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39th Union World Conference on Lung Health
Newsmaker Interviews - MARIO RAVIGLIONE
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JILL BRADEN BALDERAS: Mario Raviglione, director of WHO's Stop TB Department, thanks for joining us today!

MARIO RAVIGLIONE, M.D.: Thank you.

JILL BRADEN BALDERAS: So this week, the WHO released a report on the state of primary care around the world, and I found this quote about tuberculosis. It says, "It makes no sense to treat someone's tuberculosis without considering their HIV status or whether they smoke." How often does this happen?

MARIO RAVIGLIONE, M.D.: Well, I would guess that today, in the majority of the programs around the world, this is not systematically done. When it comes to HIV there is definitely progress. Over the last two or three years we have seen more and more TB cases that once they are diagnosed, are also referred for HIV testing, or tested on the spot for HIV. This is growing, and it has achieved quite good levels in some countries like Rwanda or Kenya, where in fact now they are testing the majority of cases, and the testing obviously has implications, because once a person test positive, then the implication is that they can be referred for the proper treatment for HIV if necessary, and the prevention of other bacteria and infections, for instance, with the use of clotrimoxazol. In the case of smoking, I mean this is something very important of which we are becoming more and more aware, but a smoke is at higher risk of developing TB, and once TB's developed, at a higher risk of dying from TB. So there is

there space for counseling against smoking when a patient with TB is tested.

I don't think it is done systematically. It is done in pilot areas in some projects, for instance Nepal I'm aware of, but it's something we'll insist on.

JILL BRADEN BALDERAS: So, recent literature that was reviewed by WHO affirmed that was long suspected that, as you said, tobacco exacerbates TB, incidence, morbidity, and mortality, so how does this knowledge change TB control in treatment programs?

MARIO RAVIGLIONE, M.D.: Well, the reality is that unfortunately, the impact of smoke, or smoking, on TB, is before they develop TB. So, once a program, a clinic, detects a TB case, it's too late, because TB has already developed as a consequence of smoking. It has facilitated the passage between the status of infection, latent dormant infection, into the stage of real disease. So it's far too late. What needs to be done, rather, is to advocate more that smoking cessation campaigns must now also speak about the risk for tuberculosis, besides other risks of other non communicable disease that are linked with smoking. So, I would say that the impact on actual activities of TB Program would probably be limited to counseling against smoking, because once you have tuberculosis, too late, but still you can prevent some deaths because we know that it increases the risk of dying once TB has been detected and developed.

JILL BRADEN BALDERAS: And one big focus of this conference is on health systems. Can you talk about how weak health systems impair TB treatment and control?

MARIO RAVIGLIONE, M.D.: When you have a weak health system, it means you also have – it makes you have weak managerial capacity. You have weak services, weak primary care services. You have weak laboratories. You don't have sufficient and trained personnel, human resources. You don't have sometimes, a system of delivery of drugs which are effective. So, all of this elements are integral part of any TB control approach. So you don't have a primary care physician that can suspect tuberculosis and therefore say okay, I need to collect your sputum to be sent to the laboratory. Then you are in deep trouble, because TB would not be recognized, it might be recognized six months later when it is too late, people die. So there is no doubt in my mind that health systems strengthening is paramount, not just for TB obviously, but for all disease control programs that are there in the world, whether they deal with TB, with HIV, with malaria, with child health, with other disease that are there that are out there. So it is absolutely something that we supporting as an integral part of our new strategy, the Stop TB Strategy. Element number three speaks specifically to contribute to health systems strengthening. It means that national TB programs, their managers, need to work with the

understanding of what is going on in the broader discussion about health systems and take the measures that are needed.

JILL BRADEN BALDERAS: Can you give some examples of where those national Tb programs have contributed to health systems strengthening?

