Joint meeting of the global GLC Committee and the MDR-TB Core Group, Geneva, Switzerland 18 -19 April 2013

Meeting report

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Welcome address

Dr Mario Raviglione, Director, Stop TB Department (STB) welcomed participants to the joint meeting of the global Green Light Committee (gGLC) and the Core Group (CG) of the MDR-TB Working Group. He said that progress is being made in the scale up of MDR-TB services and care, particularly in the introduction of rapid diagnostic tests. However the scale up of MDR-TB services is still too slow and lags behind what was anticipated and planned for. As Dr Chan, Director General, WHO, said on 2013 World TB Day "We are treading water at a time when we desperately need to scale up our response to MDR-TB. We have gained a lot of ground in TB control through international collaboration, but it can easily be lost if we do not act now." MDR-TB clinical and management services urgently need to scale up to match the impressive scale up of rapid diagnostic services. This will require an estimated US$1.3 billion per year, as we reported from the demand forecasting exercise done with the Global Fund (TGF). All countries will need up to date National Strategic Plans, including all components for the scale up of MDR-TB services, in order to convince both national and international funding agencies to invest the required funds.

The ideas generated during the meeting held in Geneva in June 2012 and then taken forward to the Stakeholders Meeting on Scaling up MDR-TB Care Delivery in Kuala Lumpur last November 2012 had a general consensus towards a strengthened focus on the support to countries for scale up of PMDT services. This topic will remain at the core of discussions. In addition, there is an on-going discussion within the Partnership in relation to the role and structure of the Working Groups (WGs) and their respective sub-groups. This was discussed at the meeting of the Stop TB Partnership's (TBP) Executive Committee in Seattle, in March 2013. Further discussions and decisions are needed in advance of the next TBP Board Meeting in July 2013.

Dr Lucica Ditiu, Executive Secretary, Stop TB Partnership while welcoming the participants reiterated the need for rapid scale-up of PMDT. There are country variations which need to be addressed locally. In a recent meeting with TGF, it has also been informed that there is a committed amount of US $2 billion for TB control that needs to be utilised. Dr Ditiu encouraged meeting participants to explore what technical assistance should be provided to countries with committed TGF amounts for their efficient and early utilisation. She also briefly mentioned about the new funding model being introduced by TGF and how countries could be supported to access funds.

Dr Chuck Daley, Chair of the gGLC and Dr Aamir Khan, Chair of the MDR-CG thanked the speakers and also welcomed participants.

Declaration of Interests

The gGLC Secretariat presented the interests declared by all participants in the meeting. No conflict of interest was identified.

Meeting objectives

Dr Karin Weyer, Co-ordinator, Laboratories, Diagnostics and Drug Resistance (LDR) Unit, STB, WHO presented the objectives of the joint gGLC/CG of MDR-TB WG meeting, namely:

- To follow up on recommendations made and action points agreed upon during 3rd gGLC meeting;
- To provide an update on:
  - progress and achievements of the rGLCs in supporting MDR-TB management scale-up;

  - WHO's work relating to palliative case for MDR-TB cases and "short" regimens for the treatment of MDR-TB cases;
  - new policies of the Global Fund;
  - WHO's new policy on case definitions and treatment outcomes;
  - WHO's actions in relation to new TB drugs and their rational introduction;
  - The GDF and drug availability
- To present evidence for use of H in the treatment of all MDR-TB cases; and
- To discuss the way forward for accelerated support to scale-up of MDR-TB services and care.

Technical Sessions

Session 1: To follow up on recommendations made and action points agreed upon during the 3rd gGLC meeting

Dr Fraser Wares, LDR unit, STB presented the status of action taken on recommendations made during the 3rd gGLC meeting held from 17-19 October 2012 and other activity updates since the last meeting.

1. Technical support

All 6 regional Green Light Committees (rGLCs) and their respective Secretariats are now established and operational. Monitoring and technical assistance (TA) missions on wide aspects of Programmatic Management of Drug Resistant TB (PMDT) are being coordinated by the rGLCs and Secretariats. Countries wishing to introduce "short regimens" are being supported to have an appropriate protocol to implement such regimen in an operational research framework. Technical support was provided to 9 countries who participated in the TGF demand forecast 2014-2016 workshop held in January 2013. The output of the workshop fed into the development of global estimates of funding needs and gaps for TB control, which were presented at the TGF's "eve of the pre-replenishment" meeting in Brussels, Belgium on 9–10 April. Support is also being provided for the scale up of rapid drug susceptibility testing (DST), including via the EXPAND TB and TBXpert projects. The concept of implementation of intensified TA in a limited number of identified countries was developed and presented at the "Stakeholders meeting on scaling up MDR-TB care delivery", Kuala Lumpar, November 2012, with the meeting consensus on moving forward with the concept.

