



All-Party Parliamentary Group on Global Tuberculosis

Minutes

Inaugural Meeting – Wednesday 25 October 2006

Global TB: Challenges and Opportunities

Presenters

Dr. Mario Raviglione: Director, Stop TB Department, World Health Organization, Geneva

Gareth Thomas MP: Under-Secretary of State for International Development

Dr. Bobby John: Principle Partner, Global Health Advocates, India

Winstone Zulu: Patient Advocate, Zambia

Welcome – Andrew George MP

The APPG on Global Tuberculosis was established and will be jointly chaired by Andrew George MP, Julie Morgan MP and Nick Herbert MP to demonstrate cross-party concern for the growing scale and impact of the global TB problem. Each has recently witnessed first-hand the TB emergency in Africa; by participating in Parliamentary delegations to high burden countries and share a determination to take further action to Stop TB.

The Secretariat for the APPG will be provided by RESULTS UK, a non-profit advocacy organisation who campaign on a range of development issues including TB.

Each year TB kills almost two million people – more than any other curable infectious disease in the world – yet it generates relatively little public, political or media attention in comparison with other diseases.

The APPG on Global TB was formed therefore to help raise the profile of the Global TB epidemic and use the influence of British Parliamentarians to help accelerate efforts to meet Millennium Development Goal Targets on TB.

Presentation – Dr. Mario Raviglione

TB control is important for global development. TB is a disease of poverty: favoured by poverty and producing poverty. TB control is a human right, a public good and an MDG “quick win”.

There were 8.9 million new cases of TB in 2005. In the same year, 1.6 million people died from TB – 98% of these deaths were in the developing world.

TB has a huge economic impact. A 10% increase in TB incidence cuts economic growth by 0.2-0.4% per year. Yet, the DOTS strategy is very cost-effective.

The Global incidence of TB is rising largely as a result of the TB/HIV co-epidemic in Africa and the high levels of drug-resistant TB in Eastern Europe. The emergence of

'extensive' drug resistant strains of TB (XDR-TB) poses a major threat to TB control efforts and requires urgent action.

Global TB control targets are to reduce TB prevalence and death rates by 50% and to have halted and began to reverse the incidence of TB by 2015. The WHO has produced a new 'Stop TB Strategy' which identifies the six priority areas that need to be addressed in order to meet these targets. The Stop TB Strategy underpins and strengthens the Global Plan to Stop TB 2006-2015 that was launched in January 2006.

If fully funded, the Global Plan will result in 50 million TB patients treated and 14 million extra lives saved. Over 10 years, the Global Plan requires an investment of \$56 billion for implementation and research and development into new tools. The current funding gap is in the region on \$31 billion.

The UK is already playing a leading role in global TB control through support of National TB Control Programmes, the Global Fund to Fight AIDS, TB and Malaria, the Stop TB Partnership and research initiatives. The UK also has a critical role to play in building political and financial support for TB through its Africa agenda, bilateral and multilateral mechanisms. As Gordon Brown said at the launch of the Global Plan: "If 2005 was the year of commitment, then 2006 must be the year of delivery."

Note – A copy of Dr. Raviglione's presentation is available upon request.

Presentation – Gareth Thomas MP

DFID believe there are 3 key issues in the effort to control TB:

1. the catastrophic linkage between the twin epidemics of TB and HIV,
2. the emergence of extreme drug resistant TB, and
3. weak health systems.

Whilst DOTS has ensured significant progress over the past decade the challenge – and particularly the resource need – remains considerable.

The TB control funding gap of \$31 billion over the next ten years will not be met if we continue with business as usual. TB must be recognised in country plans and budgets, and commitments from country governments, the Global Fund and UNITAID (the International Drug Purchasing Facility) must be maximised.

