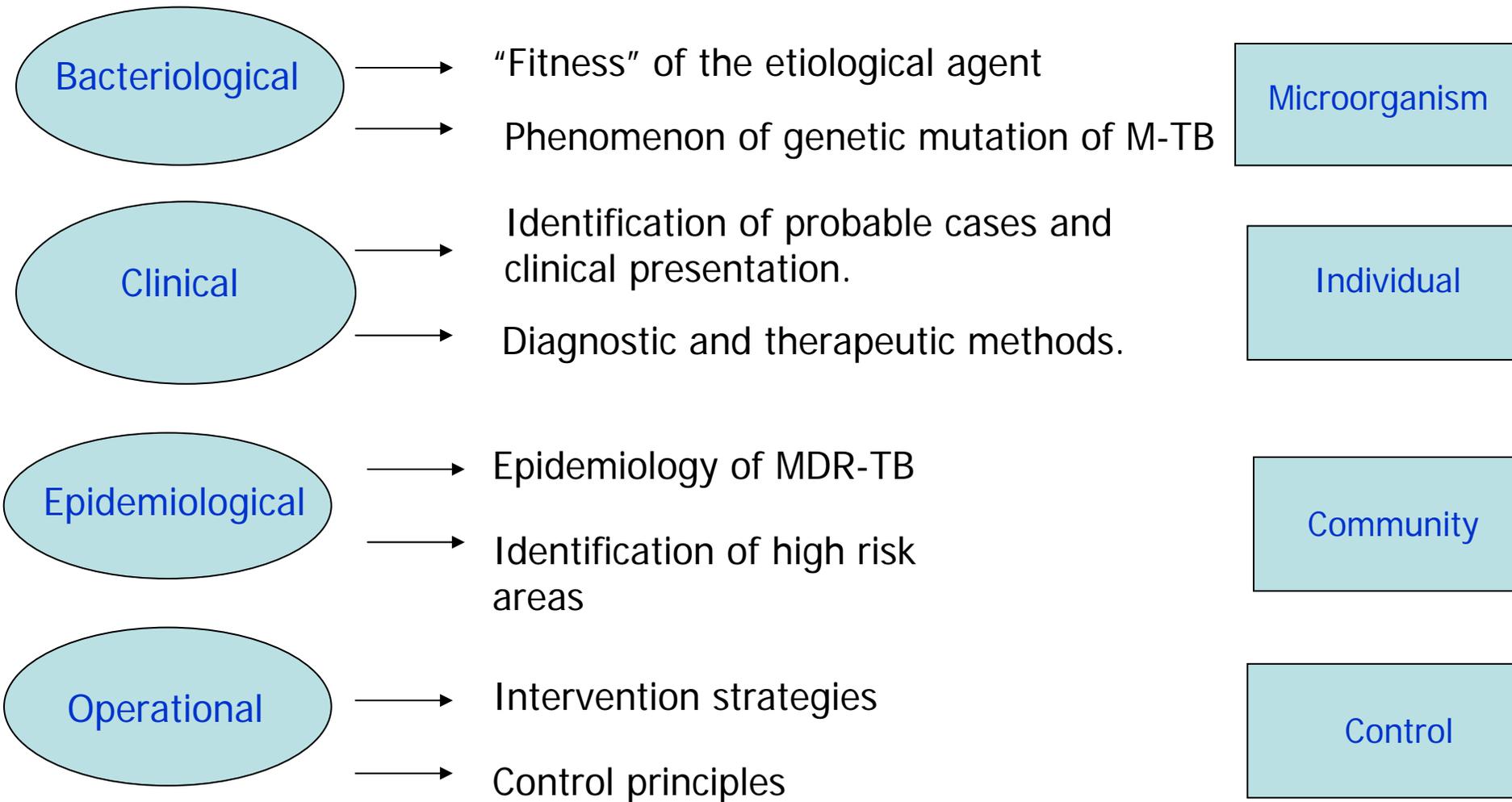


**CHILDREN WITH MDR-TB < 18 YEARS THAT CONSENTED TO STANDARD AND INDIVIDUALIZED RETREATMENT, TREND LINE AT THREE YEARS.  
PERU 1996-2004**