2. Second-line Drugs

All countries now have direct access to the Global Drug Facility (GDF) for procurement of quality assured (QA) second line drugs (SLDs). There is also the possibility to procure partial regimens through the GDF, with the provision that these drugs are used only in conjunction with QA drugs. In 2012, a total of 30,000 patient treatments were supplied by GDF (against 19,605 supplied in 2011). There are on-going discussions with manufacturers in relation to price reduction for Clofazimine and Linezolid.

3. Advocacy

There has been some progress in advocacy. Though a significant step in itself, the advocacy to date has been limited to inputs into the World TB Day statements from the Director General, WHO and the Executive Director, TGF, and high level advocacy from WHO with TGF for a special "MDR-TB Booster Initiative".

Reporting on PMDT progress has been through a chapter in 2012 WHO Annual TB Control Report.

4. Monitoring and Evaluation

The 2013 plans for annual monitoring missions have been developed by the respective rGLCs and their Secretariats. There is an on-going 6-monthly data collection (MDR-TB cases detected and enrolled on treatment) from 32 countries with estimated >1,000 cases amongst notified cases using on-line data entry via WHO data collection site. The collection of 2012 data is on-going and the WHO 2013 Global TB Report is expected to be released Q3 2013.

5. Policy and Guidelines

i. Treatment Guidelines

An Expert Group meeting was convened by the WHO on the use of Bedaquiline in treatment of MDR-TB in January 2013. An interim Policy Guidance document has been submitted to WHO guidelines review committee (GRC) in April 2013. A "How to do" document will be drafted after GRC approval of policy guidance has been received. The next meeting of Task Force on “New drugs and their rationale introduction" is scheduled for 22-23 April 2013, with 2 gGLC members on the Task Force.

ii. Recording and reporting

The WHO document on "Definitions and reporting framework for tuberculosis – 2013 revision", WHO/HTM/TB/2013.2, including simplified definitions of cure and failure for DR-TB, has now been published. Electronic Recording & Reporting systems for PMDT were implemented in 7 countries in last year.

Products planned in 2012-13

These include: “Companion handbook” to PMDT 2011 Update (Q2 2013); Modules for Training of Trainers (ToT) on PMDT (Q3 2013); Updated guidance on the use of Xpert MTB/RIF (Q3 2013); and Analytical and policy work on PPM-MDR TB, m-health and community based care for MDR-TB (supporting product developed by TBCARE II) (Q2-Q4 2013).

6. Advice to funding agencies

On-going to funding agencies is being provided on a regular basis. This is an important role in TGF Phase 2 discussions prior to the TGF's Renewal Panel meetings.

7. Other activities

Tele/Webex conferences have been held between the rGLC and gGLC Secretariats January 2013, and the gGLC members and gGLC Secretariat in February 2013. The common PMDT SharePoint is being revitalized.

Funding for global PMDT support framework via WHO

WHO receives USG TGF TA set aside funds to support utilisation of TGF grants. In the Financial Year (FY) October 2011 to September 2012, USD $2.4m was approved and received by WHO in February 2012. For the FY October 2012 to September 2013, approval is still awaited from USG on the proposal submitted by WHO for funding.

Recommendations

With the utmost concern, the gGLC and Core Group noted the lack of a comprehensive and coordinated global advocacy strategy and regional specific strategies, worsened by inadequate advocacy funding for PMDT, and strongly recommend:

- The prompt development of advocacy plans at the global level by TBP and subsequently at the regional level by the respective rGLCs for stronger advocacy for PMDT expansion:

  - Including a focus on countries identified on the basis of highest potential of progress, funding availability and local commitment
  - Prioritization of advocacy targets and recommendations to be taken up by rGLCs
  - Highlighting the potential lives saved with additional funding; and
- Wide dissemination of success stories collated by rGLCs (TBP, gGLC).