DFID is a key contributor to UNITAID, the Global Fund and WHO, but recognises that more money alone will not be enough. Progress depends on three other actions:

1. Strengthening and expanding existing strategies for TB control.
2. Strengthening health services so they can treat all major causes of ill health – including TB
3. Better co-ordinating the response to TB and HIV

Where DFID is supporting the health sector of partner countries through bilateral work it is also taking steps to ensure that TB is properly addressed within health sector plans, which has been effective in a number of countries such as Uganda and Malawi.

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Research and development for new tools and technologies is paramount. A rapid diagnostic test, a new vaccine and shorter and simpler drug regimes should all be priorities. To this end, DFID is supporting a number of Product Development Partnerships, including the Global TB Alliance.

The recent emergence of XDR-TB has made it clear that we need to do better - to improve prescribing practices, to ensure good quality drugs and regular drug supplies, and to provide information and support to patients to complete their TB treatment.

Presentation – Dr. Bobby John

The population of India makes up one-sixth of humanity and in turn is burdened with more than one sixth of the global TB burden. Every year, around 370,000 people die from TB in India.

The Indian National TB Control Programme is the largest health programme in the world. Thanks to considerable financial support from donors including the UK Government, the World Bank and the Global Fund, the Programme has been able to scale up considerably. The amount of investment in TB control does not however offset the economic impact of TB in India – estimated at \$3 billion per year.

20,000 people become newly infected with TB each day across India of which a quarter will develop the disease. A major challenge for the National TB Programme is that despite massive improvements in laboratory services and availability of quality TB drugs, not enough people are using the Programme. Education and social mobilisation is needed, particularly at district level, to encourage people to actively come forward for testing and treatment.

India also has the highest number of people living with HIV/AIDS in the world. At present there are no robust systems in place for the delivery of ARVs or monitoring the actual number of people living with the disease. HIV programmes should therefore be making use of existing TB services which provide a good entry point for offering HIV counselling, testing and treatment. TB and HIV programmes need to be fully integrated and health care providers trained to provide a broad range of services.

Civil society in India has a key role to play in generating greater demand for TB and TB/HIV services. They can also help hold the Government to account and ensure that TB control is being delivered effectively. There is concern in India that many donors, including the UK are moving away from supporting civil society initiatives in favour of directing 100% of resources through direct budget support.

Presentation – Winstone Zulu

Winstone is 42 years old which is considered very old in Zambia because the life expectancy is only 37.

The reason that many people die in Zambia is commonly thought to be HIV. However, if you look closer you will see that most people are actually dying from TB.

Winstone planned to study political science in the Soviet Union in 1990, but discovered that he was HIV positive after a routine immigration HIV test. He became the first person in Zambia to publicly acknowledge his positive status. Seven years later he began to develop symptoms of TB, but his doctors were slow to diagnose it.

Winstone recognised that his symptoms were similar to those of his younger brother who was receiving treatment for TB and started taking TB drugs that he obtained through contacts in the army. He said that if he had waited for the hospital to diagnose and treat his TB he could be dead now.

Winstone completed his course of TB drugs and recovered. His four brothers all died from TB because they were not able to get access to the same life-saving drugs. Winstone's brothers were also all HIV-positive. Although antiretrovirals are what they ultimately needed, access to a full course of quality TB drugs costing less than £10 would have prolonged their lives. Winstone now cares for the children that his brothers left behind.

Questions

Annette Brooke MP – What is the UK's position on two major decisions being made at the Global Fund Board meeting next week, the appointment of a new Executive Director and on the future size of the Fund?

[Gareth Thomas] The most important question is who the new Executive Director will be. This is a much bigger question than what size the Fund should grow to and is the reason why he is attending the meeting in person. The UK Government believes that the Global Fund is very important and doing well otherwise they wouldn't have increased their funding. There are concerns however over harmonisation and about Civil Society Organisations not getting access to resources.

Dr. Amina Jindani, St. George's Hospital – Given the high expertise in the UK, how can we ensure that British efforts in the field of research and development are well funded?

Peter Ellis, Biotec Ltd – How can we ensure that British companies conducting important research abroad are still able to access UK funding?