## **5. MDR-TB INTERVENTION STRATEGIES**

# METHODOLOGICAL FOUNDATIONS AND IMPACT OF MDR-TB CONTROL



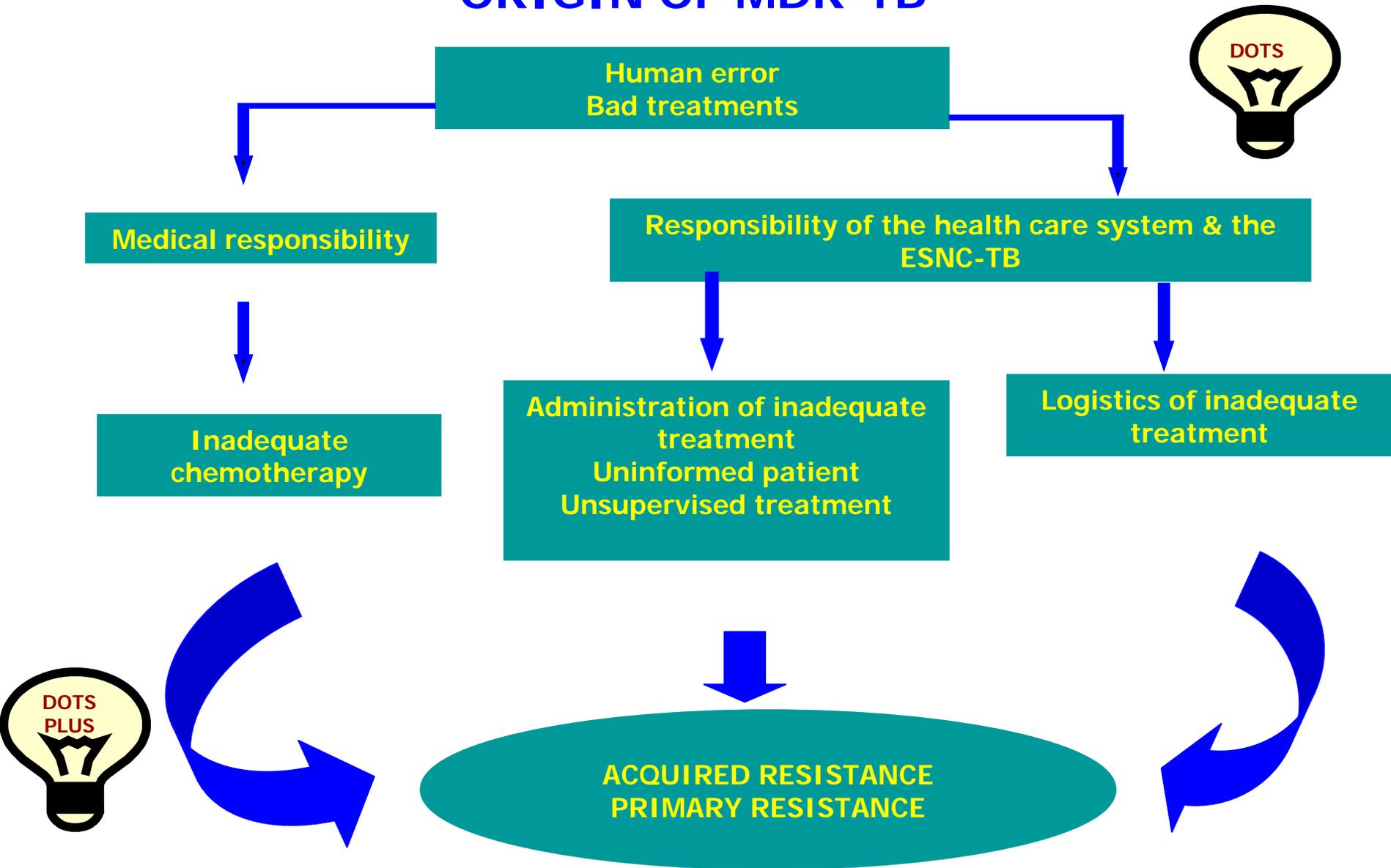
# POINT OF EQUILIBRIUM OR RUPTURE OF BALANCE

## Control Strategies



# MULTI-DRUG RESISTANT TUBERCULOSIS

# ORIGIN OF MDR-TB



## FOCUS ON MDR-TB CONTROL WITHIN THE CONTROL PROGRAM PLANS

- ✓ Adequate therapeutic arsenal.
- ✓ Rapid diagnostic tests that are accessible at low cost.
- ✓ Organizational support :
  - Case identification and rapid initiation of treatment.
  - DOTS strategy that prevents irregularity and defaults.
  - Monitoring and consistent clinical follow-up.
  - Management of RAFA.
  - Complementary interventions.

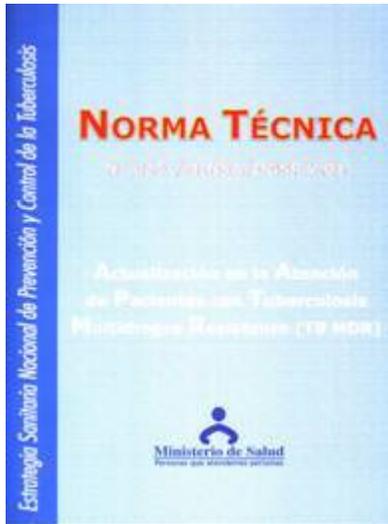
## **FOCUS ON MDR-TB CONTROL WITHIN THE CONTROL PROGRAM PLANS**

- ✓ Efficient application of the DOTS strategy.
- ✓ A TB control strategy integrated into the health care system.
- ✓ Population with access to health care services.
- ✓ Strategic partnerships.
- ✓ Community participation.