Session 2: To provide an update on progress and achievements of the respective rGLCs in supporting MDR-TB management scale-up

The session included presentations from the respective rGLCs on progress made since the establishment of these committees. The rGLCs for all six regions and the secretariats for the African, American, European, Eastern Mediterranean, South-East Asian and Western Pacific Regions are now established and operational. Dr Domingo Palmero, Chair AMR rGLC, Dr Essam Elmoghazy, Chair EMR rGLC, Dr Andrey Maryandyshev, Chair EUR rGLC, and Dr Lee Reichman, Chair WPR rGLC, provided updates on the activities of the respective rGLCs. Reports from AFR rGLC was presented by Dr Daniel Kibuga and from SEAR rGLC by Dr Rim Kwang on behalf of their respective rGLC Chairs.

AFR rGLC

The AFRO rGLC has recently been constituted and the first meeting is expected to be held in July 2013. The first meeting will nominate a Chair and agree on standardized reporting and missions for the next year. In the meantime, the monitoring and TA missions are being undertaken in countries regularly, either as stand-alone PMDT missions or in combination with wider programme reviews. When a review is planned, it is ensured that a review member of the team is assigned to specifically address GLC and PMDT issues and feed into the wider programme review.

Key issues:

- Availability of 2nd line medicines.
- Slow pace of enrolment of patients in some countries. Specifically Nigeria is a high burden country with slow uptake.
- TB control in the mining industry, especially in South Africa.

AMR rGLC

- In July 2011, an “ad hoc” AMR rGLC, with 9 members plus 2 NTP managers as observers (Brazil and Salvador), was constituted in Guatemala City. At the end of October 2012, an open call was released for new members to a “regular” r-GLC (for a 2 + optional 2 years period). Among the applicants, eight (7 technical and 1 Civil Society member) were selected by a panel composed of members of PAHO, WHO and partners. A body of procedures, standardized forms for monitoring and consultants were created. Monitoring and TA visits were actively conducted during the last year and half. A renewed r-GLC-AMERICAS, with a mix of old and new members, is starting the activities, with the first meeting expected in May 2013.

Key issues:

- Need of updated expansion plans from most of the countries and updated guidelines (DR-TB management, infection control).
- Case detection: Implementation of rapid molecular techniques required.
- Implementation of infection control measures.
- Supply of SLDs in a timely manner.

- Need for increased TA for to support countries with development of Guidelines, implementation of infection control measures, and increased case detection.
- Continuation of training activities in drug management, and continued work with the PAHO Strategic Fund and/or GDF.
- Fulfilling the financial gaps mainly through governmental funds.

EMR rGLC

The first EMR-rGLC committee meeting was held in December 2012, with the election of chair and co-chair of the EMR-GLC in February 2013. Preparations are underway for the 2nd EMR rGLC meeting, planned in May 2013. Regular monitoring and TA missions are being conducted. A regional MDR-TB training course on community based PMDT and ethical consideration was held from 10-14 June 2012. The secretariat has provided support to Afghanistan, Egypt, Pakistan, Somalia, South Sudan and Yemen to finalize DRS plans and protocols. Training of nationals in Iraq, Somalia, South Sudan and Pakistan has been undertaken in 2012.

Key issues:

- Limited laboratory capacity
    - Culture and DST is not available in Somalia and South Sudan
    - New diagnostics: Most of the countries in the region have not introduced the new diagnostics widely.
    - DR survey and surveillance:
        - Updated surveys are needed in Iraq, Iran, Pakistan, Sudan, and Syria.
        - Expanded continuous surveillance in 12 countries implementing PMDT
        - Document/report results of DR surveillance that is on-going in GCC countries.
- GCC countries (including Yemen), and Libya, do not have proper MDR management yet.
- During 2011-2012, there were significant delays in expanding PMDT due to disturbed security situation in most of the countries in the region.
- Problems in drug procurement due to:
    - Financial gaps (Somalia, South Sudan, and Yemen),
    - Limited availability of certain 2nd line drugs (Egypt, Lebanon)
        - Delay in procurement (Afghanistan, Pakistan, and Syria),
        - Shortages due to refugees and security reasons (Lebanon, Jordan, and Syria).
- Expected financial gap to support scaling up MDR-TB activities in most countries, particularly in Djibouti, Egypt, and Pakistan.
- Limited human resources at country level (MDR local support on continuous basis is needed in Afghanistan, Iraq, Pakistan and Sudan mainly).
- Limited consultancy capacity in the region in general (a team of 5 consultants was established last year to support countries)