3rd Global GLC meeting
World Health Organization, Geneva, Switzerland, 17-19 October 2012
Meeting report

WHO/HTM/TB/2012.13

Contents

Welcome of participants

Dr Karin Weyer, Co-ordinator, LDR Unit, STB, WHO, and Aamir Khan, Chair, MDR-TB Working Group, Stop TB Partnership, welcomed all the members to the third gGLC meeting. The global discussions on MDR-TB have significantly moved forwards from the earlier ones on procedural issues to the crucial topic of how the global framework and partners are to support the countries in their efforts to scale-up MDR-TB services and management. To plan for the next steps on the moving forwards with global support to scale-up MDR-TB services and care, the members of the MDR-TB Working Group's Core Group have been invited to attend the 3rd gGLC meeting and were welcomed to the meeting. On the morning of 19 October 2012, the plan is hold a joint gGLC and Core Group meeting to further discuss the way forward.

Members were reminded of the need during the meeting to focus on the important strategic issues such as: access to diagnostics; access to quality assured second line drugs (SLD) and the market dynamics related to SLDs; and issues with treatment regimens for R-resistant and MDR-TB cases. These and other issues were to be discussed during the meeting, and WHO is looking forward to the gGLC's advice.

Declaration of Interests

Chuck Daley, Chair of the gGLC, thanked the speakers and all participants introduced themselves. Interests were declared and discussed. No conflict of interest was identified.

Meeting objectives

The objectives of the 3rd gGLC meeting were presented, namely:

- To provide an update on progress and achievements of the rGLCs in supporting MDR-TB management scale-up
- To provide an update on WHO Expert Group meetings, consultations and proposed new policies
- To provide an update on the Global Drug Facility and drug availability
- To provide advice on treatment regimens for R-resistant TB patients
- To provide an update on "short" regimens for MDR-TB treatment, and to present WHO's position and action
- To discuss the "Moving Forwards" on global support to scale-up MDR-TB services and care

Session 1 – Report from the gGLC Secretariat

Objective: To follow up on recommendations made and action points agreed upon during the 2nd gGLC meeting

Dr Fraser Wares, gGLC Secretariat, presented the global position of MDR-TB and scale-up of services, and progress made in implementing the recommendations and action points from the 2nd gGLC meeting.

In 2010, the Stop TB Partnership launched its Global Plan to Stop TB (GPSTB), 2011-2015 having, as an ultimate focus, the elimination of TB in the world by 2050. The plan has important implications for the funding of MDR-TB activities to detect patients, notify them and place them on adequate treatment. The plan includes 6 objectives aimed at reducing the global burden of drug-resistant TB with intermediate targets to be reached by 2015.

In 2011, it was estimated that the global incidence of TB was 125 cases per 100,000 population, with most cases occurring in Asia (59%), and Africa (26%). Out of the 12 million (10-13 m) prevalent TB cases, around 630,000 were estimated to be multidrug-resistant, with over 60% of cases estimated to occur in Brazil, China, India, the Russian Federation and South Africa. When it comes to MDR-TB incidence, it is difficult to conclude on global or regional trends as a result of incomplete data on the frequency of MDR among TB cases. For some countries (e.g. Latvia and USA) and regions (e.g. Orel and Tomsk in the Russian Federation), time trends based on observations over several years indicate a decrease in MDR-TB frequency of late, while in others (e.g. Botswana and Swaziland) there appears to be an increase.

Another cause of concern is that the highest levels of MDR-TB ever reported occurred in recent years. In Belarus, parts of the Russian Federation, and in Uzbekistan, more than 1/5 of new TB cases now have MDR-TB. Swaziland reported the highest level of primary MDR-TB ever reported in Africa in 2009 (7.7%). While MDR-TB occurs in about 3.7% (95% CI 2.1%-5.2%) of new TB patients, levels are much higher in those previously treated – 20% (95% CI 13%-26%). There has been important progress in recent years in the global coverage of data on anti-TB drug resistance. To date, 135 countries have data from at least one representative survey or, in the case of 63 countries, from good-quality continuous surveillance systems. By early 2013, it is expected that all high TB and high MDR-TB burden countries will have baseline data on drug-resistance.