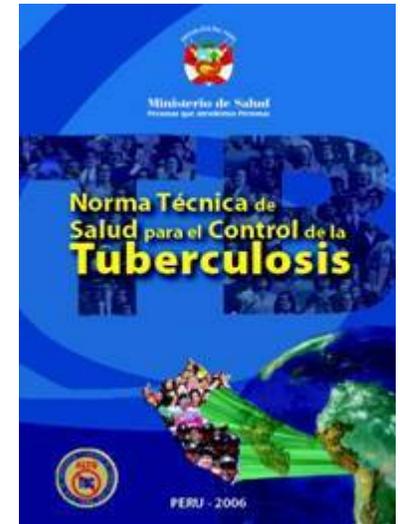
# **FACTORS THAT HAVE FACILITATED THE STRENGTHENING OF MDR-TB MANAGEMENT**

1. To implant the DOTS strategy, tuberculosis control must fulfill the standards established by the WHO. Thus, it is safe to give credence to the treatment results obtained by the Peruvian program. These results reflect the general effectiveness of treatment strategies that employ first- and second-line drugs.
2. The situation in Peru is unique, as it is a country where these strategies of standardized and individualized treatment have been employed side by side.
3. In Peru, the use of treatment with second-line drugs has evolved over time.

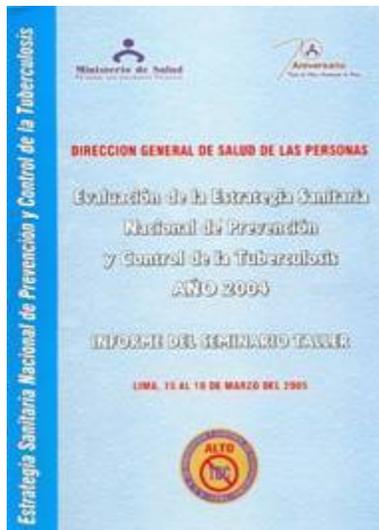
# TECHNICAL HEALTH STANDARDS (TS) AND PUBLICATIONS



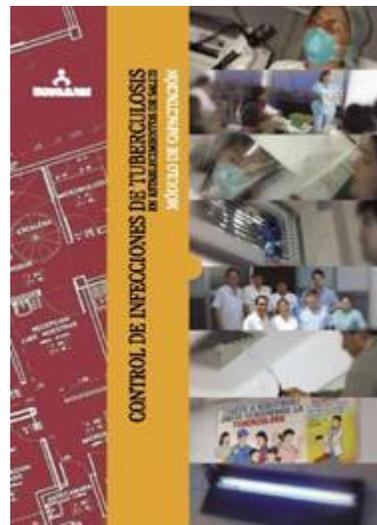
TS MDR-TB



TS – TUBERCULOSIS



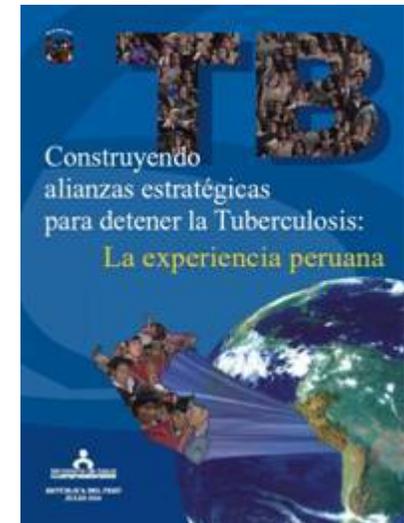
Evaluation Report  
ESN-PCT 2004



Biosafety Training  
Module



Tuberculosis  
Training Module



Building Strategic  
Partnerships

# 6 IMPORTANT REASONS WHY IT IS NECESSARY TO BE CONCERNED ABOUT MDR-TB

## 1. PUBLIC HEALTH

MDR-TB exerts pressure on the epidemiological nature of the disease. Patients that are not treated represent sources of future infection and a public health risk in the community.

## 2. ECONOMICAL

When cases of MDR-TB are not given appropriate treatment regimens, a curable illness that can be treated at low cost becomes an unmanageable health problem.

## 3. SOCIO-MEDICAL ANTHROPOLOGICAL

MDR-TB patients face disability and/or death.

# 6 IMPORTANT REASONS WHY IT IS NECESSARY TO BE CONCERNED ABOUT MDR-TB

## 4. POLITICAL

To be concerned with MDR-TB is to be concerned with those who are the most poor and marginalized. To confront MDR-TB can signify the eradication of one of the most severe kinds of poverty and discrimination.

