WHO REPORT: TOWARDS UNIVERSAL ACCESS TO DIAGNOSIS AND TREATMENT OF MDR-TB & XDR-TB BY 2015

"Progress is being made, but the response is far from sufficient and too slow given the MDR-TB threat facing the world. This WHO report underlines the need for countries to implement all necessary measures to address MDR-TB, otherwise the universal access target, set by the World Health Assembly, will not be achieved by 2015, with the loss of hundreds of thousands of lives,”

Dr Mario Raviglione, Director, Stop TB Department, WHO

KEY FINDINGS from the 27 countries* with a high burden of MDR-TB and XDR-TB

Action Plans:
• 26 countries have updated the MDR-TB component of their National TB Control plans.

Funding:
• In 23 countries, funding for MDR-TB care and treatment has increased from US$ 0.1b in 2009 to US$ 0.5b in 2011. The Global Plan to Stop TB estimates that US$ 0.9b is needed in 2011 to address MDR-TB worldwide.
• Only Estonia, Latvia, the Russian Fed. and South Africa, are using domestic sources to provide most if not all of the MDR-TB control funding. If domestic funding is not mobilized, the Global Fund may be the sole source of funding for second-line drugs and MDR-TB management in Armenia, Bangladesh, Bulgaria, Georgia, Tajikistan, Kyrgyzstan and Uzbekistan.

Laboratories:
• 16 countries achieved by the end of 2009, the recommended target of having at least one laboratory with capacity to perform culture per 5 million population, and one laboratory with capacity to perform drug susceptibility testing per 10 million population.
• 11 countries are introducing the rapid MDR-TB Xpert diagnostic test.

* representing approximately over 85% of the world’s estimated number of incident MDR-TB and XDR-TB cases: Armenia, Azerbaijan, Bangladesh, Belarus, Bulgaria, China, DR Congo, Estonia, Ethiopia, Georgia, India, Indonesia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Myanmar, Nigeria, Pakistan, Philippines, Rep of Moldova, Russian Fed, South Africa, Tajikistan, Ukraine, Uzbekistan and Viet Nam

Treatment:
• Of the estimated 250,000 MDR-TB cases expected to occur among all TB patients notified in 2009 in the high MDR-TB/XDR-TB burden countries, 24,511 were reported to have been enrolled on treatment.
• 13 countries with data on treatment outcomes for MDR-TB cases reported a success of 25%-82% among patients that started on treatment in 2007.

Drugs:
• Since 2008, the Global Drug Facility has more than doubled the number of finished pharmaceutical products (FPP) for MDR-TB treatment from 11 to 25, and also increased the number of eligible suppliers.

Infection Control:
• 14 countries have conducted a national situation assessment of TB infection control and 11 have developed national action plans.

Surveillance Data:
• The number of new drug resistance surveys under way or planned increased from 1 in 2008, to 10 in 2011, while the number of countries with representative drug resistance data increased from 19 to 22.
• The number of high MDR-TB burden countries able to report high-quality continuous surveillance data has increased from 4 in 2008, to 8 in 2010.
• Recent drug resistance surveys have identified high rates of MDR-TB in southern Africa. The proportion of MDR-TB among new TB cases has increased in Swaziland from 0.9% to 7.7% between 1995 and 2009, while in Botswana the point estimates were 0.3% in 1996 and 2.5% in 2008.

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WHAT ARE MDR-TB & XDR-TB?

- Drug-resistant TB is widespread and found in all countries surveyed. It emerges as a result of treatment mismanagement, and is passed from person to person in the same way as drug-sensitive TB.

- Multidrug-resistant TB (MDR-TB) is caused by bacteria that are resistant to the most effective anti-TB drugs (isoniazid and rifampicin). MDR-TB results from either primary infection or may develop in the course of a patient's treatment.

- Extensively drug-resistant TB (XDR-TB) is a form of TB caused by bacteria that are resistant to isoniazid and rifampicin (i.e. MDR-TB) as well as any fluoroquinolone and any of the second-line anti-TB injectable drugs (amikacin, kanamycin or capreomycin). These forms of TB do not respond to the standard six month treatment with first-line anti-TB drugs and can take two years or more to treat with drugs that are less potent, more toxic and much more expensive.

**Argentina, Armenia, Australia, Austria, Azerbaijan, Bangladesh, Belgium, Botswana, Brazil, Burkina Faso, Bhutan, Cambodia, Canada, Chile, China, Colombia, Czech Rep, Ecuador, Egypt, Estonia, France, Georgia, Germany, Greece, India, Indonesia, Islamic Rep of Iran, Ireland, Israel, Italy, Japan, Kazakhstan, Kenya, Kyrgyzstan, Latvia, Lesotho, Lithuania, Mexico, Mozambique, Myanmar, Namibia, Nepal, Netherlands, Norway, Pakistan, Peru, Philippines, Poland, Portugal, Qatar, Rep of Korea, Rep of Moldova, Romania, Russian Fed, Slovenia, South Africa, Spain, Swaziland, Sweden, Tajikistan, Thailand, Togo, Tunisia, Ukraine, UAE, UK, USA, Uzbekistan, Viet Nam**