WR’s Speech on inaugural ceremony of Community based Programmatic Management of Drug resistance TB (CPMDT).

The Chief guest Prof. Dr. A.F.M. Ruhul Haque M.P Hon’ble Minister, Ministry of Health and Family Welfare, Respected Chair person Prof. Dr. Khondhaker Md. Shefyetullah, Director General, Directorate General of Health Services, MOH&FW, respected guests from country and abroad, ladies and gentleman

Good morning!

It is my great pleasure to be here in the launching ceremony of Community–based Programmatic Management of Drug resistance TB (cPMRD), an intervention in Bangladesh for treatment of Drug-Resistant Tuberculosis (DR-TB) which is funded through USAID manned TB CARE II project with technical support from WHO

Countries in the WHO South-East Asia (SEA) Region have made significant progress towards the TB-related MDGs. The estimated incidence, prevalence and mortality of all forms of TB continue to show a downward trend.

In Bangladesh, TB prevalence rate is showing a declining trend from 1990 to 2010, with lesser declining slope in the last five years. TB mortality rate is showing a declining trend from 1990 to 2010, with rather steep slope between 2000 and 2005, and a slighter decline afterwards; the analysis of trend in TB incidence from the notification data proves to be difficult due to the considerable change in notification due to enhanced case-finding efforts, thus incidence was assumed to follow a horizontal trend going through the most recent estimate of incidence.

Multi-drug resistance (MDR) and extensively drug resistance (XDR) TB raise many difficult issues concerning the management of patients, for example, whether to isolate patients, the need for institutional, palliative or end-of-life care, and the compassionate use of new drugs.

According to the WHO Global Tuberculosis Control Report 2011, less than 2% of new TB cases and 6% of re-treatment cases were tested for MDR-TB globally, with particularly low levels of testing in the South-East Asia and Western Pacific regions. Outcomes of treatment for
MDR-TB are available for a small number of patients only. Lack of laboratory capacity and slow technology transfer to resource-limited settings is a crucial barrier for detection of DR-TB. Even countries with Drug Susceptibility Testing (DST) facilities need to have more quality-assured laboratories to offer the test to all those who need to be tested for drug resistant forms of TB.

At the 62nd World Health Assembly in May 2009, member states committed to achieve universal access to diagnosis and treatment of multi-drug-resistant TB (MDR-TB) by 2015. In response to the need for scaling up programmatic management of drug-resistant TB (PMDT), a new framework for Global Green Light Committee (g-GLC) and Regional GLCs (r-GLCs) were established to bring Programmatic management of Drug Resistant TB (PMDT) services closer to the countries and benefit from the greater involvement of key national and international partners in the scale-up of MDR-TB services and care in the countries of the Region. Bangladesh is one of the beneficiaries of this effort. In May 2012 SEAR constituted a 9- Member of experts to advice r-GLC Secretariat to support countries in scale up, implement and monitor PMDT.

On the other hand, introduction of newer diagnostics like LED Fluorescent Microscopy (Light-emitting diode fluorescence), Line Probe Assay (LPA) and automated liquid culture are also envisaged and crucial. However, the later tests have specific infrastructure needs, which include strict infection control in the laboratories performing the tests. The capacity for these tests must thus be built
before they are introduced. Bangladesh TB Programme is working hard to establish newer diagnostics phase-wise.

Gene X-pert was endorsed by WHO in December 2010. Discussions around when to scale up new diagnostics and how to include them in diagnostic algorithms have increased recently, particularly in light of the rollout of Gene-Xpert. However, all operational challenges will have to be sorted out before this rapid test is rolled out on a large scale in-country.

WHO work with NTPs and partners are to develop a few key interventions linking diagnostics with MDR-TB service delivery (ie. ensuring that all diagnosed cases are placed timely on treatment), accelerate scale-up of PMDT services particularly in high-burden MDR-TB areas, implement innovative approaches to MDR-TB care delivery including Public-Private Mix models (PPM), and accelerate capacity building at country level (including human resource development), engage civil society to prioritize advocacy for Programmatic Management of drug-resistant TB (PMDT), facilitate capacity building amongst civil society to undertake effective advocacy, and address issues of sustainability of such efforts

Community based Programmatic Management of Drug resistance TB (cPMDT) focuses on the detection and treatment of drug-resistant TB in settings where resources are limited. Patients with DR-TB should be treated using mainly
ambulatory care rather than models of care based principally on hospitalization. Conceptually almost all high DR-TB burden countries in SEAR are implementing ambulatory care (cPMDT) like wise DOTS for drug sensitive TB, though challenging due to diagnostic complexity, human resources and adverse reactions of second/third line anti-TB drugs. More needed on drug regulation or rational use of first/second-line anti-TB drugs

Priority topics identified by WHO in this field were:

- case-finding (use of rapid molecular tests; investigation of contacts and other high risk groups); The detection of Rifampicin Resistance by X-pert MTB/RIF usually suffices to start a patient on a second-line TB regimen
- regimens for DR-TB and their duration in HIV-positive and HIV-negative patients;
- monitoring during treatment;
- models of care.

Piloting implementation of cPMDT in Bangladesh will improve the case finding and management of drug resistance TB. But for proper implementation of cPMDT services, the countries would need to monitor the progress. The objectives of the monitoring process are to ensure that activities are undertaken as planned; to reveal the progress towards identified targets and goals, to identify problem areas and ensure that corrective action is developed and taken. The countries should aim for a national consensus statement endorsed by nationally
recognized experts and professional societies. WHO is also encouraging further operational research on new shorter regimen that may reduce the sufferings of the patients.

I wish with the strong political commitment of the Government of Bangladesh and with the support of all donors, development partners, NGOs and civil society Bangladesh will overcome all the challenges for implementation of cPMDT and ultimately can reduce the burden of MDR TB.