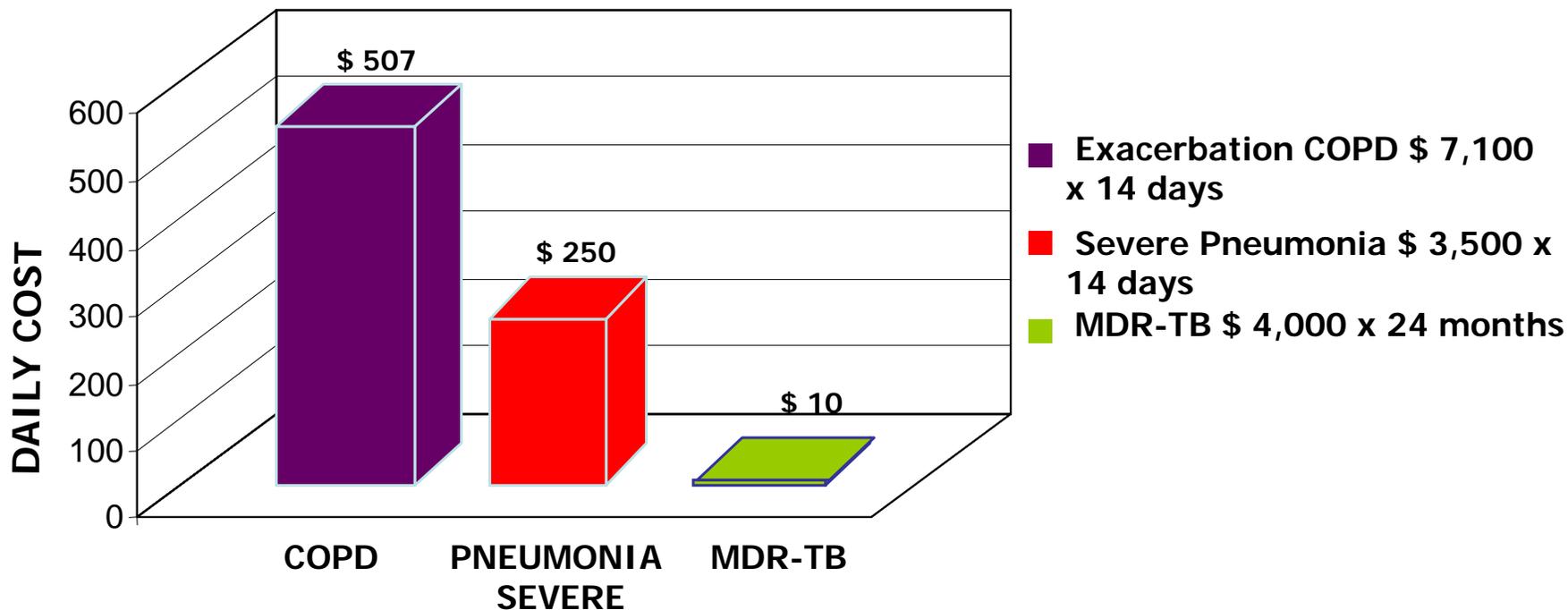
## 5. BIOETHICAL

In its human dimension, access to treatment is considered a human right.

## 6. INSTITUTIONAL IMAGE

An MDR-TB problem can lower public opinion of the health system and the National TB Program.

# HOW MUCH IS INVESTED IN PULMONARY HEALTH ?



*Khaled A, et al. Bull of The WHO 2001*

In a study conducted in 2001 by the World Health Organization (WHO) and the National TB Control Program of Peru (PNCT), the cost-effectiveness of providing second-line drugs to chronic TB patients (in comparison to the baseline situation in which these drugs were not available and the use of health services for chronic patients was considered null) was evaluated from the perspective of the public health system and found a cost benefit of \$150 to \$200 per DALY (Disability-Adjusted Life Years).

*Suarez P, Floyd K, Portocarrero J, Alarcon E, Rapiti E, Ramos G, Bonilla C, Sabogal I, Aranda I, Dye C, Raviglione M, Espinal M. Feasibility and cost effectiveness of standardised second-line drug treatment for chronic tuberculosis patients : a national cohort study in Peru. Lancet 2002 Nov 2:360 (9343):1340*

# AVERTED MORBIDITY-MORTALITY

Averted Morbidity-Mortality	2002	2003	2004	2005	2006	Total
A) Total cases in retreatment	1,423	1,679	1,919	2,365	526	7,912
B) Infected cases prevented per year (N°x10x5 years)	71,150	83,950	95,950	118,250	26,300	395,600
C) Disease cases prevented	7,115	8,395	9,595	11,825	2,630	39,560
D) Deaths prevented (A+C)	8,538	10,074	11,514	14,190	3,156	47,472