MARIO RAVIGLIONE, M.D.: It's something very important. We have the belief that in fact, national TB programs, when they are well structured, right – which also depends on the surrounding environment meaning if there is a good TB program, normally that is a good TB program because the health system works, right? But you see some elements of TB control that really can contribute to the overall system capacity. For instance, I mentioned one issue that was discussed at length a couple of days ago here; that of the engagement of all providers outside of the national programs in TB care. That is something, I would say fairly innovative for disease control programs. I think we are the first one in TB that really has pushed that notion around, and even last week in WHO in Geneva, we had a seminar on the issue of engagement of private providers. In general, this was organized by the health systems strengthening people, just to tell you that these models are the ones that can actually be easily, in a way, spread to other disease control programs.

That's an example, but the involvement of community work is another one because community workers are out there that cannot be specific for TB. They need to be trained on

some basic thing, and TB programs have contributed in many places in many settings, or the monitoring capacity of TB, which is rather unique. There are probably only a couple of other, like the vaccine programs, that monitor things like we do in TB control. These are all models that can be expanded and used then for other conditions.

JILL BRADEN BALDERAS: You mentioned that you had a meeting last week at the WHO. Do you feel like this issue of collaboration is more on WHO's radar screen and given more importance than say, a few years ago?

MARIO RAVIGLIONE, M.D.: Oh, no doubt. I mean, the entire organization now, with the new administration and the new director general, is focused very much on primary health care and on health systems strengthening, so we are now celebrating the 30th anniversary of the famous Alma-Ata Declaration that was on primary health care, and we feel that we have a lot to contribute in terms of TB control, to the broad agenda of WHO, but that's basically all that we are talking about in Geneva now, is the strengthening of the health system in such a way that any disease control then can be delivering what needs to be delivered. That is an important thing. There are people talking about synergies. To me it's not so much synergies, because I never understood why people believe that TB control programs are sort of outside the health system. They're an integral part, obviously, of the health systems – many years that we are preaching that primary care is

essential for TB control. We are not dealing with agriculture. We are dealing with health, and we part of health system and ministers of health and ministries of health, and their work.

JILL BRADEN BALDERAS: And when you and I spoke a couple of years ago, you used the word nightmare to describe the extensively drug resistant TB situation, coupled with HIV and TB co infection. Would you still use that word to describe it, and do you think it's gotten better or worse?

MARIO RAVIGLIONE, M.D.: Well, I will probably use now the word catastrophe if I can, because the issue of MDR and XDR TB, now we know, thanks to the report that we issued earlier this year in February, is actually worse than we thought. There are parts of the world, namely the Former Soviet Union, some countries there, that have achieved the maximum level ever described in the history of TB control. There are a couple of places where more than 20-percent of the cases of TB, the new cases of TB, when they present for the first time, are multi-drug resistant from the start, which means that they have to go to different regimens, one out of five, so that is serious business. And fortunately it's not something that is spread all over the world, MDR is everywhere, but not at that level of 20-percent. So, focus really needs to be now on the MDR and XDR TB care and control, and for this particular reason we are holding a major meeting next year in April, most likely in Beijing, where we will call the 27 highest burden countries for

MDR TB, for multi-drug resistant TB, and discuss policies, and what they need to do, in order to face this growing problem.

JILL BRADEN BALDERAS: Now, could you characterize how well you think political leaders are addressing this issue of drug-resistant TB? Are they on board in terms of acknowledging the problem and putting funding towards these programs, especially in these 27 high-burden countries?

MARIO RAVIGLIONE, M.D.: Definitely. I mean, definitely not. Unfortunately, the reason why actually we want to hold this meeting in Beijing is exactly that one, that we want to make political leaders and ministers and so on, much more aware of the consequences of having this growing epidemic in their own country. If TB gets more and more into MDR TB, in essence, if MDR TB strains tend now to replace, in some settings, normal tuberculosis, we are all in trouble because we don't envisage completely new regimens or completely new drugs, for the next several years. So we have to handle the problem of what we have today, and therefore we have to limit as much as possible the creation of MDR TB, which is something that begins with good TB control program in place, to basically turn the tap off in the production, and it means at the same time, managing the cases that exist already. So this requires a lot of resources, and these resources are not just TB control program resources. They require health system strengthening. We need to have proper primary care once again that detects the cases, we need to have proper laboratories to make the

diagnosis, even using now the more modern tools that we have available. We need capacity to procure and to manage drugs such as the second line drugs which are difficult to manage, difficult to obtain even from the national program perspective, so there are a lot of bottlenecks that need to be, in a way, faced. And if we don't have political commitment, broad government commitment, we are not going to be able to face it.