By 2011, 21 of the 36 countries with either a high burden of TB or MDR-TB had at least 1 laboratory capable of performing culture for tuberculosis per 5 million population. The Global Plan target for 2015 is that all 36 countries reach the minimum threshold. In most of the countries in Africa and the Indian sub-continent, the coverage is particularly low, while conversely many of the countries in eastern Europe are over-provided raising concerns about the quality of analyses performed. Of the 36 countries, 9 reported >1 laboratory / 5 million population using line probe assay to detect rifampicin and isoniazid resistance.

Globally 4% of new bacteriologically positive TB cases were reported to have tested for drug-susceptibility (DST) in 2011, far short of the 20% target set for 2015 by the Global Plan. The low score is partly due to a lack of sufficient access of TB patients to (DST). Another reason could be low capture of results from laboratories owing to inadequate TB information systems. DST coverage is higher among retreatment cases than among new cases but still distant from the 100% overall target of by 2015. In the European Region, while the coverage in new cases has exceeded the 20% level targeted by the Global Plan (56%), incomplete reporting on certain categories of retreatment cases is common in

the Russian Federation and elsewhere, and as a result the overall coverage among retreatment cases is low (27%).

About 9% (6.7-11.2%) of MDR-TB cases in countries with representative surveillance data have additional resistance to a fluoroquinolone and a 2nd line injectable agent (extensively drug resistance; XDR-TB). The detection of XDR-TB is important for programme management and 2nd line DST is recommended for all confirmed MDR-TB patients. In 2010, only 23% of MDR-TB patients were reported with a test result. The high coverage in Africa drops to 9% without the data from South Africa. Under-reporting of test results accounts for a large degree of the low coverage in certain Regions. By October 2012, 84 countries had reported at least one case of XDR-TB. Coverage of testing for second-line DST among MDR-TB cases is particularly low in the African continent as a result of low capacity for testing.

A substantial increase in the notification of MDR-TB cases and their enrolment on treatment occurred between 2009 (30,485) and 2011 (55,597). Notifications in 2011 were however less than a half of what was aimed for in the Global Plan and represents less than a fifth of the estimated burden of cases which could have been detected had DST been accessible to all TB cases notified in the world. Regional variations are large and coverage is lowest in the regions where the large majority of TB cases occur.

The proportion of MDR-TB patients with a successful treatment outcome varied substantially between countries, and averaged to about 48% globally. Of the 107 countries reporting outcomes, only 30 achieved or exceeded the Global Plan target of 75% success.

In 2015, it is estimated that USD $2 billion will be required for the diagnosis and treatment of MDR-TB. Funding available for MDR-TB has increased from USD $0.5 billion in 2009 to USD $0.6 billion in 2011 in countries with data (representing 75% of estimated MDR-TB cases in the world). Costs for second-line drugs alone amount to USD $0.3 billion a year. Funding for MDR-TB has however been increasing in all country groups and is expected to total USD $0.7 billion in 2013, much of which is accounted for by the “BRICS” countries. Low- and lower middle-income countries estimate a funding gap of about one third of their MDR-TB budget in 2013. About 85% of available funding is currently concentrated in the 27 high MDR-TB burden countries. There is domestic capacity to fund the investments needed for basic TB care and control in the BRICS countries. An increase in domestic allocations for TB care and control in line with forecast growth in GDP per capita would be sufficient to mobilize the funding needed for diagnosis and treatment of MDR-TB in BRCS. In India, without growth in domestic allocations for TB above forecast growth in GDP per capita, about USD $0.1 billion per year is needed from donor sources. 14 countries not in the list of 22 HBCs but are in the list of 27 high MDR-TB burden countries are all European countries. 6 are UMICs and 1 is a HIC. Of the 7 LICs and LMICs, domestic funds may be adequate if rationalization of hospital care is done. The 17 non-BRICS HBCs need donor funding of USD $0.3-0.5 billion per year to reach the GPSTB targets. LICs need USD $0.2-0.3 billion per year, of which

USD $0.1-0.2 billion per year is in countries outside of the 22 HBCs. Additional investments are needed to scale-up rapid molecular diagnostics