[Gareth Thomas] Funding for research and development has already increased and a commitment has been made in DFID's White Paper to double funding for research. The UK has made a recent commitment to the Global TB Drug Alliance and is also supporting WHO's programme on tropical disease research. It is important to take a broad view and to take advantage of the best proposals. This may mean going beyond the UK.

Andrew George MP – On TB/HIV co-infection, what role can government and NGOs play in delivering services?

[Gareth Thomas] To tackle both diseases, we need to focus on the overall development of health systems. In particular, investment must be made to increase the capacity and to ensure that health workers are trained to manage TB, HIV and other diseases.

Peter Moszynski, British Medical Journal – How has XDR happened?

[Mario Raviglione] MDR-TB is a manmade problem. The main cause is mismanagement of treatment especially in the hospital setting where resistant strains of TB spread among populations with weakened immune systems. In South Africa, a study is being conducted to understand how the outbreak of XDR-TB arose. It is suspected that at least four different strains of the disease were created in parallel. Drug resistant TB is fuelled by HIV/AIDS and is found to be a huge problem in migrant communities in Southern Africa such as those who work in mines. A faster diagnostic tool is needed, particularly one that can detect resistance to rifampicin. There are no additional resources to deal with XDR-TB (at WHO or country level).

Francis Drobniowski, Health Protection Agency – How can we in the UK best help regions with high TB burden e.g. Eastern Europe and Africa?

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[Gareth Thomas] We need to ensure that developing countries have ownership of programmes. This is why the UK wants to prioritise supporting governments through direct budget support (where there is sufficient confidence in government and top management). The UK Government is looking at twinning NHS institutions with those in developing countries in order to share skills and help expand capacities.

Jeffrey Mecaskey, British Medical Trust – What is needed to integrate TB and HIV and to ensure that people with TB complete their treatment?

[Winstone Zulu] Integration of TB and HIV needs to happen at every level – including between APPGs on HIV and TB! To ensure that patients complete their TB treatment it is vital that there are sufficient, well-trained health workers in place to support patients.

Prof. Peter Davies, Cardiothoracic Centre, Liverpool – The UK has seen a 2% rise in TB; London 5%. There are currently 8,000 cases of TB in the UK of which one in twenty die. Should we not look at our own problem first?

[Julie Morgan MP] The APPG is looking at the global TB problem which includes the UK.

[Mario Raviglione] We know that the main cause of TB in the UK is migration from high burden countries. We cannot therefore look at just one country in isolation. You cannot eliminate TB anywhere unless you intervene globally.

[Bobby John] Investments in TB control made outside of the UK will benefit us all.

Alistair Story, Health Protection Agency – ‘Enlightened self interest’ is needed to tackle TB globally.

Jennifer Woolley, Aeras Global TB Vaccine Foundation – Where are some of the other major challenge areas in TB control?

[Mario Raviglione] There is a big problem of drug resistance in the Baltic countries and former Soviet Union. In Estonia and Latvia, for example, around 20% of MDR-TB cases are XDR-TB. Other hotspots are the USA where 4% of MDR are XDR and South Korea with 15%. New drugs are urgently needed – current second line drugs are toxic, weak and very expensive.

John McFarlane, British Thoracic Society – How can TB Professionals help people in the developing world?

[Winstone Zulu] The developing world lacks both resources and personnel. More trained nurses and health workers are needed.

[Bobby John] The British Thoracic Society and other partners can also help countries to build capacity at the grassroots level.

Sheila Davie, RESULTS UK – What challenges would the speakers ask the APPG to take forward?

[Bobby John] The APPG should evaluate DFID’s current and future funding for TB i.e. its policy of directing the bulk of its support for TB through government budgets. To combat TB worldwide, we need to invest directly in TB. Also, the APPG can help to ensure that the UK Government votes for the best person for the job when the new Executive Director of the Global Fund is elected next week.

[Mario Raviglione] In addition, the APPG can help to mobilise in an intensified way more resources for technical support and NGOs that assist in implementation and disbursement of resources.

[end]