So, just to conclude, I wanted to say that the Balkan countries are a good example on how this can be faced, and they are about the few in the world that have done it in a proper way.

JILL BRADEN BALDERAS: Now you mentioned treatment and managing the treatment of the MDR TB right now, and one statistic that I found was less than 3-percent of current drug resistant cases are actually treated according to WHO guidelines, which is pretty alarming. So why is that?

MARIO RAVIGLIONE, M.D.: Because of the bottlenecks I was talking about just now. Many countries are just not equipped to do the job. Once you don't have a laboratory that is capable of detecting multidrug resistance promptly, you don't even know that multidrug resistance exists, so let alone the idea of treating them just as an example. So, laboratories is a bottleneck. Proper drug availability supply is a bottleneck. Infection control measures which are almost nonexistent, not just for TB, in general, in the world, in hospitals, in poly [misspelled? 00:12:15] clinics, is another

bottleneck. The outbreak in KwaZulu-Natal, South Africa, was probably largely due to transmission within the congregate setting, right? So we have a large amount of issues, challenges that have to be really faced if we want to progress on this number. I must say also that through the green light committee, we are seeing now basically a doubling of the number of cases, compared to the year before, that have entered into programs that we would consider up to the international standards. So, for instance, in the last one year we estimate about, if I remember correctly, 25,000 or so cases having been approved for treatment, compared to the 25,000 we accumulated to last year since 2001 when we started. So, this is progressing, but as you mentioned, we are far from reaching out to the probably near half a million MDR TB cases that arrive every year in the world.

JILL BRADEN BALDERAS: Now, one thing that seems to have been bubbling up within the global health and development communities is some concern about funding in the future, given the current global economic situation. Do you share that concern?

MARIO RAVIGLIONE, M.D.: Oh, definitely. We don't know yet the consequences, right – too early in the game to understand what the consequences will be of the current financial crisis on development cooperation agencies, for instance, and therefore, on the grants in the end, through mechanisms such as the Global Fund, for instance for HIV/AIDS,

TB, and malaria, or through other bilateral – the consequences of the funding that goes to these agencies and then from these agencies is transferred as international support to the countries in need – we also don't know the consequences of the financial crisis in the west of the world on the south of the world. So, there is a concern there. There is a concern also that some donors are now – I was just reading this morning a piece by activists. They are saying basically, some donors are shifting away resources because they believe the job on HIV, TB, malaria, is done. The job on HIV, TB, malaria, in my view has just started! We are – I think Churchill said that, "We are not at the end of the world, we are not even at the beginning of the end, we are just at the end of the beginning." So, there is a lot of work to be done if we really want to face epidemics such as that of tuberculosis.

So, I believe that the amount of money and investment that should go into health from developing countries from international agencies, has to double and triple, not being shifted away or reconsidered because of other issues emerging. These other issues such as health systems strengthening are major ones, so they need to have their own money. Like the fight against HIV, TB, malaria, needs to have its own money, otherwise we are going to lose all the progress that has been done in the last few years.

JILL BRADEN BALDERAS: And last question, going forward you just laid out the groundwork, that there still is a lot of

work to be done. What do you hope will come out of this conference to contribute?

MARIO RAVIGLIONE, M.D.: This conference, like any congress on tuberculosis, normally is the conference of the converted to the issue, so all of the people here, the 2,500 or so, know that TB is a big issue, that's why they are here. The problem is to reach outside of our little community, in a way, of converted to the TB fight, and making people, politicians, and others, decision makers basically, understand that here we are dealing with a serious problem. A problem, once again, that kills 1.7 million people every year, unnecessarily. A problem that risks becoming much worse than it is today because of this growing MDR TB problem, if that is not stopped in some parts of the world.

JILL BRADEN BALDERAS: Mario Raviglione, director of WHO's Stop TB Department. Thanks for joining us today.

MARIO RAVIGLIONE, M.D.: Thank you.

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