Report of the second meeting of the WHO Task Force on XDR-TB

WHO headquarters, Geneva, Switzerland
9–10 April 2008

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Summary

The second meeting of the WHO Task Force on XDR-TB was held on 9–10 April 2008 at the headquarters of the World Health Organization (WHO) in Geneva, Switzerland. Some 93 participants attended the meeting, representing countries, bilateral and multilateral agencies, international organizations, nongovernmental organizations, the pharmaceutical industry and academia (Annex 1). The objectives of the meeting were to review progress in implementing the recommendations of the first XDR-TB Task Force Meeting (Geneva, October 2006), to assess progress in implementing the Global MDR-TB and XDR-TB Response Plan 2007–2008 and to agree on steps to accelerate its implementation.

The meeting was structured around five sessions: (i) assessing progress; (ii) new evidence, updated guidelines; (iii) accelerating scale up of the response to MDR-TB and XDR-TB; (iv) mobilizing resources for universal access to MDR-TB diagnosis and treatment by 2015; and (v) recommendations.

Major progress was reported on several fronts:

- Peru had become the first low-resource setting reporting universal access to diagnosis of multidrug-resistant tuberculosis (MDR-TB) and treatment of MDR-TB patients.
- WHO guidelines for the management of drug-resistant TB (DR-TB) had been updated.
- The Global Laboratory Initiative was leading the strengthening of laboratory capacity.
- Line-probe assays had been successfully evaluated in South Africa.
- The Global Drug Facility was making progress in addressing the procurement crisis.
- Epidemiological research indicated that poor TB control in KwaZulu Natal in 1994–2002, nosocomial spread and poor infection control were the most likely explanation for the outbreak of extensively drug-resistant TB (XDR-TB) in Tugela Ferry.
- Evidence had emerged that MDR-TB could be managed in very difficult circumstances, such as settings with high HIV prevalence, but that it involved major ethical and legal challenges.

An overview of progress in 27 high-priority MDR-TB countries, however, showed enormous gaps, with the number of patients on treatment well below targets. The chief recommendations of the Task Force were:

- WHO and the Stop TB Partnership to convene a meeting with high-level officials of **all** 27 high-priority countries early in 2009:
  - to present progress achieved by the 27 high-priority countries in the programmatic management of MDR-TB;
  - to discuss and identify the main factors hampering progress;
  - to foster and support the development of medium-term plans for scaling-up the programmatic management of MDR-TB that will address the obstacles to progress;

  - to secure political commitment for the urgent scale-up of MDR-TB management.

- Countries to involve all health-care providers in the global response to MDR-TB and XDR-TB.

- MDR-TB Working Group to develop further the framework of Centres of Excellence for promoting development of human resources in MDR-TB management.

- WHO to produce training modules for the programmatic management of DR-TB and make them available as quickly as possible.

- WHO to provide guidance on implementation of line-probe assays for MDR-TB within specific country settings.

- WHO to produce and disseminate practical guidance on ethical and legal issues to support patient-centred TB care, including community-based MDR-TB care.

- The 27 priority countries to produce comprehensive national response plans to MDR-TB/XDR-TB, with the support of WHO and the Stop TB Partnership.

Meeting objectives

The objectives of the second WHO XDR-TB Task Force meeting were:

- To create awareness of, and political support for, the global emergency of MDR-TB and XDR-TB in order to plan a more accelerated response by countries and partner organizations.
- To review the current status of TB control and antituberculosis drug resistance surveillance in the world in 2008.
- To examine the progress made by countries in scaling-up MDR-TB control according to the Global Plan to Stop TB, 2006–2015[1] and to make decisions about ways of accelerating control activities.
- To identify bottlenecks hampering scale-up of the MDR-TB and XDR-TB response, including management of human resources, laboratory capacity, drug procurement, financial resources and political commitment, and agree on mechanisms to address these issues.
- To examine ways of scaling up the use of new technologies, diagnostic tools, infection control systems and updated WHO guidelines on the programmatic management of DR-TB.

Session 1 Assessing progress

Taking stock of the progress made in implementing the global response to MDR-TB and XDR-TB, the task force noted that many positive developments had taken place since its first meeting, including significant progress in drug procurement, improving laboratory capacity, infection control, availability of resources, and new drugs and diagnostics. The increased demand for services from the Green Light Committee (GLC) has contributed to expansion in the number of GLC-approved projects. There is generally greater global awareness of MDR-TB and XDR-TB issues.

Many challenges remain, however, with too few patients being effectively diagnosed and the number of patients on treatment well below targets. External funding for the response mostly targets the African Region and not the Eastern European Region where the highest prevalence rate of DR-TB cases occurs. India and China were highlighted as having the highest burden of cases and need to do more.

The experience presented at the meeting by the National TB Control Programme of the Philippines revealed the need for standardized training modules for the programmatic management of DR-TB, in order to facilitate the development and strengthening of human resources.

The Russian Federation showed a successful model for expanding quality assurance for TB culture and drug susceptibility testing (DST), whereby external quality assurance is coordinated outside of the national reference laboratory system (taking the burden off the national laboratory system) with assistance of the supranational reference laboratory for DST. The constraints experienced in the Russian Federation include the human resources capacity at all levels with reported shortage of young

[1] Stop TB Partnership. *The Global Plan to Stop TB, 2006–2015*. Geneva, World Health Organization, 2006 (WHO/HTM/STB/2006.35).

staff, infrastructure and biosafety problems, as well as shortage of funds for external quality assurance.

South Africa reported significant progress in integrating infection control into MDR-TB and XDR-TB management, with infection control guidelines adopted, containment, infection prevention and control policy in place and infection control officers appointed. Training and training material have been prepared for several groups and a risk assessment performed in five out of nine MDR-TB hospitals. A new risk assessment tool is being developed. However, a more comprehensive strategy to integrate infection control is needed, and training on infection control needs to be formalized as a discipline. Further community education and improved infrastructure are required.

With regard to the availability of new drugs, the TB Alliance informed the meeting that seven products are being evaluated (two in phase I, three in phase II, and two in phase III).

Peru presented its unique experience in capacity building to provide universal access (at least 80% of population covered) for diagnosis and treatment of MDR-TB. The overview of the scale up and financing of MDR-TB in Peru revealed that financing shifted from Partners In Health, at its early stage, to the Global Fund and finally to the government over a 10-year period. The important elements of ensuring this successful experience, which could be replicated by other countries, have been the role of civil society, GLC involvement, coordination of support from technical agencies, support from major donors such as the Global Fund and strong political commitment from the government.

The session concluded by reviewing an analysis of gaps in the response to MDR-TB and XDR-TB at national level. An overview of progress in the 27 high priority MDR-TB countries showed enormous gaps. The meeting noted an urgent need to scale up the response and the importance of seizing the opportunity at a time when donors were willing to contribute and when momentum is high.

Session 2 New evidence, updated guidelines

The fourth report of the WHO/IUATLD Global Project on Antituberculosis Drug Resistance Surveillance, published in February 2008,[1] reveals the highest rates of