Progress and achievements made since the 2nd meeting was presented following the 6 points under the "Global Framework for Management of MDR-TB", namely:

1. Technical support
i. 4 rGLCs are fully operational; the rGLCs in AFR and EMR are expected to be operational in the coming months (see **Session 2**).
ii. From October 2011 to September 2012:

- 75 monitoring and technical assistance (TA) missions for MDR-TB management capacity building to 67 countries were carried out;
- TA was provided to 14 countries for the design and implementation of surveys and surveillance to monitor the magnitude of anti-TB drug resistance;
- TA was provided to 8 countries to reinforce the recording and reporting of drug-resistant TB care;
- TA was provided to 9 countries for the development, implementation or monitoring of infection control guidelines; and
- TA was provided to 35 countries in relation to country-specific TB diagnostics capacity building needs.

iii. Case study of 12 countries on-going to identify bottlenecks and delays in scale-up of MDR-TB services, and recommend solutions to tackle the identified bottlenecks and delays. Findings will be presented at the 4th gGLC meeting.

2. Second-line anti-TB drugs
i. Since July 2011, there has been direct access to GDF for procurement of QA SLDs. It is also possible to procure partial regimens through GDF, with the proviso that the SLDs supplied are used only in conjunction with QA drugs.
ii. From September 2011 to October 2012, orders for SLDs were received by GDF from 72 countries. To date, almost 29,000 patient MDR-TB treatments have been supplied in 2012 (c.f. 2011: 19,605 supplied).
iii. Updates on GDF and status on SLDs, and on clofazimine provided during **Session 5**.

3. Advocacy
i. There has been limited progress on the development of the comprehensive advocacy strategy to support the expansion of DR-TB management as supported by the gGLC. This was for further discussion in the **Sessions 9 and 10**.
ii. Two chapters dedicated respectively to "Drug-resistant TB" and "Diagnostics and laboratory strengthening" were included in the 2012 WHO Annual TB Control Report. The report was launched in October 2012. For 2012, this replaced the request from the gGLC for WHO to produce annual MDR-TB progress reports until 2015.

4. Monitoring and Evaluation
In addition to the wealth of information and data included in the 2012 WHO Annual TB Control Report:

i. The respective rGLCs have planned and implemented annual monitoring missions for 2012. The 2013 plans will be developed in the coming months
ii. Monitoring missions were undertaken to 51 countries from October 2011 to September 2012.
iii. A progress report on the WHA Resolution 62.15 was provided to the WHO Executive Board meeting (January 2012) and to the World Health Assembly (May 2012).
iv. The timeliness of submission of reports appears to be still a challenge, and the respective rGLCs were requested to comment further on this matter **(Session 2)**. In view of the crucial role played by the Global Fund (TGF) in supporting much of the monitoring activities under the GLC Initiative, the timely submission of reports will become even more important with the signing of the new Memorandum of Understanding between TGF AND WHO, and the increased imperative of TGF to provide evidence for "value for money" of all funds disbursed.
v. In 2012, the LDR and TME Units, STB, have "systematised" the six-monthly collection of "early" data on three indicators: (i) notified MDR-TB cases; and enrolments on (ii) MDR-TB and (iii) XDR-TB treatment, from 32 priority countries. To date, 26 countries had reported.
vi. The development of plan for the evaluation of the Global Framework is pending. This needs further discussion and advice from the gGLC and rGLCs.

5. Policy and Guidelines
i. Acceleration in diagnostics:

- The Guidance for Xpert MTB/RIF implementation is being refined based on the increasing evidence on the use of WHO-recommended diagnostic and clinical algorithms in different epidemiological and health care settings, following "Early Implementers" meeting, April 2012; and
- Guidance on 2nd line DST from EGM, March 2012. **(Session 4)**
- Increased access to new diagnostics and laboratory strengthening (GLI, and EXPAND-TB and TBXpert projects – **Session 8**).

ii. An updated version of the MDR-TB Planning Tool, developed jointly between PATH and WHO, is available at www.path.org/publications/detail.php?i=1678.
iii. Treatment Guidelines:

- A technical consultation on "TDR-TB" was held by WHO in March 2012 **(Session 4)**.