Disease prevented: USA \$ 118,680,000    Deaths prevented: USA \$ 142,416,000

**TOTAL PREVENTED: USA \$ 261,096,000**



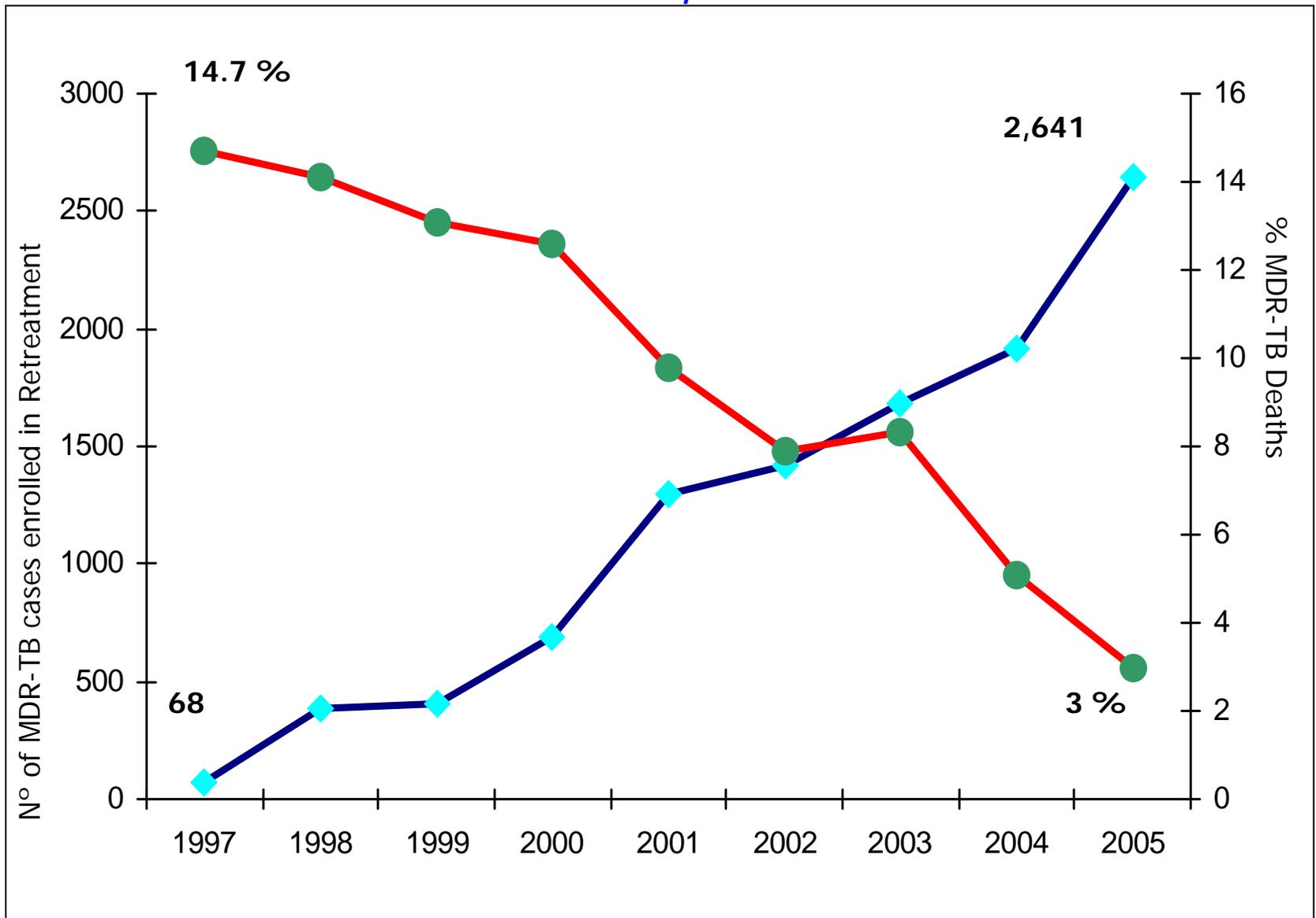
**WORLD TUBERCULOSIS DAY**  
**MARCH 24, 2005**



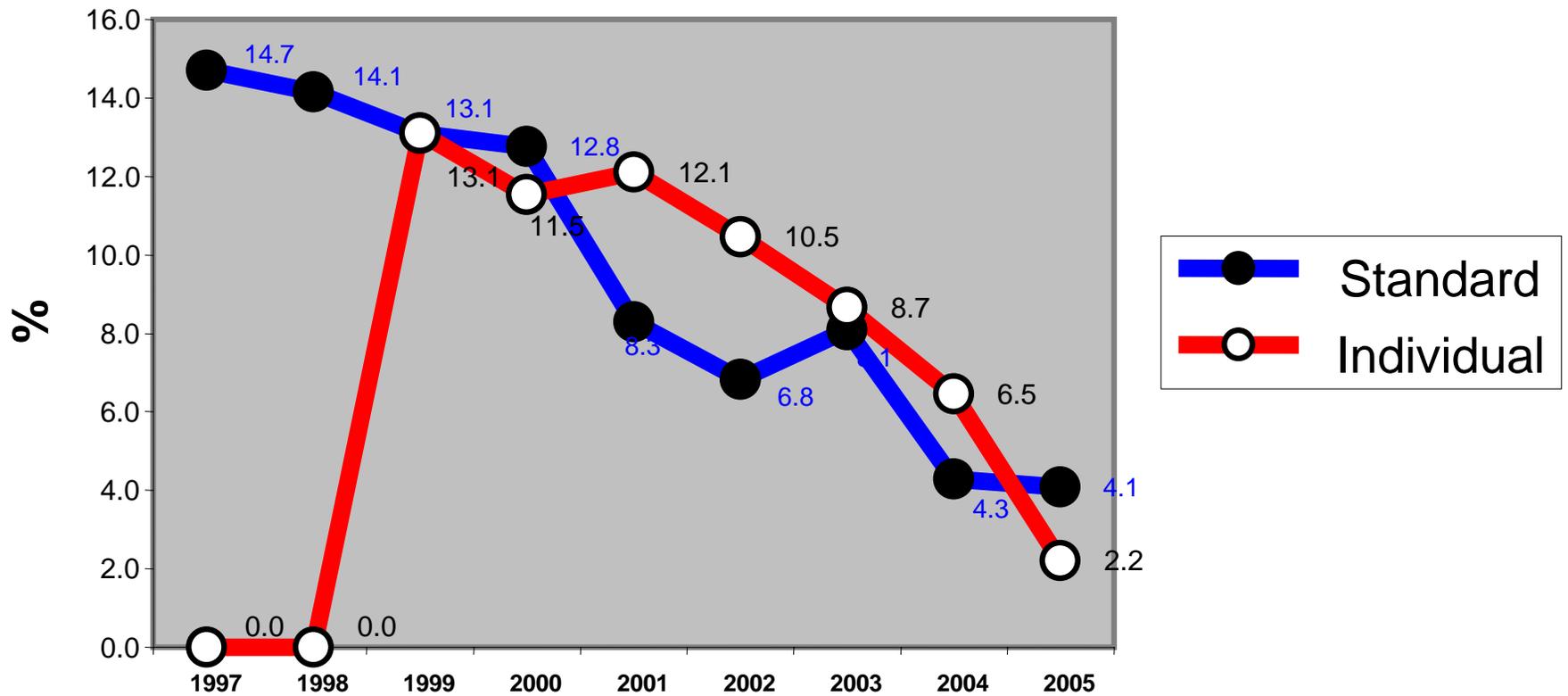
**WORLD TUBERCULOSIS DAY**  
**MARCH 24, 2006**

## **7. TECHNICAL EFFICIENCY IN RESOURCE UTILIZATION**

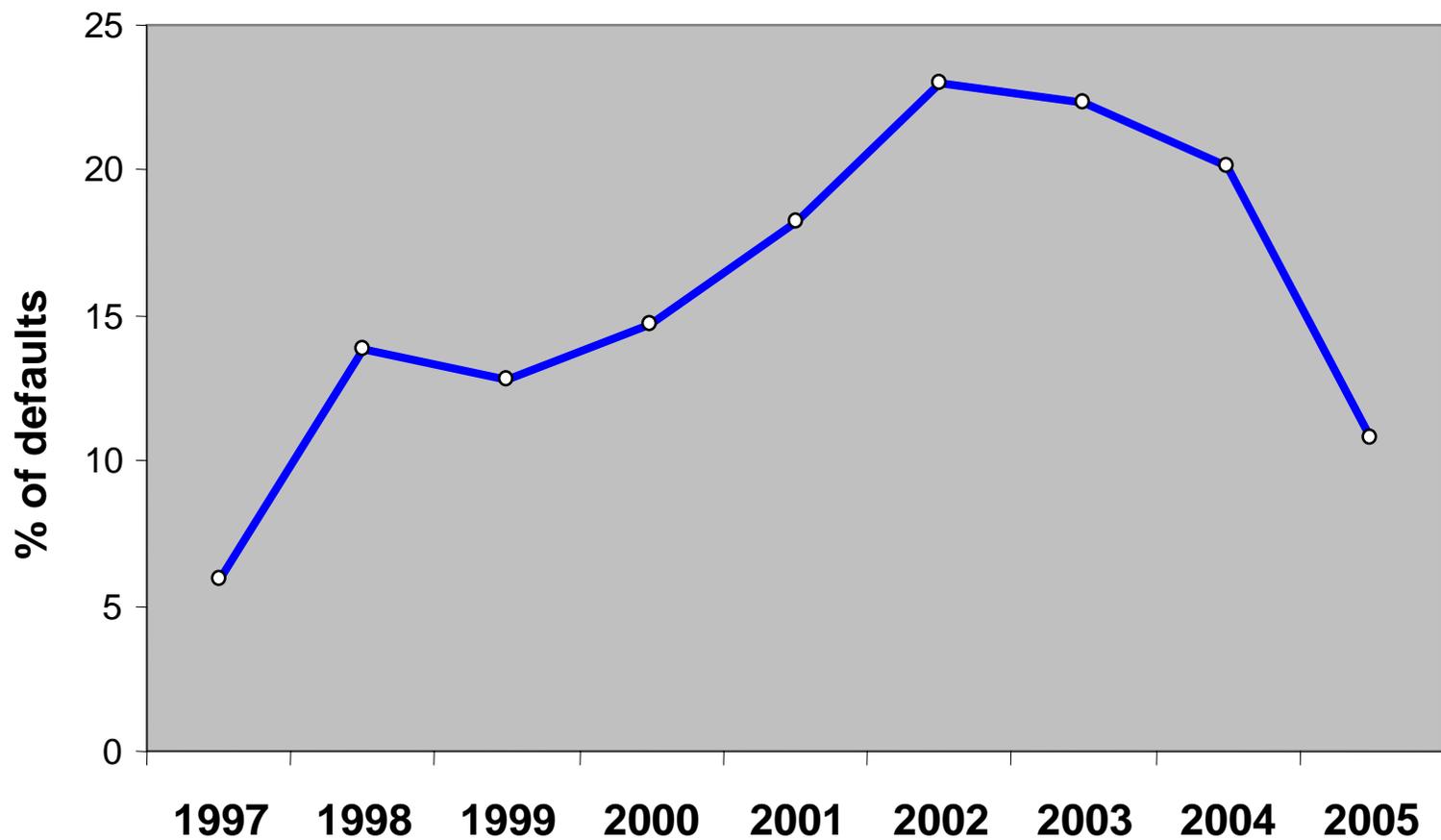
# CASES ENROLLED IN MDR-TB TREATMENT AND % OF DEATHS, PERU 1997 – 2005



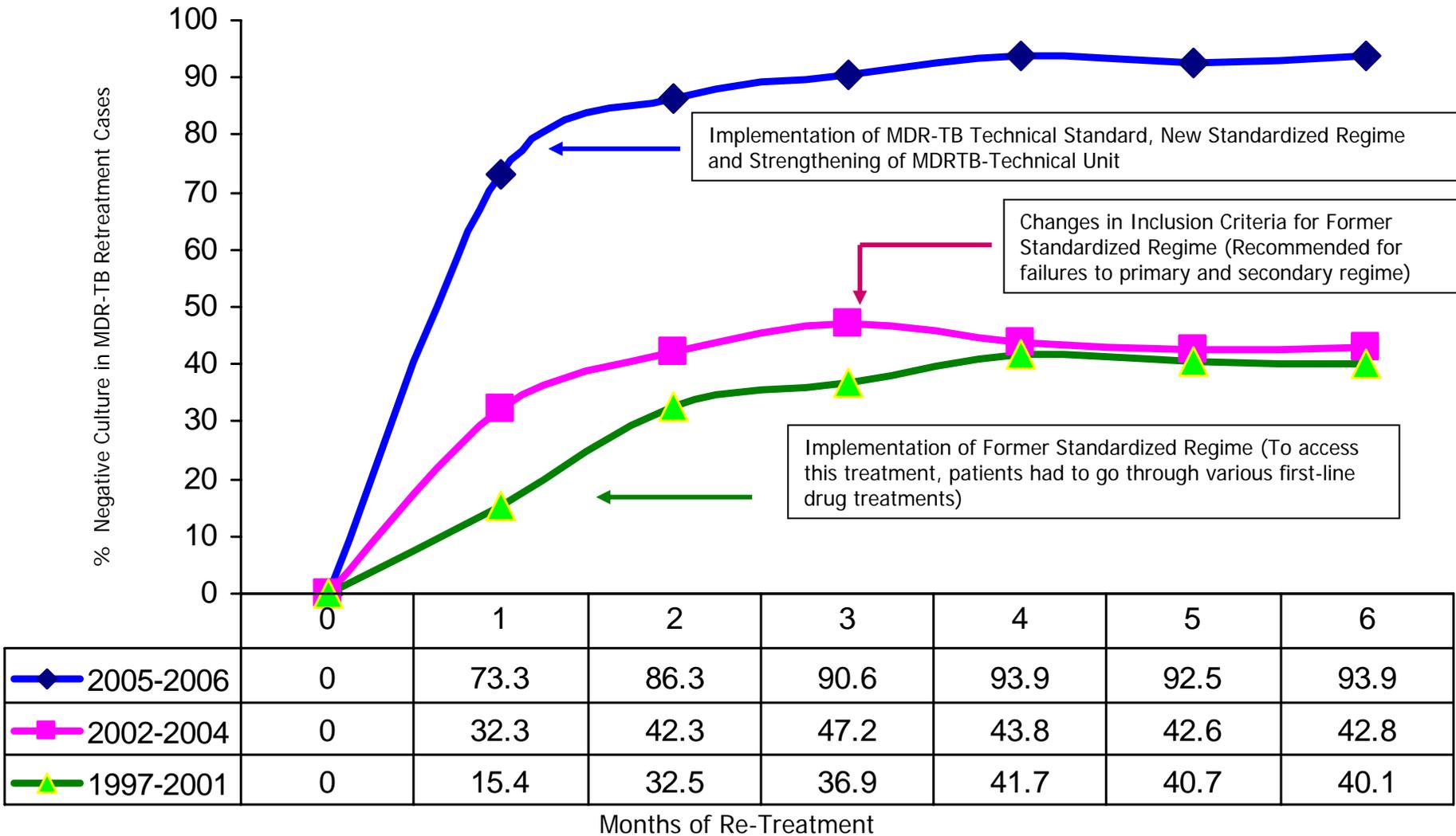
# FATALITY RATE DURING STANDARDIZED VS INDIVIDUALIZED RETREATMENT 1997-2005



## DEFAULTS FROM MDR-TB RETREATMENT BY YEAR, Peru 1997-2005



# BACTERIOLOGICAL CONVERSION THROUGH SIX MONTHS OF MDR-TB RETREATMENT, PERU 1997 – 2006



Source: National Health Strategy for TB Prevention and Control-DGSP/MINSA

## **8. CONSOLIDATING POLITICAL COMMITMENT**

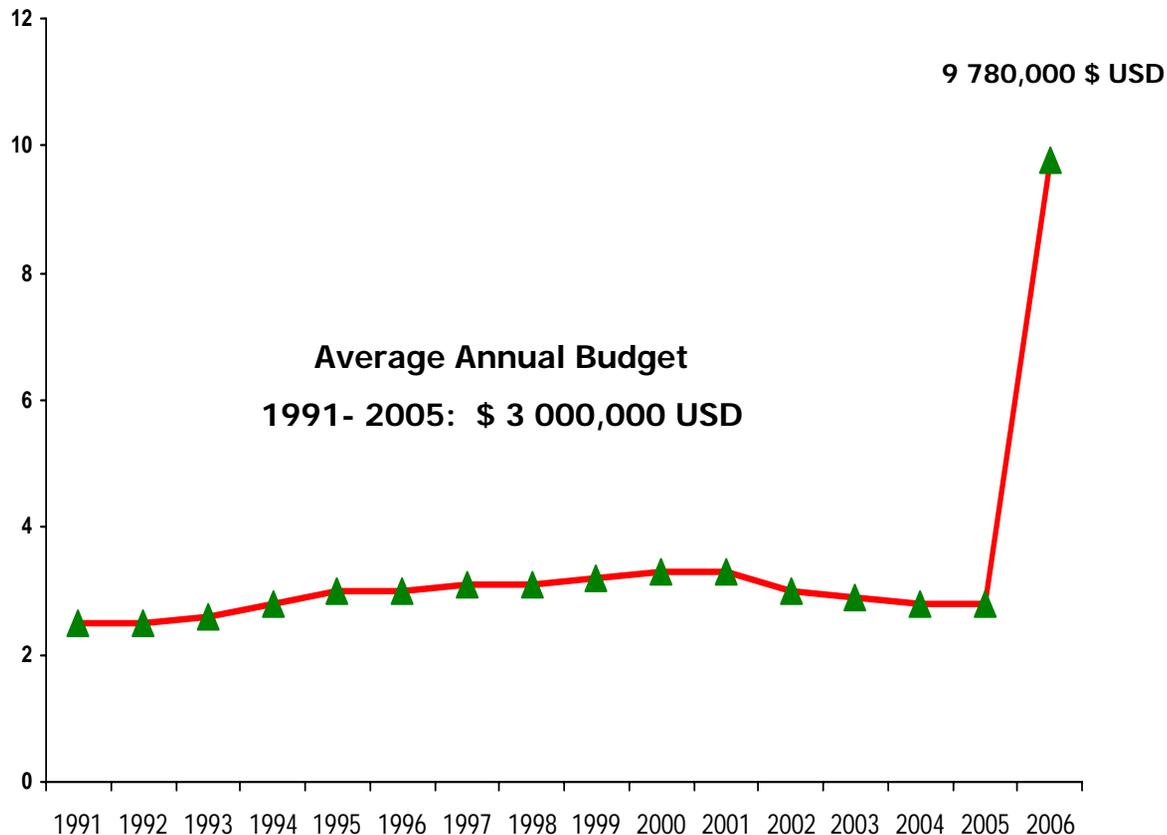
# PERU STOP TB PARTNERSHIP



**CEREMONY FOR INSTALLATION OF THE COMMITTEE**

# BUDGET OF THE NATIONAL HEALTH STRATEGY FOR TB PREVENTION AND CONTROL, PERU 1991-2006

Millions \$ USD



**DOTS STRATEGY:  
POLITICAL  
COMMITMENT**

*Source: National Health Strategy for TB Prevention and Control-DGSP/MINSA*

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  - Technical efficiency in resource utilization.
  - Investigation: operational, epidemiological, and clinical.
5. Consolidating political commitment.

# Where do we come from? Who are we? Where are we going?

Paul Gauguin

